

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER INFINITY CARE OF EAST LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP CODE 101 S FICKETT STREET LOS ANGELES, CA 90033	
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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint and an Facility Reported Incident (FRI) during an Annual Recertification Survey conducted on 6/12/2025. FRI Number: CA00966074 Complaint Number: CA00967030 Total Resident Population: 88 Total Resident Sample Size: 23 Highest scope and severity: E FRI Number: CA00966074: Refer to F tag F609 Complaint Number: CA00967030: Refer to F tag F880	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550	Immediate Corrective Action for resident affected by this deficient practice On 6/12/25, Administrator ordered 4 Height Adjustable Stools to provide to Staff to better assist them with providing meals to the residents in a dignified manner. Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken; On 6/13/25, DON did rounds with DSD and found 9 other residents who are assisted with meals by CNAs, all were observed sitting down at eye level and exchanging rapport and socializing in a dignified manner.	06/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Valerie Deerwester, RN, DON

TITLE

DIRECTOR OF NURSING

(X6) DATE

07/07/25

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 550	<p>Continued From page 2</p> <p>During a review of Resident 24's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 4/3/2024, with diagnosis of dementia (a progressive state of decline in mental abilities), sacral pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and pressure ulcer of right and left heel.</p> <p>During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 4/10/2025, indicated Resident 24's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 24 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>During a review of Resident 24's care plan that focuses on Resident 24 at risk for dehydration (dangerous loss of body fluid caused by illness, sweating, or inadequate intake) and dependence on staff for Activities of Daily Living (ADLs-activities such as bathing, dressing and toileting a person performs daily), initiated on 10/10/2024, the Care Plan indicated the staff interventions included were to assist at mealtime and for all food and fluids offerings.</p> <p>During an observation on 6/10/2025 at 12:26 PM in Resident 24's room, CNA 5 was observed assisting Resident 24 in bed with lunch meal. CNA 5 was observed standing on the right side of the bed and above Resident 24's eye level while</p>	F 550			

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F 550	<p>Continued From page 3</p> <p>feeding the resident's lunch meal.</p> <p>During a concurrent observation and interview on 6/10/2025 at 12:28 with Licensed Vocational Nurse 6 (LVN 6), in Resident 24's room, LVN 6 verified CNA 5 was standing while feeding Resident 24. LVN 6 also stated CNA 5 and Resident 24 were not in the same eye level.</p> <p>During an interview on 6/10/2025 at 2:30 PM with CNA 5, CNA 5 stated she did not sit in a chair while assisting Resident 24 with lunch meal because she is short, and it will be hard for her to reach Resident 24 when she is in sitting position.</p> <p>During an interview on 6/11/2025 at 1:52 PM with LVN 2, LVN 2 stated staff need to maintain eye level, talk to the residents, and tell them what food they are giving when providing assistance with feeding.</p> <p>During an interview on 6/12/2-25 at 11:47 AM with Registered Nurse 1 (RN 1), RN 1 stated staff need to sit down and be at an eye level with the residents to establish rapport and to show respect. RN 1 stated, "It is a different perspective when you are eye level with another person, instead of being looked down at." RN1 also stated, "There is a risk of resident's aspiration when the staff assisting is higher than resident."</p> <p>During a review of the facility's undated policy and procedure (P&P) titled, "Quality of Life-Dignity," the P&P indicated, "Each resident shall be cared for in a manner that promote, and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem." It also indicated "Residents are treated with dignity and respect at all times."</p>	F 550			

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F 550	Continued From page 4	F 550			
F 584 SS=E	<p>During a review of facility's P&P titled, "Assistance with Meals", revised in March 2022, indicated "Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for not standing over residents while assisting them with meals."</p> <p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p>	F 584	<p>Immediate Corrective Action</p> <p>a. The plastic bag tying resident 33's closet was removed by the Maintenance Supervisor on 6/9/25.</p> <p>b. The Housekeeping Supervisor replaced the worn-out bedsheet of resident 55 on 6/9/25.</p> <p>c. The Maintenance Supervisor installed a towel rack on 6/17/25 in the shared restroom for Residents 37 and 57. On 6/17/25, the Maintenance Supervisor patched the ceiling of the restroom for Residents 37 and 57.</p> <p>d. On 6/18/25, the Maintenance Supervisor painted the wall for resident 64, near to the head of the resident bed.</p> <p>e. The Maintenance Supervisor replaced on 6/9/25 Resident 7's rollator with a newer one.</p> <p>f. The Maintenance Supervisor replaced on 6/9/25 Resident 66's wheelchair with a newer one.</p> <p>Corrective Action for Others Affected</p> <p>a. On 6/16/25, the Maintenance Supervisor began daily rounds and found no other residents affected by the deficient practice related to paint and wheelchairs and rollators.</p>	06/16/25	

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F 584	Continued From page 5 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, and home like environment for seven (7) of 7 sampled residents (Residents 7, 33, 55, 37, 57, 64, and 66) when facility failed to ensure: 1. Resident 33's closet handle was not tied using a plastic bag. 2. Resident 55's bed sheet was not worn out and discolored. 3. and 4. Residents 37 and 57's shared restroom had a rack to hang towels, and the ceiling paint was not peeled off. 5. Resident 64's room wall next to the resident's head of bed area was free of multiple scratches. 6. Resident 7 was provided with a rollator walker's (a mobility aid, essentially a wheeled walker, that provides support and stability for individuals with walking difficulties. Unlike traditional walkers, rollators have wheels [usually four], often a seat, and hand brakes, allowing for easier movement and the ability to rest without needing to lift the device) cushion that was well repaired and not chipped. 7. Resident 66 was provided with a wheelchair in good working condition.	F 584	Measures Taken to Prevent Reoccurrence a. The Administrator in-serviced the Housekeeping Director on 6/16/2025 regarding quality control in the distribution of linens. b. The DSD in-serviced the CNA staff on 6/16/2025 regarding safe clean comfortable home like environment. c. The Administrator in-serviced the Maintenance Supervisor on 6/17/25 regarding proper maintenance of wheelchairs, walkers, and rollators. Performance Monitoring to Ensure that Solutions are Sustained. a. Beginning 6/16/25, The DSD shall make random rounds monthly, for the next 3 months, and check 5 random rooms to make sure that resident are using good quality linens being. b. Beginning 7/01/25, The Maintenance Supervisor will report monthly to the Administrator status of painting and patching for the next 3 months.	6/17/25	

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F 584	<p>Continued From page 6</p> <p>These deficient practices had the potential to result in discomfort, injury, and violate resident's right to be treated with dignity to Residents 7, 33, 55, 37, 57, 64, and 66, which had the potential to negatively affect the residents' overall well-being and quality of life.</p> <p>Findings:</p> <p>1. During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 was originally admitted to the facility on 3/6/2023 and readmitted on 6/6/2025. Resident 33's diagnoses included type 2 diabetes mellitus (a medication condition characterized by the body's inability to regulate blood sugar level), muscle weakness in general, and lack of coordination.</p> <p>During a review of Resident 33's Minimum Data Set (MDS- resident assessment tool), dated 4/29/2025, the MDS indicated Resident 33's cognitive skill (ability to understand and make decisions) for daily decision making was moderately impaired. The MDS also indicated Resident 33 was assessed to require partial/moderate assistance (helper does less than half the effort) with shower/bathe self, lower body dressing, and putting on/taking off footwear.</p> <p>During an interview and observation, on 6/9/2025 at 11:10 AM, in Resident 33's room, Resident 33's closet handle was observed with a clear plastic trash bag tied around it. Resident 33 stated, "I used the trash bag to make a loop as an extension, to make it easier to open the closet door."</p>	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 584	<p>Continued From page 7</p> <p>During a concurrent observation and interview, on 6/10/2025 at 9:46 AM, in Resident 33's room with Director of Staff Development (DSD), DSD stated, "It poses a safety risk for residents, as residents could get caught in the trash bag loop and injure themselves." DSD stated, "Maintenance Supervisor (unable to give a name) will replace the trash bag with the proper handle for Resident 33."</p> <p>2. During a review of Resident 55's Admission Record, the Admission Record indicated Resident 55 was originally admitted to the facility on 3/6/2023 and readmitted on 9/23/2024. Resident 55's diagnoses included encephalopathy (brain disease that alters brain function or structure), cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area), and lack of coordination.</p> <p>During a review of Resident 55's MDS, dated 4/2/2025, the MDS indicated Resident 55's cognitive skill for daily decision making was moderately impaired. The MDS also indicated Resident 55 was assessed to require supervision or assistance (Helper provides verbal cues and touching/steadying and/or contact guard assistance as resident completes activity) with shower/bathe self. The MDS indicated Resident 55 was assessed to require setup or clean-up assistance (helper sets up or clean up, resident completes activity) with toilet hygiene, personal hygiene, and eating.</p> <p>During an observation on 6/9/2025 at 11:06 AM, in the Resident 55's room, Resident 55's bedsheet was observed worn-out, thin and can be seen through the mattress, discolored, and old.</p>	F 584			

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F 584	<p>Continued From page 8</p> <p>During a concurrent observation and interview with the Licensed Vocational Nurse 7 (LVN 7), on 6/10/2025 at 11:08 AM, in Resident 55's room, LVN 7 confirmed the bed sheet was old, worn out, and was discolored. LVN 7 stated the bed sheet needed to be replaced and disposed.</p> <p>3. and 4. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was originally admitted to the facility on 11/4/2023 and readmitted on 9/7/2024. Resident 37's diagnoses included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), encephalopathy, and lack of coordination.</p> <p>During a review of Resident 37's MDS, dated 3/19/2025, the MDS indicated Resident 37's cognitive skill for daily decision making was moderately impaired. The MDS also indicated Resident 37 was assessed to require with toilet hygiene, shower/bathe self, and personal hygiene. The MDS also indicated Resident 37 normally used walker and wheelchair.</p> <p>During a review of Resident 57's Admission Record, the Admission Record indicated Resident 57 was originally admitted to the facility on 11/22/2023 and readmitted on 8/1/2024. Resident 57's diagnoses included cardiomegaly (an enlarged heart), muscle wasting and atrophy (the decrease in size and strength of muscle tissue), and lack of coordination.</p> <p>During a review of Resident 57's MDS, dated 5/9/2025, the MDS indicated Resident 57's cognitive skill for daily decision making was</p>	F 584			

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F 584	<p>Continued From page 9</p> <p>intact. The MDS also indicated Resident 57 was assessed to require supervision or assistance with shower/bathe self and required setup or clean-up assistance with eating and personal hygiene.</p> <p>During a concurrent observation and interview, on 6/9/2025 at 11:43 AM, in Residents 37 and 57's shared restroom, a white hand towel was observed hanging on top of the soap dispenser above the sink. There were two other white hand towels observed hanging on the toilet paper holder and on top of the shower hose. The restroom's ceiling was also observed with peeled off paint. Resident 37 stated she wished the facility made a towel rack for them.</p> <p>During the same interview, on 6/9/2025 at 11:43 AM, Resident 57 stated it was not safe for Resident 37 to reach for the towels that were hanging on the shower hose. Resident 57 stated having towels hung everywhere were unsanitary.</p> <p>During an interviewed with DSD, on 6/10/2025 at 8:25 AM, in the Residents 37 and 57's shared bathroom, DSD stated Resident 37 needed assistance from sit to stand position and it was unsafe for the resident to reach for the towels. DSD stated it was unsanitary and disorganized to have the towels hung everywhere especially by the toilet. DSD stated it was not homelike to have paint peeling off the ceiling of Resident 37 and 57's bathroom.</p> <p>5. During a review of Resident 64's Admission Record, the Admission Record indicated Resident 64 was admitted to the facility on 10/27/24 and readmitted on 4/26/2025 with diagnoses that included dementia (the loss of cognitive</p>	F 584			

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F 584	<p>Continued From page 10</p> <p>functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) muscle weakness (a reduced ability of one or more muscles to generate force, making it harder to perform tasks that require strength), and ataxic gait (awkward, uncoordinated walking).</p> <p>During a review of Resident 64's MDS, dated 5/7/2025, the MDS indicated Resident 64 was able to understand others and made herself understood. Resident 64 was dependent, (helper does all the effort) on lower body dressing, shower, bath, toilet use, bed mobility and transfer. And moderate physical assistance with oral hygiene.</p> <p>During an observation of Resident 64's room on 6/9/2025 at 10:34 AM, Resident 64's room wall next to the resident's bed near the head area was observed to have discolorations and multiple scratches.</p> <p>During an interview with Resident 64 on 6/10/2025 at 12:26 PM in her room, Resident 64 stated the discolored and scratched wall makes Resident 64 feel disgusted.</p> <p>During an interview with Maintenance Director (MD) on 6/10/25, at 3:33 PM, MD stated the discoloration, and scratches may have been caused by the bed hitting the wall. MD stated this is not a homelike environment for the residents. MD stated the residents like it when everything in the resident's room is fixed and homelike.</p> <p>6. During a review of Resident 7's Admission Record, the Admission Record indicated Resident</p>	F 584			

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F 584	<p>Continued From page 11</p> <p>7 was initially admitted to the facility on 10/18/2023 with diagnoses that included ataxic gait (awkward, uncoordinated walking), thrombocytopenia), alzheimer's disease (a progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), and type II diabetes mellitus.</p> <p>During a review of Resident 7's MDS, dated 3/20/2025, the MDS indicated Resident 7 needed supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for eating, eating, oral hygiene, toileting hygiene, shower/bathe self, change of position, and transfer.</p> <p>During an observation of Resident 7's room on 6/9/2025 at 10:36 AM, Resident 7's rollator walker's seat cushion cover was chipped with exposed yellow cushions or foam from inside with two big hole measuring five inches by one inch.</p> <p>During an interview with Maintenance Director (MD) on 6/10/25, at 3:35 PM, MD stated he was not made aware of Resident 7's chipped seat cushion. MD stated the nurses should have reported it to him so that he could have fixed it. MD stated all the wheelchairs should be maintained and in good repair to ensure they are all properly functioning.</p> <p>During a review of the facility's P&P titled, "Homelike Environment," revised 3/2024, the P&P indicated the Facility will provide residents with a clean, sanitary and orderly environment.</p> <p>During a review of the facility's P&P titled,</p>	F 584			

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F 584	<p>Continued From page 12</p> <p>"Maintenance Service," revised 3/2024, the P&P indicated, "The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times." The P&P further indicated, "Functions of the Maintenance Department may include, but are not limited to maintaining the building in good repair and free from hazards."</p> <p>7. During a review of Resident 66's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 8/24/2023 and readmitted 5/31/2025 with diagnoses of polyneuropathies (nerve damage affecting many different nerves throughout the body) and difficulty in walking.</p> <p>During a review of Resident 66's MDS, dated 6/3/2025, the MDS indicated the resident was cognitively intact with cognitive skills for daily decision making. Resident 66 needed substantial/maximal assistance (helper does more than half the effort) with putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). Resident 66 needed partial/moderate assistance with transfers (how resident moves to and from bed, chair, wheelchair, standing position) and upper body dressing (the ability to dress and undress above the waist) and needed supervision or touching assistance with eating.</p> <p>During a review of Resident 66's Care Plan dated 5/31/2025, the Care Plan indicated Resident 66 had a diagnosis of polyneuropathy, had potential for poor circulation, irregular pulse and shortness of breath (SOB), leg pains or edema and included an intervention to place the resident in a comfortable position in bed or in her wheelchair.</p>	F 584			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 584	<p>Continued From page 13</p> <p>During a concurrent observation and interview on 6/9/2025 at 1:23 PM with Resident 66 inside her room, Resident 66 was observed sitting in her wheelchair with the wheelchair's right armrest observed to be cracked with a piece of tape holding it together and the backrest of her wheelchair was observed to be worn down, cracked, faded and sagging down not giving any back support. Resident 66 stated her wheelchair is old, not giving the resident a back support and would like a new one.</p> <p>During a concurrent observation and interview on 6/12/2025 at 8:57 AM with Resident 66 inside her room, Resident 66's wheelchair was observed to have a crack in the right arm rest with tape holding it together, the backrest was observed to be cracked, faded and sagging down offering no back support and the edge of the seat was observed to have cracks and multiple faded areas with missing vinyl. Resident 66 stated the right armrest was wobbly and the back is sagging and old.</p> <p>During an interview on 6/12/2025 at 8:57 AM with Maintenance Supervisor (MS), MS stated when a resident's wheelchair is no longer in good repair, they replace them and further stated it is important that resident's wheelchairs are checked and replaced for resident safety.</p> <p>During a concurrent observation and interview on 6/12/2025 at 9:01 AM with MS and Resident 66 inside Resident 66's room, Resident 66's wheelchair was observed to have a cracked right armrest with tape holding it together, the backrest was observed to be faded, cracked, missing vinyl and sagging down and the edge of the seat was</p>	F 584			

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F 584	<p>Continued From page 14</p> <p>observed to be faded with areas missing vinyl. MS stated Resident 66's wheelchair is falling apart and not in good repair. Resident 66 stated she had told the Director of Staff Development (DSD) she wanted a new wheelchair around a month prior.</p> <p>During an interview on 6/12/2025 at 9:20 AM with the Director of Nursing (DON) and Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated wheelchairs should be checked once a month to ensure they are in good repair. The DON stated resident's wheelchairs need to be in good repair to prevent risk for injury and also to make sure it is functional enough for the residents to use them safely.</p> <p>During a review of the facility's P&P titled, "Quality of Life - Homelike Environment" revised May 2017, the P&P indicated, "Residents are provided with a safe, clean, comfortable and homelike environment and encourages to use their personal belongings to the extent possible." The P&P further indicated:</p> <ol style="list-style-type: none"> a. "Staff shall provide person-centered care that emphasizes the resident's comfort, independence and personal needs an preferences. b. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: <ol style="list-style-type: none"> a. Clean, sanitary and orderly environment; b. Inviting colors and decor; c. Personalized furniture and room arrangements; d. Clean bed and bath linens that are in good condition." 	F 584			

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F 584	Continued From page 15 During a review of the facility's policy and procedure (P&P) titled, "Assistive Devices and Equipment," revised February 2021, the P&P indicated, "Our facility maintains and supervises the use of assistive devices and equipment for residents." The P&P also indicated: a. "The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment. a. Device condition - devise and equipment are maintained on schedule and according to the manufacturer's instructions. Defective or worn devices are discarded or repaired."	F 584			
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604	Immediate Corrective Action for resident affected by this deficient practice; DON added on EHR Restraint-Physical assessment and attained consents and orders for residents 81,86,85,77. Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken; Admission assessment will include 19. Physical Restraint Initial/Quarterly/Annual Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur; DON and or designee will add to her Chart Review to include Restraint Physical assessment which is done initially and Quarterly, annually with IDT members	06/16/25	

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F 604	<p>Continued From page 16</p> <p>§483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure two (2) of three (3) sampled resident (Resident 81 and 86) was free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body) when the facility failed to:</p> <ol style="list-style-type: none"> 1. Conduct an assessment for Resident 81 and 86 for the use of geriatric chair (Geri chair- a large, padded, and mobile reclining chair that prevents a resident from rising). 2. Obtain a physician's order for Resident 81 and 86 for the use of Geri chair. <p>These deficient practices had the potential to result in limiting Resident 81 and 86's mobility and cause injury. This also had the potential for Resident 81 and 86 not to be being treated with respect and dignity with the use of restraints</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 81's Admission Record, the Admission Record indicated Resident 81 was admitted to the facility on 7/1/2024. It also indicated, Resident 81's diagnoses included dementia (a progressive state of decline in 	F 604	<p>Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Beginning 7/01/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance. Monthly QA discussion will occur for 3 months.</p>		

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F 604	<p>Continued From page 17</p> <p>mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and muscle weakness.</p> <p>During a review of Resident 81's Minimum Data Set (MDS, a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 81's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 81 required partial/moderate assistance (helper does less than half the effort) with upper body dressing. The MDS indicated Resident 81 required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene and personal hygiene. The MDS indicated Resident 81 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with toileting hygiene, shower/bath, upper, lower body dressing and putting on/off footwear. The MDS indicated Resident 81 uses wheelchair while in the facility.</p> <p>During an observation on 6/9/2025 at 11:29 AM, in the hallway, across nursing station 2, Resident 81 was sitting in a Geri chair.</p> <p>During an interview on 6/10/2025 at 2:49 PM with Certified Nurse Assistant 8 (CNA 8), CNA 8 stated Resident 81 is on a Geri chair when not in bed so staff can watch her due to episodes of getting out of bed and Geri chair without assistance. CNA 8 stated, in Geri chair, unlike wheelchair, Resident 81 cannot get up easily because there is limit of movement.</p> <p>During a concurrent record review and interview</p>	F 604			

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F 604	<p>Continued From page 18</p> <p>on 6/10/2025 at 3 PM with Registered Nurse Supervisor 2 (RNS 2), Resident 81's active orders were reviewed. RNS 2 stated she had seen Resident 81 in a Geri chair and verified that there was no physician's order for the use of Geri chair. RNS 2 also verified that there is no restraint assessment documentation prior to the use of Geri chair to Resident 81. RNS 2 stated Resident 81 has unpredictable movements and putting her in Geri chair will limit her movements and prevent the resident from getting up.</p> <p>2. During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted to the facility on 12/27/2024. Resident 86's diagnoses included dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease).</p> <p>During a review of Resident 86's MDS dated 4/7/2025, the MDS indicated Resident 86's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 86 required partial/moderate assistance with eating. The MDS indicated Resident 86 was dependent with oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/off footwear and personal hygiene. The MDS indicated Resident 86 uses wheelchair while in the facility.</p> <p>During an observation on 6/9/2025 at 11:30 AM, in the hallway, across nursing station 2, Resident 86 was sitting in a Geri chair.</p> <p>During an observation on 6/10/2025 at 12:24 PM,</p>	F 604			

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F 604	<p>Continued From page 19</p> <p>in Resident 86's room, Resident 86 was sitting in a Geri chair while eating lunch meal.</p> <p>During an interview on 6/10/2025 at 2:50 PM with CNA 8, she stated Resident 86 is on a Geri chair when not in bed so staff can watch her due to episodes of getting out of bed and Geri chair without assistance. CNA 8 stated that it's harder for Resident 86 to get out of the Geri chair than being in wheelchair.</p> <p>During a concurrent record review and interview on 6/10/2025 at 3:01 PM with RNS 2, Resident 86's active physician's orders and nursing assessments dated 6/10/2025 were reviewed. RNS 2 stated she had seen Resident 86 in a Geri chair and verified Resident 86 did not and should have had a physician's order for the use of Geri chair. RNS 2 stated Resident 86 did not and should have an assessment for the use of Geri chair.</p> <p>During an interview on 6/12/2025 at 11:20 AM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated that prior to use of Gerichair, the interdisciplinary team (IDT) should conduct an assessment for its use because it can be a form of restraint. RNS 1 stated a physician's order to include use and purpose of the Geri chair should be obtained prior to use. RNS 1 also stated that Gerichair is a device that limits movement, and that means it is considered as a restraint.</p> <p>During a Facility's Policy and Procedure (P&P) titled "Use of Restraints", revised in April 2017, indicated the following: " Examples of devises that are/may be considered physical restraints include Geri chairs. " Prior to placing a resident in restraints, there</p>	F 604			

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F 605	<p>Continued From page 21</p> <p>affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.</p> <p>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these</p>	F 605	<p>Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur; DON added new Template Program labeled: Order Listing Report , to monitor PRN Psychotropic drug to include active PRN Psychotropic drug and DON and or designee will run daily. Included Instructions to audit PRN psychotropic drugs. Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Beginning 7/01/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings to ensure total compliance is achieved. Monthly QA discussion will occur for 3 months.</p>	07/01/25	

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F 605	<p>Continued From page 22</p> <p>drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two (2) of six (6) sampled residents (Resident 85 and 86) was free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure (P&P) by failing to ensure Resident 85 and 86's Lorazepam (medication used to treat anxiety [persistent and excessive worry that interferes with daily activities) as needed (PRN) order was discontinued after 14 days from the order date.</p> <p>This deficient practice had the potential to place Resident 85 and 86 at risk for significant adverse</p>	F 605			

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F 605	<p>Continued From page 23</p> <p>consequences from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status.</p> <p>Findings:</p> <p>1. During a review of Resident 85's Admission Record, the Admission Record indicated Resident 85 was admitted to the facility on 1/13/2025. Resident 85's diagnoses included dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease).</p> <p>During a review of Resident 85's MDS (MDS - a resident assessment tool) dated 4/23/2025, the MDS indicated Resident 85's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 85 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/off footwear and personal hygiene.</p> <p>During a review of Resident 85's Lorazepam as needed, give one (1) milligram (mg, unit of measurement) sublingual, every four (4) hours for anxiety manifested by restlessness, ordered on 6/6/2024, indicated a stop date of "indefinite."</p> <p>During a concurrent record review and interview on 6/12/2025 at 11:19 AM with Registered Nurse Supervisor 1 (RNS 1), Resident 85's lorazepam orders was reviewed. RNS 1 verified Resident 85</p>	F 605			

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F 605	<p>Continued From page 24</p> <p>has an order of lorazepam as needed order for anxiety on 6/6/2025, with no stop date. RNS 1 stated PRN Lorazepam ordered on 6/6/2025 should have been discontinued after 14 days from order date.</p> <p>2. During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted to the facility on 12/27/2024. Resident 86's diagnoses included dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder.</p> <p>During a review of Resident 86's MDS dated 4/7/2025, the MDS indicated Resident 86's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 86 required partial/moderate (helper does less than half) assistance with eating. The MDS indicated Resident 86 was dependent with oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/off footwear and personal hygiene. The MDS indicated Resident 86 uses wheelchair while in the facility.</p> <p>During a review of Resident 86's Lorazepam order of 1 mg, give 0.5 milliliter (ml, unit of measurement) orally every four hours PRN order for anxiety manifested by persistent restlessness, ordered on 2/17/2025, indicated a stop date of "indefinite."</p> <p>During a concurrent record review and interview on 6/12/2025 at 11:20 AM with Registered Nurse Supervisor 1 (RNS 1), Resident 86's Lorazepam orders was reviewed. RNS 1 verified Resident 86 has an order of Lorazepam as needed order for anxiety since 2/17/2025, with no stop date. RNS 1</p>	F 605			

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F 605	Continued From page 25 also stated the lorazepam as needed order was changed on 6/10/2025 because frequency was changed to every 2 hours from every 4 hours, and order was kept indefinite, which means no stop date. RNS 1 stated PRN Lorazepam ordered on 2/17/2025 should have been discontinued after 14 days from order date. RNS 1 was unable to provide a written documentation from Resident 86's Physician's regarding extending the PRN Lorazepam order beyond 14 days. During a concurrent record review and interview on 6/12/2025 at 1:33 PM with the Director of Nursing (DON), Resident 85 and 86's Lorazepam orders were reviewed. The DON did not know what happened why Resident 86's as needed Lorazepam order on 2/17/2025 has no stop date and was only discontinued on 6/10/2025 when the order was changed for increase in frequency. The DON verified the new order as needed Lorazepam order on 6/10/2025 has no stop date as well for Resident 86. The DON stated as needed Lorazepam order should be limited to 14 days to make sure resident's physician is aware of resident's status, and the need to adjust medication if it's being effective after 14 days of order. During a review of Facility's P&P titled "Psychotropic Medication Use," revised in February 2025, indicated "PRN orders for psychotropic medications are limited to 14 days."	F 605			
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609	Immediate Corrective Action a. The new administrator faxed over the SOC-341 to the CDPH and Long-Term Care (LTC) Ombudsman, and reported to the local police district on 6/5/25, after being informed by the MDS Coordinator about the alleged altercation between residents 15 and 241, as	06/11/25	

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F 609	<p>Continued From page 26</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement its abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and includes verbal abuse [a range of words of behaviors used to manipulate, intimidate, and maintain power and control over someone]) policy for two (2) of 2 sampled residents (Residents 15 and 241) by failing to report an allegation of abuse to the state agency (CDPH, California Department of Public Health), the state ombudsman (advocates for residents of</p>	F 609	<p>b. The final investigation report was faxed over to the CDPH on 6/11/25, within 5 working days from submitting the SOC-341.</p> <p>Corrective Action for Others Affected</p> <p>a. The progress notes for the residents contained in the census of 6/5/25 were reviewed by the MDS Coordinator and did not find any other residents affected by the deficient practice.</p> <p>Measures Taken to Prevent Recurrence</p> <p>a. The previous DON resigned on 6/2/25 with immediate effectivity.</p> <p>Measures Taken to Prevent Recurrence</p> <p>b. LVN 3 was in-serviced over the phone by the new administrator on 6/6/25 regarding the timely reporting and documentation of allegations of abuse.</p> <p>c. The administrator in-serviced all staff on 6/6/25 and 6/11/25 regarding the reporting and documentation of allegations of abuse.</p> <p>c. The administrator in-serviced all staff on 6/6/25</p> <p>Reformace Monitoring to Ensure that Solutions are Sustained</p> <p>documentation of allegations of abuse.</p> <p>a. The MDS Coordinator will review on a twice a month basis 6/6/2025 for the next 3 months and monthly for the following 3 months for a total of 6 months, 5 random progress notes of residents to verify and documentation of allegation of abuse. The MDS Coordinator will report the findings of the month and 6 monthly review during the monthly QAPI Meeting contained in the progress note of LVN 3.</p> <p>The MDS Coordinator will report in the resident 241 during the stand meeting at around 9:50 a.m. contained in the progress note of LVN 3. Once the MDS Coordinator is achieved. Monthly QAPI resident 241 during the stand meeting at discussion will occur for 3 months.</p>	06/11/25

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F 609	<p>Continued From page 27</p> <p>nursing homes, board and care homes and assisted living facilities), and local law enforcement (Police Department) within 2 hours.</p> <p>This deficient practice had the potential to compromise or impede the protection of Resident 15 from further abuse, which could affect the residents' emotional and mental wellbeing.</p> <p>Findings:</p> <p>1. During a review of Resident 15's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 5/7/2025 with diagnoses of nontraumatic (not caused by trauma or injury to the body) intracerebral hemorrhage (ICH; also known as hemorrhagic stroke is a medical emergency where bleeding occurs within the brain tissue) in brain stem (the lower part of the brain that connects to the spinal cord [a tube of tissue that carries nerve signals from the brain to the rest of the body]) and type 2 diabetes mellitus (DM2; a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (damage to the kidneys caused by long-standing high sugar levels leading to impaired kidney function and potentially kidney failure).</p> <p>During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 5/14/2025, the MDS indicated the Resident 1 was severely impaired (difficulty with or unable to make decisions, learn remember things) with cognitive (ability to think, remember and reason) skills for daily decision making. Resident 1 needed substantial/maximal assistance (helper</p>	F 609			

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F 609	<p>Continued From page 28</p> <p>does more than half the effort) with walking 10 feet. Resident 1 needed partial/moderate assistance (helper does less than half the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position), personal hygiene, putting on/taking off footwear, upper and lower body dressing (the ability to dress and undress above and below the waist) and needed setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating.</p> <p>During a review of Resident 15's Situation, Background, Assessment and Recommendation (SBAR; a communication tool used by healthcare workers when there is a change of condition among the residents) documentation dated 6/5/2025, the SBAR indicated it was reported to the Director of Nursing (DON) that on 6/1/2025 an alleged verbal altercation happened between Resident 15 and roommate, Resident 241.</p> <p>During a review of Resident 15's Care Plan dated 6/5/2025, Resident 15's Care Plan indicated that Resident 15 was at risk for emotional and psychosocial distress due to alleged verbal altercation with his roommate, Resident 241 on 6/1/2025.</p> <p>2. During a review of Resident 241's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 5/29/2025 with diagnoses of encephalopathy (a condition where the brain does not function properly) and psychosis (a mental health condition characterized by a loss of touch with reality) not due to a substance or known psychological (relating to the mind and mental</p>	F 609			

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F 609	<p>Continued From page 29 processes) condition.</p> <p>During a review of Resident 241's MDS, dated 6/4/2025, the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. Resident 241 needed setup or clean-up assistance with personal hygiene and eating and was independent (resident completes the activity by themselves with no assistance from a helper) with walking 150, 50 and 10 feet, transfers, upper and lower body dressing, and putting on/taking off footwear.</p> <p>During a review of Resident 241's Licensed Nurse Progress Note, dated 6/1/2025, Resident 241's Licensed Nurse Progress Note indicated Resident 241 was assigned to a new room due to an attempted altercation with his roommate, Resident 15.</p> <p>During an interview on 6/12/2025 at 8:40 AM with the DON, the DON stated she was informed about the situation that happened on 6/1/2025 between Resident 15 and 241 by the new Administrator (ADM) on 6/5/2025 and created the SBAR documentation but was not present on 6/1/2025 when the alleged altercation occurred.</p> <p>During an interview on 6/12/2025 at 9:13 AM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated on 6/1/2025, Resident 15 and Resident 241 had a verbal confrontation and were yelling at each other. CNA 3 stated Resident 241 got close to Resident 15 arguing that he needed space. CNA 3 then stated she put the call light on, and</p>	F 609			

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F 609	<p>Continued From page 30</p> <p>Licensed Vocational Nurse 3 (LVN 3) came into the room and immediately moved Resident 241 into a new room.</p> <p>During an interview on 6/12/2025 at 10:15 AM with LVN 3, LVN 3 stated when she entered Resident 241 and 15's room after noticing the call light being on, she observed Resident 241 yelling at Resident 15 and Resident 15 told Resident 241 to leave the room. LVN 3 then stated Resident 241 then picked up a pillow and attempted to hit Resident 15 with it but was able to immediately pull Resident 241 out of the room and called the DON at the time to notify her that she was moving Resident 241 to a new room. LVN 3 stated after informing the DON over the phone about the incident, she did not make an incident report and did not report the incident to California Department of Public Health (CDPH), law enforcement or the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) and only documented the room change in the communication book.</p> <p>During the same interview on 6/12/2025 at 10:15 AM with LVN 3, LVN 3 stated she is a mandated reporter and the incident between Resident 15 and 241 should have been reported within two (2) hours. LVN 3 further stated it is important to report the incident for the residents' safety and to prevent them from injuring themselves and others.</p> <p>During an interview on 6/12/2025 at 10:45 AM with the ADM, ADM stated the altercation between Resident 15 and 241 should have been reported on 6/1/2025 within 2 hours to CDPH, the</p>	F 609			

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F 609	<p>Continued From page 31</p> <p>ombudsman and the police. ADM stated they were not able to report the incident to the three (3) entities until 6/5/2025 when they were made aware in a meeting by the MDS Coordinator who found the information after auditing Resident 241's progress notes. ADM further stated the incident was reported late and should have been reported on 6/1/2025 to prevent a future happening of abuse and that the facility needs to not only have a system of abuse prevention and reporting but also need to assess residents for any behaviors so that they can be addressed.</p> <p>During a review of the facility's policy and procedure (P&P) titled "Abuse Investigation and Reporting" dated March 2025, the P&P indicated, "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ('abuse') shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." The P&P also indicated:</p> <ol style="list-style-type: none"> a. All alleged violation involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); 	F 609			

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F 609	Continued From page 32 e. Law enforcement officials; f. The resident's Attending Physician; and b. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse of any kind.	F 609	Immediate Corrective Actions for resident affected by this deficient practice. On 6/12/25, DON and DSD immediately placed bilateral heel protectors for both residents 42 and 54.	07/02/25
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide necessary treatment and services to prevent development of pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) by not following a physician's (MD) order for heel offloading (to shift weight off the heel) for two (2) of 2 sampled residents (Residents 42 and 54).	F 686	Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken; All other Residents with orders for Off-Loading heels were checked and verified by Treatment Nurse and DON on 6/12/25 and found no other deficient practices. Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur. On 07/02/25, DSD and DON in-serviced all licensed Nurses regarding proper implementation of heel protectors as ordered by the physician. Starting 7/01/25, Medical Records Director will Audit daily EHR orders for heel protectors and report to the DON any deficient practice. Facility Plan to Monitor Corrective action(s); and Sustain Compliance: DON or Designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance starting 7/01/25. Monthly QA discussion will occur for 3 months.	07/02/25

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F 686	<p>Continued From page 33</p> <p>This deficient practice had the potential to put Residents 42 and 52 at risk for developing a pressure ulcer.</p> <p>Findings:</p> <p>1. During a review of Resident 42's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 9/4/2019 and readmitted 6/7/2025 with diagnoses of cerebral infarction (a medical condition where a part of the brain is damaged due to a lack of blood supply) and contracture of muscle (a stiffening/shortening at an any joint, that reduces the joint's range of motion) in multiple sites.</p> <p>During a review of Resident 42's History and Physical Examination (H&P), dated 9/16/2024, the H&P indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 5/27/2025, the MDS indicated the resident was dependent (helper does all of the effort. Resident does none of the effort to complete activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with putting on/taking off footwear, lower body dressing (the ability to dress and undress below the waist), and toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). Resident 42 needed partial/moderate assistance (helper does less than half the effort) with rolling left and right in bed and upper body dressing (the ability to dress and undress above the waist).</p> <p>During a review of Resident 42's Order Summary Report dated 6/11/2025, Resident 42's Order</p>	F 686			

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F 686	<p>Continued From page 34</p> <p>Summary Report indicated an order from 6/8/2025 to offload bilateral (both sides) heels as tolerated to prevent skin breakdown every shift for contracture of bilateral lower extremities.</p> <p>During a review of Resident 42's Care Plan dated 6/9/2025, Resident 42's Care Plan indicated Resident 42 was at risk for development of skin breakdown of pressure sore (pressure ulcer) related to decreased mobility, incontinence of bowel and bladder (B&B), contractures and malnutrition(lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat) and indicated an intervention to asses for possible need for heel protectors and provide as needed (PRN) and to provide treatment as ordered.</p> <p>During a review of Resident 42's Pressure Injury Risk Assessment dated 6/8/2025, Resident 42's Pressure Injury Risk Assessment indicated Resident 42 was at high risk for developing a pressure injury with a score of 13.</p> <p>During an observation on 6/10/2025 at 3:57 PM inside Resident 42's room, Resident 42 was observed lying down in bed with his legs bent underneath him with his feet towards the right side of his bed with no heel protectors on or a pillow underneath his heels for heel offloading .</p> <p>During a concurrent observation and interview on 6/11/2025 at 9:51 AM with Resident 42 inside his room, Resident 42 was observed lying down in bed with his heels bent underneath him. No heel protectors of pillow observed on or underneath his legs or heels for offloading. Resident 42 stated staff has not been putting heel protectors</p>	F 686			

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F 686	<p>Continued From page 35</p> <p>on him or placing a pillow underneath his heels.</p> <p>During a concurrent observation and interview on 6/11/2025 at 10:12 AM with Certified Nursing Assistant 2 (CNA 2) inside Resident 42's room. Resident 42's heel protectors were observed inside his closet. CNA 2 stated when a resident has an order for heel offloading, they will either use heel protector or place a pillow underneath the resident's heel to offload them.</p> <p>During an interview on 6/11/2025 at 10:15 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated if a resident has an order for heel offloading, it would either be the treatment nurse (TXN) or Restorative Nursing Assistant (RNA) who would place the resident's heel protectors on. LVN 2 also stated for a resident with an order for heel offloading, the expectation would be to ensure the resident does have their heels offloaded every time she is able to have eyes on the resident especially if she is aware that the resident tends to remove them.</p> <p>During a concurrent observation and interview on 6/11/2025 at 10:25 AM with CNA 3 inside Resident 42's room, Resident 42 was observed lying down in bed with no heel protectors on or a pillow underneath his heels for offloading. CNA 3 stated Resident 42 did not have any heel protectors on or pillow underneath his heels to offload them. CNA 3 stated that Resident 42 has not had any heel offloading since she came in for her shift at 7:00 AM on 6/11/2025 and also stated Resident 42 did not have any heel offloading on 6/10/2025 during her shift from 7:00 AM - 3:00 PM. CNA 3 further stated it is normally the RNA or physical therapist (PT) who puts the resident's heel protectors on and stated if the resident</p>	F 686			

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F 686	<p>Continued From page 36</p> <p>refuses, the refusal should be charted by the RNA.</p> <p>During an interview on 6/11/2025 at 10:28 AM with RNA 1, RNA 1 stated if a resident has an order for heel offloading, the RNA is the one who would put them on and stated that she was not aware Resident 42 had an order for heel offloading and stated on 6/10/2025 on the 7:00 AM-3:00 PM shift, she did not put on Resident 42's heel protectors and that Resident 42 did not have any heel protectors or heel offloading for the morning of 6/11/2025. RNA 1 further stated it is important to follow the order to offload the resident's heels to prevent pressure sores and skin breakdown.</p> <p>During an interview on 6/12/2025 with the Director of Nursing (DON), the DON stated an order for heel offloading for a resident needs to be followed to prevent skin breakdown and decrease the risk for developing a deep tissue injury (DTI; damage to underlying soft tissues, often beneath intact skin, caused by pressure or shear forces).</p> <p>2. During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was originally admitted to the facility on 4/25/2023 and readmitted on 5/1/2025. Resident 54's diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pressure ulcer of right heel unstageable (a type of pressure injury where the true depth of the wound cannot be determined due to the presence of dead tissue obscuring the wound bed.), and type II type 2 diabetes mellitus (a medication condition characterized by the body's inability to regulate blood sugar level).</p>	F 686			

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F 686	<p>Continued From page 37</p> <p>During a review of Resident 54's MDS, dated 5/8/2025, the MDS indicated Resident 54's cognitive skill for daily decision making was moderately impaired. The MDS indicated Resident 54 was dependent from staff for toileting hygiene, shower/bathe self, and upper/lower body dressing. The MDS indicated Resident 54 was at risk of developing pressure ulcers/injuries.</p> <p>During a review of Resident 54's Care Plan, the Care Plan indicated Resident 54 had impaired skin integrity related to right dorsal foot diabetic wound, initiated on 5/1/2025. The care plan indicated intervention to provide offload right heel at all times, may remove when providing care.</p> <p>During a review of Resident 54's Order Summary Report for June 2025, the Order Summary indicated, on 5/11/2025 to provide offload right heel at all times, to prevent further skin damage every shift for surgical wound to right heel S/T (status post) I&D (incision and drainage- it is a medical procedure that involves making a small cut in the affected area and removing accumulated pus, fluid, or debris from the infected area).</p> <p>During a review of Resident 54's Pressure Injury Risk Assessment Tool (PIRAT- is used to identify individual at risk of developing pressure ulcers) with an effective date 5/8/2025, the PIRAT indicated Resident 54 was at high risk for developing pressure ulcer.</p> <p>During an observation on 6/10/25 11:32 AM, in Resident 54's room, Resident 54 was observed sleeping on her right side on the bed cross legged, with her right foot underneath her left</p>	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 686	<p>Continued From page 38</p> <p>foot. Her right foot was wrapped with kerlix and was not offload with pillows and Resident 54's right foot without heel protector and no heel protector was observed in the room.</p> <p>During an observation and interview with CNA 1 on 06/10/25 11:39 AM, in Resident 54's room, CNA 1 confirmed the Resident's right foot was not offloaded as indicated on the care plan. CNA 1 stated Resident 54 did not have a pillow under the resident's leg and/ or heel protector. CNA 1 stated Resident 54 was at risk for further injury to her right foot.</p> <p>During a concurrent observation on 6/11/25 1:32 PM, in Resident 54's room, Resident 54 was observed lying on the bed on supine position (a body position where a person lies flat on his/her back, with the face and torso facing upward). Resident 54 was observed her right foot was not offloaded as indicated per the MD order.</p> <p>During an interview with LVN 2, on 6/11/2025 at 1:33 PM, in Resident 54's room, LVN 2 stated Resident 54's heels had the order to be offloaded at all times. LVN 2 stated failure to follow doctor's order to provide offloading for a pressure injury could lead to severe complication including discomfort, pain, and delayed healing.</p> <p>During an interview with Registered Nurse Supervisor (RNS) 1, on 6/12/2025 at 10:19 AM, RNS 1 stated offloading was crucial for Resident 54's right foot wound. RNS 1 stated the offloading would reduce and/ or redistribute pressure on the affected area to promote healing and prevent further damage. RNS 1 it was not done for Resident 54.</p>	F 686			

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F 686	Continued From page 39 During a review of facility's policies and procedures (P&P) titled "Pressure Injury (ulcer) Risk Assessment," revised dated March 2020, the P&P indicated the purpose of this procedure was to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper care and treatment for gastrostomy tube (G-tube, a	F 693	Immediate Corrective Action for resident affected by this deficient practice; On 6/11/25, LVN 4 disinfected the G-Tube tubing tip. DSD checked resident 28 was checked for residual prior to connecting the G-Tube Feeding on 06/11/25. Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken. DSD rounded on 06/11/25 for all other gastric tube residual and found no other resident affected by same deficient practice Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur; Starting 7/01/25, LVN 4 will be observed q monthly by Pharmacy Consultant and random medication pass with medication review and cart check twice a month per regulation. On 6/16/25, LVN 4 was given a 1:1 in service to properly disinfect extension tubing at enteral feeding port also showed proficiency with checking Gastric Volume Residual with DON and Pharmacy Nurse Consultant. Medication Administration Clinical Competency Skills check for all licensed nurses done by DON from 6/19/25 to 7/04/25 and found no other residents affected by same deficient practice.	06/16/25

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F 693	<p>Continued From page 40</p> <p>tube inserted through the abdomen that delivers nutrition directly to the stomach) for one of two (2) sampled residents (Resident 28) by failing to:</p> <p>a. Check Resident 28's G-tube placement by checking the gastric residual volume (GRV, the amount of liquid drained from a stomach following administration of enteral feed [a method of providing nutrition directly into the gastrointestinal (GI) tract when a person cannot consume enough food or nutrients orally])</p> <p>b. Disinfect the tip of the resident's G-tube before administering G-tube feeding (a liquid food mixture provided through the G-tube).</p> <p>This deficient practice had the potential for Resident 28 to have complications including aspiration (when something swallowed enters the lungs) which could lead to pneumonia (infection that inflames air sacs in one or both lungs) and/or choking (severe difficulty in breathing because of a constricted or obstructed throat or a lack of air).</p> <p>Findings:</p> <p>During a review of Resident 28's Admission Record, the Admission Record indicated that Resident 28 was originally admitted to the facility on 7/19/2019 and re-admitted on 3/27/2025 with dysphagia oropharyngeal phase (when a person has difficulty swallowing due to damage to the oropharynx or throat.), type 2 diabetes mellitus (a medication condition characterized by the body's inability to regulate blood sugar level), and heart failure (a chronic condition in which the heart does not pump and fill blood adequately).</p> <p>During a review of Resident 28's Minimum Data Set (MDS - a comprehensive standardized assessment and screening tool), dated 4/3/2025,</p>	F 693	<p>Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Starting 7/01/25, the DON will immediately correct any issues reported by Pharmacy Consultant and all findings will be reviewed by Administrator and reported to QAPI monthly meetings for compliance for 3 months.</p>	06/16/25	

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F 693	<p>Continued From page 41</p> <p>the MDS indicated Resident 28's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 28 required total dependence (full staff performance) on staff for oral hygiene, toilet hygiene, and personal hygiene. The MDS indicated Resident 28 was on feeding tube.</p> <p>During a review of Resident 28's Physician Oder, order date 3/27/2025, the Physician Order indicated the following:</p> <ol style="list-style-type: none"> 1. Check tube placement and patency every shift, 2. Check residual every shift and hold tube feeding if residual is above 100 ml (milliliter- unit measurement in volume) for 2 hours and then resume feeding every shift. <p>During a review of Resident 28's Care Plan, initiated on 3/28/2025, the Care Plan indicated Resident 28 required tube feeding due to poor oral intake. It also indicated Resident 28 was at risk for aspiration, nausea, vomiting, and abdominal distention. Staff interventions included were to check tube placement and patency every shift prior to giving feeding and to check residual every shift and hold tube feeding if residual is above 100ml for 2 hours and then resume feeding every shift.</p> <p>During a concurrent observation and interview on 6/11/2025 at 1:47 PM, in Resident 28's room, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 was observed connecting the G-tube tubing to the extension feeding port, attempting to turn on the feeding pump. LVN 4 did not disinfect the tip of Resident 28's tubing and extension feeding port. LVN 4 also did check Resident 28's G-tube</p>	F 693			

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F 693	<p>Continued From page 42</p> <p>placement by checking GRV and did not check the G-tube for patency. LVN 4 stated because he did not check the GRV and patency of the G-tube, these could result in dangerously administering feeding to the wrong place and may cause Resident 28 to develop complications such as nausea, vomiting, and abdominal extension which could result in hospitalization.</p> <p>During an interview, on 6/12/2025 at 9:12 AM, with the Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated it was important to disinfect the G-Tube tubing and extension feeding port for infection control. RNS 1 stated that failure to check the placement of the feeding tube by checking the GRV prior to administer the feeding, could lead to infection, and complication such as aspiration, nausea, and vomiting.</p> <p>During a review of the facility's policy and procedure titled, "Enteral Nutrition," revised 11/2018, the policy and procedure indicated the provider will consider the need for supplemental orders, including:</p> <ol style="list-style-type: none"> confirmation of tube placement laboratory monitoring instructions for enteral nutrition preparation nutritional consultations head of bed elevation checks for gastric residual volume (GRV). <p>The policy and procedure also indicated that staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with the use of a feeding tube, such as:</p> <ol style="list-style-type: none"> aspiration tube misplacement or migration clogging of the tube nausea, vomiting, diarrhea and abdominal 	F 693			

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F 695	<p>Continued From page 44</p> <p>obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 34's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 34 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/off footwear and personal hygiene. The MDS indicated Resident 34 was on oxygen therapy while in the facility.</p> <p>During a review of Resident 34's Order Summary Report, the Order Summary Report indicated an order of oxygen at two (2) liters per minute (LPM, unit of measurement) via nasal cannula (a thin, flexible tube that wraps around your head, typically hooking around your ears), as needed for shortness of breath, ordered on 5/14/2025.</p> <p>During an observation on 6/11/2025 at 9:26 AM, in Resident 34's room, Resident 34's head of bed was observed to be almost flat in bed. Resident was observed with nasal cannula, connected to oxygen concentrator that was set at 2 LPM.</p> <p>During a concurrent observation and interview on 6/11/2025 at 9:31 AM, with Certified Nurse Assistant 8 (CNA 8), in Resident 34's room, with the presence of Licensed Vocational Nurse 5 (LVN 5), CNA 8 stated she positioned and left Resident 34 in that way at 8:45 AM.</p>	F 695			

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F 695	Continued From page 45 During a concurrent observation in Resident 34's room and interview with LVN 5 on 6/11/2025 at 9:32 AM, LVN 5 stated Resident 34's head of bed was positioned between 15-20 degrees (unit of measurement). LVN 5 stated the resident's head of bed should not be positioned that low because Resident 34 has shortness of breath, and it is harder to breath when positioned almost flat in bed. During an interview on 6/12/2025 at 11:23 AM, with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated it was important for Resident 34's head of bed to be positioned in upright position, at least 30 degrees, and should not be left in flat or almost flat position for better chest expansion and for breathing comfort. During a review of Facility's Policy and Procedure titled "Oxygen Therapy", dated 8/4/2007, indicated the following: " Resident shall be kept comfortable with head of bed elevated. " Head of bed elevated 30 degrees or higher when oxygen is applied.	F 695	Immediate Corrective Action for resident affected by this deficient practice. DON re-assessed the right femoral hemodialysis site and found the site intact and covered. Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken. No other residents were affected by the same deficient practice. Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur; 1:1 in-serviced to 5 CN for proper placement of Hemo Dialysis catheter. On 05/24/25, 05/25/25 05/27/25, 05/29/25, 05/31/25, 06/03/25. Medical Records to Audit this form daily and any deficient practices will be brought to DON to adhere to standards of practice. Hemo dialysis Nursing pre and post communication record will also accompany new form "Dialysis Alert" to double down on precise location and description of access to receive proper care. All licensed nurses were in-serviced on 6/13/2025 on accurate dialysis site assessment pre and post hemodialysis.	06/13/25	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the	F 698			

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F 698	<p>Continued From page 46</p> <p>facility failed to ensure one of one sampled resident (Resident 29), who was receiving hemodialysis (process of removing waste products and excess fluid from the body) treatment was provided dialysis care and services by failing to assess the resident's right femoral dialysis access site (the use of the femoral vein, located in the groin area, as a point of entry for dialysis catheter [a thin tube that is placed under the skin in a vein, allowing long-term access to the vein]) on 5/24/2025, 5/27/2025, 5/29/2025, 5/31/2025, and 6/3/2025 in accordance with the facility policy and physician's order.</p> <p>This deficient practice had the potential for complications such as bleeding or infection and potential for unnoticed or missed excessive bleeding and infection on Resident 29's right femoral central venous catheter dialysis access.</p> <p>Findings:</p> <p>During a review of Resident 29's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 12/24/2015 and was re admitted on 9/8/2024, with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), displacement of vascular dialysis catheter.</p> <p>During a review of Resident 29's Minimum Data Set (MDS- a resident assessment tool), dated 5/17/2025, indicated Resident 29 with modified independence (some difficult in new situations only) in terms of cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 29 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating and oral</p>	F 698	<p>Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Beginning 7/01/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance. Monthly QA discussion will occur for 3 months.</p>	06/13/25	

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F 698	<p>Continued From page 47</p> <p>hygiene. The MDS indicated Resident 29 required supervision (helper provides verbal cues) with toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear, and personal hygiene.</p> <p>During a review if Resident 29's Care Plan focused on the resident's right femoral line for dialysis site, initiated on 8/16/2024, the Care Plan indicated staff intervention included was to check resident's right femoral line site for infection or leakage.</p> <p>During a review of Resident 29's Order Summary Report, dated 6/9/2025, the Order Summary Report indicated an order to of pre and post dialysis monitoring check, vital signs, access site, weight and other patient condition, ordered on 8/27/2024. It also indicated an order to check Resident 29's right femoral line for signs and symptoms of infection or leakage, ordered on 8/27/2024.</p> <p>During a concurrent record review and interview on 6/10/2024 at 2:09 PM, with Licensed Vocational Nurse 4 (LVN 4), Resident 29's "Nursing Facility pre-dialysis assessment and communication records," dated 5/24/2025, 5/27/2025, 5/29/2025, 5/31/2025 and 6/3/2025 were reviewed. LVN 4 stated the forms indicated an inaccurate dialysis access site assessment which might cause confusion when delivering care to Resident 29.</p> <p>During a concurrent record review and interview on 6/10/2024 at 2:11 PM, with LVN 5, Resident 29's "Nursing Facility pre-dialysis assessment and communication records," dated 5/24/2025, 5/27/2025, 5/29/2025, 5/31/2025 and 6/3/2025</p>	F 698			

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F 698	<p>Continued From page 48</p> <p>were reviewed. LVN 5 stated the forms indicated an inaccurate dialysis access site assessment for Resident 29. LVN 5 stated bruit (whooshing sound heard over an artery, usually with a stethoscope, indicating turbulent blood flow, often due to a narrowing or obstruction) and thrills (palpable vibration felt over an artery, also indicating turbulent blood flow) were documented and should not be present since Resident 29 had femoral dialysis access site.</p> <p>During a concurrent record review and interview on 6/10/2025 at 2:56 PM, with Registered Nurse Supervisor 2 (RNS 2), "Resident 29's "Nursing Facility pre-dialysis assessment and communication records," dated 5/24/2025, 5/27/2025, 5/29/2025, 5/31/2025 and 6/3/2025 were reviewed. LVN 5 stated the forms indicated an inaccurate dialysis access site assessment for Resident 29. RNS 2 stated the assessment indicated a right thigh dialysis access instead of right femoral access. RNS 2 also added that the assessment of bruits and thrills were incorrect because it was for an AV (arteriovenous) fistula (abnormal connection between an artery and a vein) and not for a central venous catheter dialysis access (a surgically inserted, flexible tube used to access a large vein near the heart, facilitating blood flow to and from the dialysis machine during hemodialysis). RNS 2 stated, it was important to properly assess residents and complete the Dialysis communication record to make sure that resident will receive the proper care.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Care of a Resident with End Stage Renal Disease," revised on September 2010, the P&P indicated "Residents</p>	F 698			

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F 698	Continued From page 49 with end-stage renal disease will be cared for according to currently recognized standards of care."	F 698			
F 727 SS=D	<p>RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(b)(4)(C)(i);483.35(c)(1)-(3)</p> <p>Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility-</p> <p>(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week.</p> <p>§483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>§483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure there was a Registered Nurse</p>	F 727	<p>Immediate Corrective Action for resident affected by this deficient practice; On 6/03/25, DSD reviewed the rest of the R.N. schedule for June 2025 and found 8 hrs consecutively 7 days a week were covered. Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken; On 7/01/25, DSD reviewed the schedule for June 2025, and no other deficient practice was identified. Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur. On 7/10/25, an RN Supervisor was hired 7:00am-3:30pm Monday through Friday. Starting 6/02/25, DSD and/or DON will utilize Contracted Agency for RN as needed. Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Starting 7/01/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance for 3 months.</p>	07/10/25	
				07/10/25	

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F 727	<p>Continued From page 50</p> <p>(RN) on duty for at least eight (8) consecutive hours on 6/1/2025 to ensure all the residents' clinical needs were met either directly by the RN or indirectly by the Licensed Vocational Nurses (LVNs) or Certified Nurse Assistants (CNAs) for whom the RN was responsible for overseeing resident care.</p> <p>This failure had the potential to result in the delay in care and services and harm to residents.</p> <p>Findings:</p> <p>During a review of the Facility's Nursing Staffing Assignment and Sign-In Sheet dated 6/1/2025, the Nursing Staffing Assignment and Sign-In Sheet indicated no Registered Nurse Supervisor (RNS) for both the 7AM- 3:30 PM shift and the 3:00 PM - 11:30 PM shift.</p> <p>During a concurrent interview and record review on 6/12/2025 at 10:11 AM with Director of Staff Development (DSD), the facility's Monthly Employee Hours Schedule dated June 2025 was reviewed. The Monthly Employee Hours Schedule indicated RNS 2 was scheduled to work on 6/1/2025 for the 7AM - 3:30 PM shift and RNS 3 was scheduled to work on 6/1/2025 for the 3:00 PM - 11:30 PM shift. DSD stated, on 6/1/2025, RNS 2 did not show up for work and RNS 3 called in sick and the Director of Nursing (DON) at the time was not scheduled to work that day and was not present at the facility. DSD stated no replacement RNS was scheduled for 6/1/2025 for both the 7:00 AM - 3:30 PM and the 3:00 PM-11:30 PM shifts. DSD further stated there should always be an RN onsite at the facility for at least 8 hours to supervise and oversee everything</p>	F 727			

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F 727	Continued From page 51 so that if something were to happen, the RN would be able to assess the situation or resident as well as be a resource for the staff. During a review of the facility's Facility Assessment dated 6/2/2025, the Facility Assessment indicated the facility must ensure there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care of its residents' needs, as identified through resident assessments and plan of care. The Facility Assessment also indicated in its staffing plan that an RN Supervisor is needed every day Monday through Sunday. During a review of the facility's RNS Job description (undated) the RNS Job Description indicated the RNS supervises all nursing staff in their daily activities. Other essential duties and responsibilities included: a. Assisting with handling personnel problems and employee relations. b. Reporting findings and recommendations to the DON and or Medical Director or Attending Physician. c. Monitoring incident reports for proper documentation and initiating investigations as needed.	F 727			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services 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	F 755	Immediate Corrective Action for resident affected by this deficient practice: Resident 55 and Resident 84 were reassessed by the DON on 06/11/25 and the DON also called MD for a one time late med pass order.	06/16/25	

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F 755	<p>Continued From page 52</p> <p>personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of two (2) of five (5) sampled residents (Resident 55 and 84) as indicated on the facility policy and physician's order when during a Medication Pass observation, Licensed Vocational Nurse 4 (LVN 4) failed to administer Resident 55 and 84's medications within 60 minutes of scheduled time of 9 AM on 6/11/2025.</p>	F 755	<p>Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken; DON found two residents affected by the same deficient practice physician was notified Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur:</p> <p>1:1 in-service with LVN 4 on 6/16/2025 with DON and Pharmacy Consultant with importance of timely Medication Pass emphasis to ask for assistance by another licensed nurse and call Physicians for an order to pass medications late to reduce complications.</p> <p>All licensed Nurses are in-serviced on 6/16/25 regarding 60 minutes Pharmaceutical/ Facility Policy and Physican orders to include, " Medications must be administered within 60 minutes of scheduled time".</p> <p>Pharmacy Consultant to continue random twice Monthly med pass observation / Medication Cart Audit per Regulation and provide DON results. Any discrepancies will be addressed immediately. See Med pass Observation form.</p> <p>Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Starting 7/01/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance. Monthly QA discussion will occur for 3 months.</p>	06/16/25	

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F 755	<p>Continued From page 53</p> <p>This deficient practice had the potential to result in Resident's 55 and 84 not obtaining the therapeutic level (medicine levels in your blood are in a range that is medically helpful but not dangerous) of the medication, which could lead to complication and negatively affect the overall wellbeing of the residents.</p> <p>Cross reference: F759 Findings:</p> <p>1. During a review of Resident 84's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 11/15/2024 with diagnosis of neuralgia (a sharp, severe, and often intermittent pain caused by irritation or damage to a nerve) and right knee osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).</p> <p>During a review of Resident 84's Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 84 has some difficulty in new situations only (modified independence) with cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 84 required set up or clean up assistance (helper sets up or cleans up) with eating. The MDS indicated Resident 84 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 84 required substantial/maximal assistance (helper does more than half the effort) with lower body dressing and putting on/taking off footwear. The MDS indicated Resident 84 was dependent on toileting hygiene, and shower.</p>	F 755			

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F 755	<p>Continued From page 54</p> <p>During a review of Resident 84's Order Summary Report, the Order Summary Report indicated the following orders:</p> <p>a. Gabapentin (medicine used to treat nerve pain) capsule 300 milligrams (mg, unit of measurement), give one (1) capsule by mouth two times a day for neuropathic pain (nerve pain that can happen if your nervous system malfunctions or gets damaged). Ordered on 4/17/2025.</p> <p>b. Multivitamin with minerals (a dietary supplement that combines multiple vitamins and minerals into one product, aiming to supplement a person's intake of these essential nutrients) oral tablet, give 1 table by mouth one time a day for wound healing. Ordered on 12/10/2024.</p> <p>c. Acetaminophen (medicine to relieve pain) 325 mg, give 2 tablets by mouth every 4 hours as needed for general discomfort or mild pain. Ordered on 11/15/2024.</p> <p>During a medication administration observation on 6/11/2025 at 10:18 AM, with LVN 4, LVN 4 prepared and administered the following three (3) medications to Resident 84:</p> <p>a. Gabapentin 300 mg, 1 capsule b. Multivitamins with minerals, 1 tablet c. Acetaminophen 325 mg, 2 tablets</p> <p>2. During a review of Resident 55's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 3/6/2023 and was re admitted on 9/23/2024, with diagnosis of hypertension (high blood pressure), dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells) and encephalopathy (a term for any disease or disorder of the brain that affects its</p>	F 755			

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F 755	<p>Continued From page 55 function or structure).</p> <p>During a review of Resident 55's MDS, the MDS indicated Resident 55 has some difficulty in new situations only with cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 55 was independent with oral hygiene and upper body dressing. The MDS indicated Resident 55 required setup or clean up assistance with eating, toileting hygiene, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 55 required supervision (helper provides verbal cues) with shower.</p> <p>During a review of Resident 55's Order Summary Report dated, the Order Summary Report indicated the following orders:</p> <p>a. Aspirin (a drug that reduces pain, fever, inflammation, and blood clotting), oral tablet delayed release 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain). Ordered on 9/23/2024.</p> <p>b. Ferrous sulfate (used for the prevention and treatment of iron deficiency anemia) tablet 325 mg, give 1 tablet by mouth, one time a day for supplement. 5/22/2025.</p> <p>c. Carvedilol (medication to treat high blood pressure) oral Tablet 6.25 mg, give 1 tablet by mouth two times a day for hypertension. Ordered on 9/23/2024.</p> <p>d. Lactulose (medication used to treat constipation (having fewer than three bowel movements per week) oral solution 10 grams (unit of measurement)/15 milliliters (ml, unit of measurements), give 45 ml by mouth one time a day for high ammonia (a colorless, poisonous gas) level. Ordered on 10/16/2024.</p>	F 755			

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F 755	<p>Continued From page 56</p> <p>e. Lisinopril (medication to treat high blood pressure) oral tablet 5 mg, give 1 tablet by mouth, one time a day for hypertension. Ordered on 2/24/2025.</p> <p>f. Plavix (used to prevent blood clots) oral tablet 75 mg, give 1 tablet by mouth one time a day for Deep Vein Thrombosis (DVT, a condition where a blood clot forms in a deep vein, most commonly in the legs or pelvis). Ordered on 9/23/2024.</p> <p>During a medication administration observation on 6/11/2025 at 10:30 AM, with LVN 4, LVN 4 prepared and administered the following six (6) medications to Resident 55 :</p> <p>a. Aspirin Oral Tablet, 1 tablet b. Ferrous sulfate tablet 325 mg, 1 tablet c. Carvedilol 6.25 mg, 1 tablet d. Lactulose 45 ml e. Lisinopril 5 mg, 1 tablet f. Plavix oral tablet 75 mg, 1 tablet</p> <p>During an interview on 6/11/2025 at 10:34 AM with LVN 4, LVN 4 verified that he administered Resident 84 and 55's 9 AM medications late, after the 1-hour window because he got busy with another resident.</p> <p>During an interview on 6/11/2025 at 2:06 PM with LVN2, LVN 2 stated failing to administer medication to a resident per the physician's order can lead to medical complications possibly resulting in hospitalization. LVN 2 stated administering medications can be given one hour early and 1 hour later than the scheduled time of administration. LVN 2 stated if administering medications late or early, the licensed nurse would need to notify the physician and document the reason for the delay in the resident's progress notes.</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 755	<p>Continued From page 57</p> <p>During an interview on 6/12/2025 at 11:05 AM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated it is important to give the medication on time and as ordered by the physician to ensure efficacy of the medications and to avoid possible adverse reactions or side effects that resident can experience. RNS 1 stated the facility's morning medication administration time is scheduled at 9 AM, and medications can be administered one hour before or after 9 AM.</p> <p>During an interview on 6/12/2025 at 11:07 AM with the Director of Nursing (DON), the DON stated not following physician's order is a medication error. The DON confirmed LVN 4 administered Resident 84 and 55's due 9 AM medications late on 6/11/2025. The DON stated medications may be administered one-hour before or after the scheduled time and should not go beyond that time as it is a medication error. The DON also added that when LVN 4 is having hard time administering medications during the allotted time, LVN 4 should have asked for help, so another licensed nurse could have helped her administer the medications. The DON stated, "If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition."</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, "Administering Medications," revised on April 2019, the P&P indicated "Medications are administered in a safe and timely manner, and as prescribed." The P&P also indicated medications are administered within 1 hour of their prescribed time, unless otherwise specified (for example,</p>	F 755			

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F 756	<p>Continued From page 59</p> <p>the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure the irregularities (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) on the Medication Regimen Review (MRR, consists of a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for one (1) of five (5) sampled Residents (Resident 86) was reported to the resident's primary physician in accordance with the facility policy.</p> <p>This deficient practice had the potential for unnecessary medication administration and for Resident 86 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to the medication therapy which could lead to impairment or decline in the resident's overall wellbeing resulting to serious harm.</p> <p>Cross reference F605</p> <p>Findings:</p> <p>During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted to the facility on 12/27/2024.</p>	F 756			

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F 756	<p>Continued From page 60</p> <p>Resident 86's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease).</p> <p>During a review of Resident 86's Minimum Data Set (MDS, a resident assessment and tool) dated 4/7/2025, the MDS indicated Resident 86's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 86 required partial/moderate assistance with eating. The MDS indicated Resident 86 was dependent with oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/off footwear and personal hygiene. The MDS indicated Resident 86 uses wheelchair while in the facility.</p> <p>During a review of Resident 86's MRR, dated 2/10/2025, indicated "Psychotropic (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) orders are limited to 14 days. If longer duration of this as needed order is required, please include the documentation in the clinical record." Prescriber response indicated "per hospice (form of medical care provided to individuals who are nearing the end of life), as needed for 14 days."</p> <p>During a review of Resident 86's lorazepam (medication used to treat anxiety [persistent and excessive worry that interferes with daily activities) 1 milligram (mg, unit of measurement),</p>	F 756			

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F 756	<p>Continued From page 61</p> <p>give 0.5 milliliter (ml, unit of measurement) orally every four hours as needed (PRN) order for anxiety manifested by persistent restlessness, ordered on 2/17/2025, indicated a stop date of "indefinite."</p> <p>During a concurrent record review and interview on 6/12/2025 at 11:20 AM with Registered Nurse Supervisor 1 (RNS 1), Resident 86's lorazepam orders were reviewed. RNS 1 verified Resident 86 has an order of lorazepam as needed for anxiety since 2/17/2025, with no stop date. RNS 1 also stated the lorazepam as needed order was changed on 6/10/2025 because frequency was changed to every two (2) hours from every four (4) hours, and the order was kept indefinite, which means there was no stop date. RNS 1 stated PRN Lorazepam ordered on 2/17/2025 should have been discontinued after 14 days from order date. RNS 1 was unable to provide a written documentation from Resident 86's Physician's regarding extending the PRN Lorazepam order beyond 14 days.</p> <p>During a concurrent record review and interview on 6/12/2025 at 1:28 PM with Pharmacy Consultant (PC), Resident 86's MRR dated 2/10/2025 was reviewed. PC stated recommendation for as needed lorazepam order to be limited for 14 days was recommended in the month of February 2025. PC added MRR was done monthly but he would not duplicate the same recommendation every month. PCC stated it should have been the licensed nurse's responsibility to put a stop date to as needed lorazepam order for Resident 86.</p> <p>During a concurrent record review and interview on 6/12/2025 at 1:32 PM with the Director of Nursing (DON), Resident 86's MRR for the</p>	F 756			

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F 756	<p>Continued From page 62</p> <p>months of February 2025, March 2025, and April 2025 and Resident 86's lorazepam's order were reviewed. The DON verified the MRR for the month of February 2025 indicated to limit lorazepam as needed order to 14 days. The DON added there was no pharmacy recommendation for Resident 86 for the month of March 2025 and April 2025. The DON stated that the PC recommendation was not followed to limit the order of as needed lorazepam order to 14 days. The DON stated Resident 86's as needed lorazepam order on 2/17/2025 did not have a stop date and was only discontinued on 6/10/2025 when the order was changed due to an increase in frequency. The DON verified the new as needed lorazepam order on 6/10/2025 has no stop date as well. The DON stated as needed lorazepam order should be limited to 14 days. The DON stated Resident 86's physician was not and should have been made aware of the PC's recommendation on the MRR to ensure resident's lorazepam order was evaluated. The DON stated it was important for the physician to be aware of resident's status, and the need to adjust the resident's medication if it was effective or not after 14 days of order.</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, "Medication Regimen Reviews," revised in May 2019, the P&P indicated "The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication."</p> <p>During a review of Facility's P&P titled, "Psychotropic Medication Use," revised in February 2025, the P&P indicated "PRN orders for psychotropic medications are limited to 14 days."</p>	F 756			

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F 759	<p>Continued From page 64</p> <p>1. During a review of Resident 84's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 11/15/2024 with diagnosis of neuralgia (a sharp, severe, and often intermittent pain caused by irritation or damage to a nerve) and right knee osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).</p> <p>During a review of Resident 84's Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 84's cognitive (ability to think and reason) skills for daily decision making was modified independence (some difficulty in new situations only). The MDS indicated Resident 84 required set up or clean up assistance (helper sets up or cleans up) with eating. The MDS indicated Resident 84 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 84 required substantial/maximal assistance (helper does more than half the effort) with lower body dressing and putting on/taking off footwear. The MDS indicated Resident 84 was dependent on toileting hygiene, and shower.</p> <p>During a review of Resident 84's Order Summary Report, the Order Summary Report indicated the following orders:</p> <p>" Gabapentin (medicine used to treat nerve pain) capsule 300 milligrams (mg, unit of measurement), give one (1) capsule by mouth two times a day for neuropathic pain (nerve pain that can happen if your nervous system malfunctions or gets damaged). Ordered on 4/17/2025.</p> <p>" Multivitamin with minerals (a dietary</p>	F 759			

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F 759	<p>Continued From page 65</p> <p>supplement that combines multiple vitamins and minerals into one product, aiming to supplement a person's intake of these essential nutrients) oral tablet, give 1 table by mouth one time a day for wound healing. Ordered on 12/10/2024.</p> <p>" Acetaminophen (medicine to relieve pain) 325 mg, give 2 tablets by mouth every 4 hours as needed for general discomfort or mild pain. Ordered on 11/15/2024.</p> <p>During a medication administration observation on 6/11/2025 at 10:18 AM, with LVN 4, LVN 4 prepared and administered the following three (3) medications to Resident 84:</p> <p>" Gabapentin 300 mg, 1 capsule. " Multivitamins with minerals, 1 tablet. " Acetaminophen 325 mg, 2 tablets.</p> <p>2. During a review of Resident 55's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 3/6/2023 and was re admitted on 9/23/2024, with diagnosis of hypertension (high blood pressure), dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells) and encephalopathy (a term for any disease or disorder of the brain that affects its function or structure).</p> <p>During a review of Resident 55's MDS, the MDS indicated Resident 55's cognitive skills for daily decision making was modified independence. The MDS indicated Resident 55 was independent with oral hygiene and upper body dressing. The MDS indicated Resident 55 required setup or clean up assistance with eating, toileting hygiene, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS</p>	F 759			

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F 759	<p>Continued From page 66</p> <p>indicated Resident 55 required supervision (helper provides verbal cues) with shower.</p> <p>During a review of Resident 55's Order Summary Report dated, the Order Summary Report indicated the following orders:</p> <p>" Aspirin (a drug that reduces pain, fever, inflammation, and blood clotting), oral tablet delayed release 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain). Ordered on 9/23/2024.</p> <p>" Ferrous sulfate (used for the prevention and treatment of iron deficiency anemia) tablet 325 mg, give 1 tablet by mouth, one time a day for supplement. 5/22/2025.</p> <p>" Carvedilol (medication to treat high blood pressure) oral Tablet 6.25 mg, give 1 tablet by mouth two times a day for hypertension. Ordered on 9/23/2024.</p> <p>" Lactulose (medication used to treat constipation (having fewer than three bowel movements per week) oral solution 10 grams (unit of measurement)/15 milliliters (ml, unit of measurements), give 45 ml by mouth one time a day for high ammonia (a colorless, poisonous gas) level. Ordered on 10/16/2024.</p> <p>" Lisinopril (medication to treat high blood pressure) oral tablet 5 mg, give 1 tablet by mouth, one time a day for hypertension. Ordered on 2/24/2025.</p> <p>" Plavix (used to prevent blood clots) oral tablet 75 mg, give 1 tablet by mouth one time a day for Deep Vein Thrombosis (DVT, a condition where a blood clot forms in a deep vein, most commonly in the legs or pelvis). Ordered on 9/23/2024.</p> <p>During a medication administration observation on 6/11/2025 at 10:30 AM, with LVN 4, LVN 4</p>	F 759			

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F 759	<p>Continued From page 67</p> <p>prepared and administered the following six (6) medications to Resident 55 :</p> <ul style="list-style-type: none"> " Aspirin Oral Tablet, 1 tablet. " Ferrous sulfate tablet 325 mg, 1 tablet. " Carvedilol 6.25 mg, 1 tablet. " Lactulose 45 ml. " Lisinopril 5 mg, 1 tablet. " Plavix oral tablet 75 mg, 1 tablet. <p>During an interview on 6/11/2025 at 10:34 AM with LVN 4, LVN 4 verified that he administered Resident 84 and 55's 9 AM medications late, after the 1-hour window because he got busy with another resident.</p> <p>During an interview on 6/11/2025 at 2:06 PM with LVN2, LVN 2 stated failing to administer medication to a resident per the physician's order can lead to medical complications possibly resulting in hospitalization. LVN 2 stated administering medications can be given one hour early and 1 hour later than the scheduled time of administration. LVN 2 stated if administering medications late or early, the licensed nurse would need to notify the physician and document the reason for the delay in the resident's progress notes.</p> <p>During an interview on 6/12/2025 at 11:05 AM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated it is important to give the medication on time and as ordered by the physician to ensure efficacy of the medications and to avoid possible adverse reactions or side effects that resident can experience. RNS 1 stated the facility's morning medication administration time is scheduled at 9 AM, and medications can be administered one hour before or after 9 AM.</p>	F 759			

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F 759	Continued From page 68 During an interview on 6/12/2025 at 11:07 AM with the Director of Nursing (DON), the DON stated not following physician's order is a medication error. The DON confirmed LVN 4 administered Resident 84 and 55's due 9 AM medications late on 6/11/2025. The DON stated medications may be administered one-hour before or after the scheduled time and should not go beyond that time as it is a medication error. The DON also added that when LVN 4 is having hard time administering medications during the allotted time, LVN 4 should have asked for help, so another licensed nurse could have helped her administer the medications. The DON stated, "If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition." During a review of Facility's Policy and Procedure (P&P) titled, "Administering Medications," revised on April 2019, the P&P indicated "Medications are administered in a safe and timely manner, and as prescribed." The P&P also indicated medications are administered within 1 hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).	F 759			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide	F 760	Immediate Corrective Action for resident affected by this deficient practice: Resident 29 was assessed by DON and graham crackers were given on 06/12/25. Dietary Supervisor provided a quesadilla	06/16/25	

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F 760	<p>Continued From page 69</p> <p>pharmaceutical services to meet the needs of one (1) of 23 sampled residents (Resident 29) as indicated on the facility policy and physician's order by failing to administer Resident 29's calcium acetate (a medicine to treat high level of phosphate [necessary for the formation of bones and teeth] in the blood]) with food on 6/12/2025.</p> <p>This deficient practice had the potential to result in Residents 29 not obtaining the therapeutic level (medicine levels in your blood are in a range that is medically helpful but not dangerous) of the medication, which could lead to complications.</p> <p>Findings:</p> <p>During a review of Resident 29's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 12/24/2015 and was re admitted on 9/8/2024, with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool), dated 5/17/2025, Resident 29's cognitive skills (ability to think and reason) for daily decision making was modified independence (some difficult in new situations only). The MDS indicated Resident 29 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating and oral hygiene. The MDS indicated Resident 29 required supervision (helper provides verbal cues) with toileting hygiene, shower, upper body dressing, lower body dressing and putting</p>	F 760	<p>Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken; DON found no other resident affected by this deficient practice. Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur:</p> <p>On 06/16/25 a 1:1 Inservice with LVN 4 by DON and Pharmacy consultant regarding the of Calcium Acetate and Phosphate binders and the importance of medications be given with food.</p> <p>Observation with Pharmacy Consultant will Randomly observe Medication Pass twice a month per Facility Policy. Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Starting 7/01/25, DON and or Designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance. Monthly QA discussion will occur for 3 months.</p>	06/16/25	

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F 760	<p>Continued From page 70 on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 51's Order Summary Report, dated 6/9/2025, the Order Summary Report indicated an order of calcium acetate, 667 milligrams (mg, unit of measurement), give 2 tablets by mouth with meals for hyperphosphatemia (high level of phosphate). Ordered on 3/18/2025.</p> <p>During a concurrent observation and interview on 6/12/2025 at 12:30 PM with Resident 29, in Resident 29's room, lunch meal was observed untouched. Resident 29 stated she was given her medication (unable to state which medication) before 12 noon, before food (lunch) got delivered to her room. Resident 29 stated she does not want to eat lunch.</p> <p>During a concurrent observation and interview on 6/12/2025 at 12:43 PM with Certified Nurse Assistant 4 (CNA 4), Resident 29's lunch tray was observed. CNA 4 stated she took Resident 29's lunch tray out of the room because Resident 29 refused to eat. CNA 4 verified Resident 29 did not eat her lunch meal.</p> <p>During an interview on 6/12/2025 at 12:45 PM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated he administered Resident 29's calcium acetate medication before lunch time (12 noon).</p> <p>During an interview on 6/12/2025 at 12:46 PM with Registered Nurse 1 (RN 1), RN 1 stated medications that were ordered to be given with meals should be followed because these medications might cause stomach upset if not given with food or medication might not be effective. RN 1 stated calcium acetate is a</p>	F 760			

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F 760	Continued From page 71 phosphate binder, and if it is not given with food as per Doctor's order, Resident 29 might end up with uncontrolled phosphate level. RN 1 verified LVN 4 did not and should have administered Resident 29's calcium acetate with lunch meal. RN 1 stated LVN 4 should have waited until the lunch trays were delivered, and made sure Resident 29 was eating a meal when administering calcium acetate medication. During a review of facility's undated Policy and Procedure titled, "Administering Medications," revised April 2019, the Policy and Procedure indicated "Medications are administered in accordance with prescriber orders, including any required time frame." It also indicated medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication. b. preventing potential medication or food interaction.	F 760			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761	Immediate Corrective Action for resident affected by this deficient practice. On 6/11/25, DON immediately emptied Station 1 incineration bin to biohazard container in locked area in the back next to laundry. Plan/Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken. On 6/12/25, DON inspected all incineration bins to ensure all bin lids were properly closed and no other deficient practice was identified.	06/12/25	

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F 761	<p>Continued From page 72</p> <p>biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide 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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to follow its Medication Storage policy by failing to:</p> <ol style="list-style-type: none"> 1. Properly dispose expired and discontinued medications in the incineration (burn) bin in medication storage room 1 (MSR 1). <p>This deficient practice increased the risk for residents to accidentally receive the medication that had become ineffective or toxic due to improper storage which could possibly lead to health complications, which may result to harm and hospitalization.</p> <ol style="list-style-type: none"> 2. Ensure non-licensed nurse was left alone inside medication room 2 (MSR 2). <p>This deficient practice increased the risk for medications to be mishandled and improperly dispensed and administered.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 6/11/2025 at 10:44 AM with Licensed Vocational Nurse 4 (LVN 4), in MSR 1, the incineration bin's lid was not properly closed due to overflowing</p>	F 761	<p>Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur; On 06/12/25 an In service done to all Licensed Nurses regarding properly disposing of expired and or discontinued medications to incineration burn bin.</p> <p>New form added : Task list labeled Attention All Licensed Nurses: 8 states," 7-3 Licensed Nurses check medication room and empty incineration bin daily to biohazard bin next to laundry room". DON to check Q daily for compliance.</p> <p>Facility Plan to Monitor Corrective action(s); and Sustain Compliance:</p> <p>Beginning 7/01/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance. Monthly QA discussion will occur for 3 months.</p>	06/12/25	

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F 761	<p>Continued From page 73</p> <p>medications. LVN 4 stated incineration bin should not be overflowing because it defeats the purpose for the disposed medications not to be accessed.</p> <p>During a concurrent observation and interview on 6/11/2025 at 10:52 AM with the Director of Nursing (DON), in MSR 2, the Director of Staff Development (DSD) was observed closing the door of medication storage 2. Upon entering medication storage room 2, the Central Supply Manager (CSM) was observed inside the medication storage room 2. The CSM stated "I was asked to clean up the incineration bin, to make sure it's not overflowing like the one in medication storage room 1." The DON stated the DSD should not have closed the door of MSR 2 while the CSM was alone inside MSR 2 because the CSM is not a licensed nurse. The DON stated medications inside the MSR2 can be accessed by unauthorized individuals and could be mishandled.</p> <p>During an interview on 6/12/2025 at 10:57 with CSM, the CSM stated "I was left alone in MSR 2 yesterday after they asked me to clean up and make sure incineration bin is not overflowing." The CSM stated she was not a licensed nurse and should not have been left alone inside MSR 2. The CSM stated she should not be handling medications without licensed nurse monitoring her.</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, "Discarding and Destroying Medications," revised in November 2022, indicated "non-controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications." It also indicated</p>	F 761			

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F 761	Continued From page 74 "non-controlled substances may be disposed of in the collection receptacle." During a review of Facility's P&P titled, "Medication labeling and storage," revised in February 2023, indicated "the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner."	F 761			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices in accordance with its policy and procedure by failing to label food that were stored in the kitchen refrigerator and	F 812	Immediate Corrective Action Undated food items were immediately discarded by Kitchen Supervisor 06/09/25. Corrective Actions for Others Affected On 6/09/25, the kitchen supervisor conducted a thorough inspection and all food items were labeled properly and found no other residents affected by the deficient practice. Measures Taken to Prevent Reoccurrence On 7/01/25, the Dietary Supervisor implemented a strict policy requiring all food items to be clearly labeled with a use-by date. Starting 7/01/25, the Dietary Supervisor will conduct regular audits of food inventory to ensure compliance with labeling requirements.	06/18/25	

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F 812	<p>Continued From page 75</p> <p>freezer.</p> <p>This deficient practice had the potential to place residents at risk for developing food borne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, and diarrhea, which could lead to other serious medical complications and hospitalization</p> <p>Findings: During a concurrent observation with the Dietary Supervisor (DS), on 6/9/2025 at 7:44 AM, in the facility's kitchen, observed multiples items in the walk-in refrigerator without a use-by date. The items were as follows:</p> <ol style="list-style-type: none"> 1. Cooked chicken in a plastic container with an open date of 6/8/2025. 2. Sliced ham in a plastic container with an open date of 6/8/2025. 3. Sliced turkey in a plastic container with an open date of 6/8/2025. 4. Cooked ground beef in a plastic container with an open date of 6/8/2025. 5. Chicken salad in a plastic container with an open date of 6/8/2025. 6. Diced pears in a bucket 7. Cut honey dew in a plastic container with an open date of 6/9/2025 8. Salsa sauce in a plastic container with an open date of 6/8/2025 9. Peeled garlic in a plastic jar with a delivered date of 5/16/2025. 10. Tomato sauce in a plastic container with an open date of 6/8/2025. 11. Four (4) one-pound sticks of solid margarine with an open date of 6/7/2025. <p>Also in the facility's kitchen, were three (3) bags of 36- count corn tortillas with a use by date of 5/21/2025.</p>	F 812	<p>Dietician Consultant conducted an in- service on food storage practices on 06/18/25 with all kitchen staff to reiterate the importance of checking use-by dates when restocking the storages; notify all staff the importance of labeling and checking food for spoilages.</p> <p>Beginning 7/01/25, the Dietary Supervisor implemented a log for regularly checking and updating use-by dates.</p> <p>Performance Monitoring to Sustain Solutions</p> <ol style="list-style-type: none"> 1. Beginning 7/01/25, the Dietary Supervisor will conduct random spot checks weekly to ensure standards are maintained continuously (to be submitted and documented for monthly QAPI meetings) for 3 months. 	06/18/25	

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F 812	Continued From page 76 During a concurrent observation with the DS, on 6/9/2025 at 8:23 AM, observed multiple items in the freezer without an open-date or use-by date or both: 1. 16 single-package of frozen fish without an open or use by date. 2. One (1) packaging of frozen chicken thigh with only an open date of 6/6/2025. 3. 1 bag of frozen chicken strips without an open or use by date. 4. Two (2) bags of frozen mix vegetable with only a delivered date of 5/26/2025. 5. Seven (7) bags of frozen pea with only a delivered date of 6/3/2025. During an interview with the DS on 6/9/2025 at 8:42 AM, DS stated food that were removed from their original packaging must be labeled with open date and use by date, so that they will be used by their "use-by" date, otherwise they need to be discarded. DS stated the 3 bags of corn tortillas with a use by date of 5/21/2025 should have been discarded because they were not safe to consume. DS stated residents could get sick if the facility serve the food that should be discarded. During an interview with Administrator (ADM) on 6/10/2025 at 2:40 PM, the ADM stated it was important for the kitchen staff to know how to practice safe food handling including proper labeling of foods with open date and use by date, and to discard expired foods to help reduce risk of getting foodborne illness. During a review of facility's policy and procedure (P&P) titled, "Food Receiving and Storage," dated March 2024, the P&P indicated food shall be	F 812			

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F 812	Continued From page 77 received and stored in a manner that complies with safe food handling practices and all food stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date).	F 812	Immediate Corrective Action for resident affected by this deficient practice; On 6/11/25, CNA threw open food away with resident 54's permission. Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken; On 6/11/25, DSD conducted rounds and found no other deficient practice. Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur; On 6/11/25, the DON sign placed in Staff Lounge in English and Spanish to include Any Food brought into facility must have a name, opened date and expiration date. In-service done for CNAs 6/15/2025 regarding Personal Food Policy. CNA1 had 1:1 on 6/15/2025 in-service with DSD and educated on any food which is brought into facility and opened must have a name, opened date and expiration date of 3 days and will be thrown out. Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Starting 6/30/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance for 3 months.	06/15/25	
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to label and properly store the food found in the resident's room for one (1) of 23 sampled residents (Resident 54) in accordance with the facility policy. This deficient practice had the potential to result in food-born illnesses (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever, other serious medical complications, and hospitalization. Findings: During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was originally admitted to the facility on 4/25/2023 and readmitted on 5/1/2025. Resident 54's diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pressure ulcer (PU-injury to skin and underlying tissue resulting from prolonged pressure on the skin) of right heel unstageable (a type of pressure	F 813			

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F 813	<p>Continued From page 78</p> <p>injury where the true depth of the wound cannot be determined due to the presence of dead tissue obscuring the wound bed.), and type II type 2 diabetes mellitus (a medication condition characterized by the body's inability to regulate blood sugar level).</p> <p>During a review of Resident 54's Minimum Data Set (MDS - a comprehensive standardized assessment and screening tool), dated 5/8/2025, the MDS indicated Resident 54's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 54 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) from staff for toileting hygiene, shower/bathe self, and upper/lower body dressing.</p> <p>During on observation and interview with Certified Nursing Assistant 1 (CNA 1), on 6/11/2025 at 11:59 AM, in Resident 54's room, CNA1 confirmed a shopping bag was on the floor containing three zipped bags with food without label. Several crackers were observed in the first zipped bag. A ham sandwich was observed in the second zipped bag, and several tortillas were observed in the third bag. There were also two cups of unopened apple sauce and one cup of unopened yogurt observed on the top of Resident 54's nightstand. A half box of honey maid crackers, one cup of unopened apple juice, and one cup of unopened apple sauce were observed inside Resident 54's side drawer. CNA 1 stated all the food in Resident 52's room were brought by the resident's family and did not have a label to indicate the expiration dates. CNA1 stated it could not be determined if the food were still good</p>	F 813			

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F 813	<p>Continued From page 79</p> <p>to consume. CNA1 stated the yogurt and apple sauce should have been in the residents' refrigerator. CNA 1 stated resident could get sick and be hospitalized for consuming expired food or from not being stored in the right temperature.</p> <p>During an interview Registered Nurse Supervisor 1 (RNS 1), on 6/11/2025 at 1:34 PM, RNS 1 stated it was important for dietary staff to check the food brought in the facility from outside to ensure that they were appropriate based on the prescribed diet texture for resident to prevent choking (severe difficulty in breathing because of a constricted or obstructed throat or a lack of air). RNS 1 stated the outside food should be labeled with the date it was made as well as with the resident's name and room number to reduce the risk of foodborne illnesses including upset stomach, nausea, vomiting, diarrhea and fever, other serious medical complications, and hospitalization.</p> <p>During a review of facility's policy and procedure (P&P) titled, "Foods Brought from Outside the Facility by Family or Visitors," revised March 2022, the P&P indicated that food brought by family/visitors that is left with the resident to consume later is to be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. Perishable foods are stored in resealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the "use by" date. The P&P indicated that food that present a potential choking hazard for residents with impaired cognitive function or swallowing difficulty are taken from the resident and returned to the family/visitor.</p>	F 813			

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F 851	<p>Continued From page 81</p> <p>tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).</p> <p>§483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.</p> <p>§483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.</p> <p>§483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to submit the second quarter of 2025 Payroll Based Journal (PBJ- a system for healthcare facilities to submit staffing information . This system allows staffing information to be collected on a regular and more frequent basis than previously collected) for the month from 1/1/2025 to 3/31/ 2025 on the designated time.</p> <p>This deficient practice compromised the accuracy of the facility's staffing levels and potential for the facility to not be adequately staffed and/or have the necessary staff to provide care to meet the needs of all the residents in the facility.</p>	F 851			

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F 851	<p>Continued From page 82</p> <p>Findings:</p> <p>During a review of the CMS's (Centers for Medicare & Medicaid Services -the federal agency that provides health coverage) PBJ Staffing Data Report, dated 6/5/2025, the PBJ report indicated the facility did not submit data of staffing, for the quarter included 1/1/2025 to 3/31/2025.</p> <p>During an interview with the Payroll Coordinator (PC), on 6/11/2025 at 3:11PM, PC stated there were three errors in his staffing data report for the quarter included month of 1/1/2025 to 3/31/2025.</p> <p>During an interview with the PC, on 6/12/2025 at 11:01AM, PC stated the old payroll processing company was closed for an unknown reason. PC stated facility started using a new payroll company by the end of 5/2025. PC stated the 1/1/2025 to 3/31/2025 staffing data was resubmitted and it was accepted by the CMS on 6/3/2025.</p> <p>During an interview with the Administrator (ADM), ADM stated he has started working in this facility as the ADM since beginning of 6/2025. ADM stated he did not know anything about the failure of submission of Staffing Data Report of the first quarter. ADM stated PC should have let the former ADM knows about the closing of the old payroll processing company and they should have looking into this matter to prevent the delay of staffing data submission to the CMS.</p> <p>During a review of the facility's policy and procedure (P&P) titled " Administrative Policies and Procedures for Long Term Care ", revised on 10/2017, the P&P indicated staffing and census information will be reported electronically to CMS</p>	F 851			

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F 851	Continued From page 83 through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. The P&P also indicated: 1. Beginning with the fiscal quarter of 2016 (beginning July 1, 2016), direct-care staffing and census information will be reported electronically to CMS through the Payroll-Based Journal (PBJ) system. 2. For auditing purposes, reported staffing information is based on payroll records, or other verifiable information. 3. Information may be uploaded to the PBJ system manually, or through a payroll time and attendance system, or a combination of both. 4. Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows: Submission deadline for the fiscal quarter included January 1- March 31 is May 15. 5. Information may be uploaded to the PBJ system manually, or through a payroll time and attendance system, or a combination of both. 6. Census data is reported each fiscal quarter and includes resident census on the last day of each month of the quarter. 7. Payroll coordinator is responsible for the prepare, verify, and submit the quarterly payroll-based journal as required.	F 851			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880	Immediate Corrective Action for resident affected by this deficient practice; On 6/13/25, DSD Applied Enhance Barrier Precautions signage and isolation cart to outside of room 119. On 6/13/25, Housekeeping Supervisor placed signs to indicate clean and dirty area in Laundry Room.	06/13/25	

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F 880	<p>Continued From page 84 diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility</p>	F 880	<p>Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken. DSD with DON rounded and found no other resident affected by the same deficient practice.</p> <p>Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur.</p> <p>On 6/13/25, CNA 5 was given 1:1 by DSD in-service to render care with Enhanced Barrier Precautions (gown and gloves) to prevent cross contamination of infections. Inservice was done by DSD to all licensed Nurses and Certified Nurses Assistants on 06/15/25 that includes to wear Gown and gloves when rendering care with Residents who have indwelling catheters, open skin areas, gastronomy tubes, hemodialysis shunt sites, etc. to prevent the spread of infection. DON gave a 1:1 in-service on 06/13/25 with Infection Preventionist regarding prevention and infection control. On 6/13/25, the DON gave the Infection Preventionist an Infection Control Clinical Rounds daily check off list and will do rounds.</p> <p>Facility Plan to Monitor Corrective action(s); and Sustain Compliance: Starting 7/01/25, DON or designee will review Performance and report to Administrator and report to QAPI monthly meetings for compliance. Monthly QA discussion will occur for 3 months.</p>	06/13/25	

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F 880	<p>Continued From page 85</p> <p>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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement its policy and procedure on infection control for four (2) of 23 sampled residents (Resident 24 and 29) and in the laundry when:</p> <ol style="list-style-type: none"> 1. Staff did not use personal protective equipment (PPE, used to prevent or minimize exposure and to protect from potential transmission of biological agents that can be transferred from person to person by direct and indirect contact) while rendering care to Resident 24 who was on enhanced barrier precaution (EBP, use of PPE beyond anticipated blood and body fluid exposures) on 6/9/2025. 2. PPE cart and EBP signage was not available outside Resident 29's room who was on EBP precaution. 3. The facility failed to place a cart of clean linen 	F 880			

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F 880	<p>Continued From page 86</p> <p>in the clean area of the laundry room, put signs to indicate the clean and dirty area in the laundry room, and ensure laundry room's sink was not clogged with dark brown water</p> <p>These deficient practices have the potential to result in a widespread infection in the facility that could compromise the health of the residents, visitors, and staff.</p> <p>Findings:</p> <p>1. During a review of Resident 24's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on 4/3/2024, with diagnosis of dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), sacral pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and pressure ulcer of right and left heel.</p> <p>During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 4/10/2025, indicated Resident 24's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 24 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>During a review of Resident 24's Order Summary Report, dated 6/9/2025, the Order Summary Report indicated an order of Enhanced Barrier</p>	F 880			

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F 880	<p>Continued From page 87</p> <p>Precaution due to wound, ordered on 9/19/2024.</p> <p>During an observation on 6/9/2025 at 8:30 AM, in Resident 24's room, EBP signage was observed outside Resident 24's room. Resident 24 was observed in bed while Certified Nurse Assistant 5 (CNA 5) was rendering care to the resident. CNA 5 was observed wearing gloves and not wearing isolation gown.</p> <p>During an interview on 6/10/2025 at 2:32 PM, with CNA 5, CNA 5 stated she rendered care to Resident 24 yesterday (6/9/2025) while Resident 24 was in bed. CNA 5 stated she removed her isolation gown after she changed Resident 24's diaper and she continued to care for Resident 24 while only wearing gloves.</p> <p>During an interview on 6/10/2025 at 2:35 PM with MDS Nurse (MDSN), MDSN verified Resident 24 has an order for EBP. MDSN stated EBP should be followed during high-contact patient care activities such as dressing, bed bath, wound care, changing diaper and changing bed linens. MDSN stated, "CNA (CNA5) should have worn a gown until the care was finished, before leaving the room, and not only use the gown during diaper change."</p> <p>During an interview on 6/12/2025 at 11:50 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 24 has an order for EBP and should be implemented when rendering direct care. RN 1 stated that EBP is to protect residents from infections and viruses.</p> <p>2. During a review of Resident 29's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on</p>	F 880			

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F 880	<p>Continued From page 88</p> <p>12/24/2015 and was re admitted on 9/8/2024, with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), displacement of vascular dialysis catheter (a catheter [thin tube] that is placed under the skin in a vein, allowing long-term access to the vein).</p> <p>During a review of Resident 29's MDS, dated 5/17/2025, Resident 29's cognitive skills for daily decision making was modified independence (some difficult in new situations only). The MDS indicated Resident 29 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating and oral hygiene. The MDS indicated Resident 29 required supervision (helper provides verbal cues) with toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 29's Order Summary Report, dated 6/9/2025, the Order Summary Report indicated an order of Enhanced Barrier Precaution, ordered on 6/8/2025.</p> <p>During a concurrent observation and interview on 6/11/2025 at 1:12 PM, outside Resident 29's room, with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated that there was no EBP signage and no PPE cart outside Resident 29's room to alert staff and visitors to wear appropriate PPE while rendering close contact care to Resident 29.</p> <p>During an interview on 6/12/2025 at 11:51 AM with RN 1, RN 1 stated the facility does adhere EBP, wherein PPE, such as wearing gown, gloves, and mask, is needed during physical contact care like wound care treatment. RN 1 stated wearing PPE was important to protect the</p>	F 880			

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F 880	<p>Continued From page 89</p> <p>resident. RN 1 stated staff providing care to Resident 29 should wear the proper PPE for infection control because Resident 29 has central venous catheter (a catheter [thin tube] that is placed under the skin in a vein, allowing long-term access to the vein) for dialysis s (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>During a review of facility's Policy and Procedures (P&P) titled, "Enhanced Barrier Precautions Policy and Procedures," revised on 6/6/2025, the P&P indicated the following:</p> <p>" EBP expands upon standard precautions by requiring the use of gowns and gloves during specific high-contact resident care activities.</p> <p>" Examples of high-contact resident care activities requiring gown and glove use for residents on EBP include, but are not limited to providing hygiene, changing linens, changing briefs or assisting with toileting.</p> <p>" Examples of indwelling medical devices for which EBP should be used include but are not limited to central vascular lines (including hemodialysis catheters).</p> <p>" Nursing staff ensure that the resident and staff are aware of the need to use EBP and that necessary supplies are provided and regularly restocked. Provide readily available personal protective equipment (PPE), including gowns and gloves.</p> <p>" Residents and visitors should receive education on the importance of hand hygiene and adherence to facility policies, and on EBP.</p> <p>3. During an observation on 6/11/2025 at 11:30 AM in the laundry room, a clean linen cart was placed in the laundry room's dirty area next to the sink which was filled with dark brown water. The</p>	F 880			

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F 880	<p>Continued From page 90</p> <p>laundry sink was also observed clogged with sitting dark brown water. There was also no signage inside the facility's laundry area to distinguish a clean area and dirty area.</p> <p>During a concurrent observation and interview on 6/11/2025 at 11:32 AM with the Housekeeping Supervisor (HS) in the laundry area of the facility, HS stated the clean laundry linen cart should have been placed in the clean laundry area instead of the dirty area of the laundry area to prevent cross contamination of the linens.</p> <p>During a concurrent observation and interview on 6/11/2025 at 11:33 AM with the HS in the laundry area of the facility, HS stated the sink was and should not be clogged. The HS stated the sink need to keep unclogged all the time to prevent spread of bacteria and contamination.</p> <p>During an interview on 6/11/2025 at 11:35AM with the HS, in the laundry area of the facility, HS stated there should be signs to indicate the clean area and the dirty area inside the laundry area. HS stated this will ensure all laundry room workers and staff would know where to put clean laundry and dirty laundry to prevent cross contamination and stop the spread of pathogens. HS also stated clean laundry needs to be put in the clean area to prevent the clean linen from getting contaminated and to prevent the spread of infection.</p> <p>During a concurrent observation and interview on 6/11/2025 at 11:37 AM with the Maintenance Supervisor (MS) in the laundry area of the facility, MS stated the sink should be unclogged all the time to prevent the spread of bacteria, pathogens, cross contamination, and pest infestation.</p>	F 880			

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F 880	Continued From page 91 During a concurrent interview on 6/11/2025 at 3:43 PM with the Infection Preventionist Nurse (IPN), IPN stated the laundry area needs to have signage to indicate clean area and dirty area. IPN stated the clean laundry was supposed to be placed in the clean area of the laundry area to prevent cross contamination, spread of the bacteria, and to stop the communicable diseases spread to the residents. IPN stated the laundry sink needs to be kept clean and unclogged all the time to prevent the spread of bacteria, pathogens, cross contamination, and pest infestation. During a review of the facility's undated P&P titled, " Laundry & Linen, Linen Supply, Soiled & Clean Linen Storage," the P&P indicated to ensure that soiled and clean linens are not stored in the same room. Do not inter-mix the storage of soiled and clean linens. Keep all linen storage areas clean at all times. Report any problems to the supervisor. During a review of the facility's undated P& P titled, "Laundry & Linen, Maintenance of the Laundry Room & Laundry Equipment," the P&P indicated report immediately to the supervisor any problems or malfunctions of the laundry equipment. Clean all sinks daily. Report any problem with laundry room ventilation or dirt or corrosion on fans or ducts to the supervisor.	F 880			
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §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	F 912	Immediate Corrective Action A request for room waiver was submitted to the CDPH Surveyor Team on 6/9/25 for the following rooms which have less than 80 square feet for multiple residents in a room: 105, 108, 116, 201, 203, 205, 207, 212, 214, 218, and 222.	07/07/25	

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F 912	<p>Continued From page 92</p> <p>by: Based on observation, interview and record review, the facility failed to ensure 11 of 41 resident rooms (rooms 105, 108, 116, 201, 203, 205, 207, 212, 214, 218 and 222) met the square footage requirement of 80 square feet (sq. ft.) per resident in a multiple resident room.</p> <p>This failure had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care.</p> <p>Findings:</p> <p>During the initial observation on 6/9/2025 from 9:00 AM to 12:00 PM, resident rooms 105, 108, 116, 201, 203, 205, 207, 212, 214, 218 and 222 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to ambulate and/or move around in their wheelchairs freely. Nursing staff were observed to have enough space to provide safe quality care and there was enough space for beds, side tables, dressers and other medical equipment.</p> <p>During a review of the facility's room waiver dated 6/9/2025, the facility's room waiver indicated the rooms with two (2) and three (3) beds are in accordance with the needs of the residents with adequate space and do not have any adverse effects on the residents' health and safety. The facility's room waiver also indicated the following:</p> <table border="0"> <tr> <td>Room</td> <td>Sq. Ft.</td> <td>Beds</td> </tr> <tr> <td>Room 105</td> <td>- 146 sq. ft.</td> <td>- 2 beds</td> </tr> <tr> <td>Room 108</td> <td>- 234 sq. ft.</td> <td>- 3 beds</td> </tr> <tr> <td>Room 116</td> <td>- 219 sq. ft.</td> <td>- 3 beds</td> </tr> <tr> <td>Room 201</td> <td>- 143 sq. ft.</td> <td>- 2 beds</td> </tr> </table>	Room	Sq. Ft.	Beds	Room 105	- 146 sq. ft.	- 2 beds	Room 108	- 234 sq. ft.	- 3 beds	Room 116	- 219 sq. ft.	- 3 beds	Room 201	- 143 sq. ft.	- 2 beds	F 912	<p>Corrective Action for Others Affected</p> <p>The granting of waiver request will not adversely affect the resident's health and safety and is in accordance with the special needs of the residents. A completed Facility Client Accommodations Analysis indicate all other rooms met the required measurement Measures Taken to Prevent Reoccurrence Starting 7/01/25, the department heads will conduct Angel Rounds on a daily basis to ensure that the space available for the residents in the affected rooms is sufficient to provide care, provide privacy, and provide adequate space for patient care equipment and personal items.</p> <p>Performance Monitoring Starting 7/01/25, all findings will be presented by the administrator during the monthly QAPI Meeting for next 3 months to ensure total compliance is achieved.</p>	7/07/25
Room	Sq. Ft.	Beds																	
Room 105	- 146 sq. ft.	- 2 beds																	
Room 108	- 234 sq. ft.	- 3 beds																	
Room 116	- 219 sq. ft.	- 3 beds																	
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F 912	<p>Continued From page 93</p> <p>Room 203 - 143 sq. ft. - 2 beds Room 205 - 143 sq. ft. - 2 beds Room 207 - 206 sq. ft. - 3 beds Room 212 - 216 sq. ft. - 3 beds Room 214 - 154 sq. ft. - 2 beds Room 218 - 216 sq. ft. - 3 beds Room 222 - 156 sq. ft. - 2 beds</p> <p>The minimum square footage for a 2-bedroom is 160 sq. ft. and the minimum square footage for a 3-bedroom is 240 sq. ft.</p> <p>During an interview on 6/12/2025 at 2:17 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated all the rooms at the facility have enough room for him to provide care safely to the residents and stated the residents also have enough room to get around in their wheelchairs in the rooms just fine.</p> <p>During an interview on 6/12/2025 at 2:19 PM with Restorative Nursing Assistant 1 (RNA 1), RNA 1 stated that all the resident's rooms at the facility have enough room for her to provide care to the residents and that the residents also have enough room to move around safely.</p> <p>During an interview on 6/12/2025 at 2:35 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated all the resident rooms have enough space for the residents to get around & also have enough room for her to provide care to the residents safely.</p> <p>During interviews with residents both individually and collectively, the residents did not express any concerns regarding the size of their rooms. The Department would be recommending the room waiver for Rooms 105, 108, 116, 201, 203, 205, 207, 212, 214, 218 and 222 as requested by the</p>	F 912			

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NAME OF PROVIDER OR SUPPLIER INFINITY CARE OF EAST LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP CODE 101 S FICKETT STREET LOS ANGELES, CA 90033		
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F 919	<p>Continued From page 95</p> <p>4/2/2025, the MDS indicated Resident 55's cognitive skill for daily decision making was moderately impaired. The MDS also indicated Resident 55 was assessed to require supervision or assistance (Helper provides verbal cues and touching/steadying and/or contact guard assistance as resident completes activity.) with shower/bathe self. The MDS indicated Resident 55 was assessed to require setup or clean-up assistance (helper sets up or clean up, resident completes activity.) with toilet hygiene, personal hygiene, and eating.</p> <p>During an observation and interview, on 6/9/2025 at 11:06 AM, in Resident 55's room, Resident 55's call light was observed on the bed. Resident 55 stated, "The call light is broken!"</p> <p>During a concurrent observation and interview with Licensed Vocational Nurse 7 (LVN7) on 6/9/2025 at 11:10 AM, in Resident 55's room, LVN 7 was observed activating the call light, then walked to the doorway, and glanced up to see if the light above the door lit up. LVN 7 stated Resident 55's call light was not functioning because there was no audible or visible signal above Resident 55's door. LVN 7 stated each resident must have a functional call light to notify the staff if they need help.</p> <p>During an interview with Registered Nurse Supervisor 1 (RNS 1) on 6/10/2025, at 8:36 AM, RNS 1 stated it was important to always have a functional and reliable call light, so residents' safety will not get compromised.</p> <p>During a review of facility's policies and procedures (P&P) titled, "Call Light, Residents," revised dated September 2022, the P&P</p>	F 919			

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F 919	Continued From page 96 indicated that the resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. The P&P indicated that each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.	F 919	Immediate Corrective Action for resident affected by this deficient practice; DSD in-serviced CNA 6 on 6/16/2025 on Dementia Management.DSD in-serviced CNA 7 on 6/16/2025 on Dementia Management.	07/01/25	
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and records review failed to ensure dementia management was included to the nurse aide in-services at least 12 hours in a year for (2) two out of (2) two sampled certified	F 947	Plan /Process to Identify other Residents potentially affected by same deficient Practice and Corrective Action(s) to be taken. DSD rounded on 6/12/25 and found no other resident affected by the deficient practice.		

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F 947	<p>Continued From page 97 nursing assistant (CNA) employees.</p> <p>These deficient practices may result in a potential compromised resident safety and reduced quality of care.</p> <p>Findings: During a review of employee folder for CNA 6 on 6/12/2025 at 11:15 AM with the Director of Staff Development (DSD) at DSD's office, CNA 6's employee record indicated CNA 6's latest dementia management training was on 1/12/2022.</p> <p>During a review of employee folder for CNA 7 on 6/12/2025 at 11:30 AM with the DSD at DSD's office, CNA 7's employee record indicated CNA 7's latest dementia management training was on 3/5/2024.</p> <p>During a concurrent interview and record review on 6/12/2025 at 11:35 AM with the DSD, DSD stated she does not have any upcoming dementia management training to the the annual performance evaluations were older than 12 months. DSD also stated she was not able to provide any additional information for her last dementia management training to the CNAs and other facility employees. DSD stated she had no tracking system to ensure CNAs had at least 12 hours of in-service education per year. DSD stated it was important to track the in-service CNAs received to make sure CNA had enough continuing education hours and competency to ensure residents were taken cared of appropriately. DSD stated she should have keep updating all employee files in a timely manner, provide employees in services and updating the in- service calendar to prevent potential</p>	F 947	<p>Facility Measures and Systemic Changes to ensure the deficient practice does not reoccur:</p> <p>Starting 6/12/25, DSD will maintain a calendar what in-services will be given every month to include Dementia Management . DSD initiated a log on 6/19/2025 Continue Education to over see CNAs have enough CEUs that includes Dementia Management with Competency to ensure residents are properly care for</p> <p>DSD on 06/17/25 and 06/19/25 conducted required in-service training with CNAs and Licensed Nurses with emphasis given on Dementia Management that all Nurse Aides to be in- serviced quarterly and for at least 2 hours. Dementia - specific Training as part of facility orientation program.</p> <p>Administrator conducted 1:1 inservice training with the DSD on Dementia on 6/19/2025.</p> <p>Performance Monitoring:</p> <p>Starting 7/01/25, the DON will review the DSD's training calendar to ensure inclusion of Dementia Training and the DON will report in the monthly QAPI meeting for discussion and review. Monthly discussion and review will occur for 3 months.</p> <p>Facility Plan to Monitor Corrective action(s); and Sustain Compliance:</p> <p>DSD will report any deficient practices will review Performance and report to Administrator and report to QAPI monthly meetings for compliance</p>	07/01/25	

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F 947	<p>Continued From page 98</p> <p>compromised resident safety and reduced quality of care.</p> <p>During an interview on 6/12/2025 at 12:25 PM with the CNA6, CNA 6 stated the facility did not provide dementia management training to her ever since she had started working in this facility. CNA 6 stated she learned the dementia management training from her school.</p> <p>During a concurrent interview and record review on 6/12/2025 at 2:15 PM with the DSD, the facility's policy and procedure (P&P) titled, "Job Description: Director of Staff Development" undated, was reviewed. The P&P indicated it is the primary function of the Director of Staff Development to plan, develop, direct, evaluate, and coordinate the nursing assistant training program implemented by the facility in accordance with current federal, and state guidelines. It also indicated: General Functions/Duties</p> <ol style="list-style-type: none"> 1. Coordinate continuous in-service training programs to ensure that appropriate topics are included in the program and needs are being met. 2. Participate in and/or assist facility in constructing class schedules, clinical training 3. Schedules, orientation programs, and in-service training classes. 4. Provide leadership in formulating the goals and objectives of the nursing assistant training program 5. Direct the preparation, scheduling, and selection of instructional material, equipment and training aids, to ensure that a modern. meaningful training program is provided. 6. Develop and participate in annual evaluation to determine if changes in the curriculum or training techniques need to be made. 	F 947			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 947	Continued From page 99 7. Participate in the monitoring of instructional and skill training classes to ensure that course curriculum is being followed. 8. Assist in maintaining appropriate record keeping documents outlines in the course specifications, as well as may be mandated, by current federal and state requirements. 9. Plan, develop, direct, evaluate and coordinate the educational curriculum for the nursing assistant training program for long term care, as well as other allied health care institutions or agencies.	F 947		