POC Approved 05/29/2025

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

PRINTED: 05/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED	555707	A. BUILDING _____ B. WING _____	C 04/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	11441 VENTURA BLVD STUDIO CITY, CA 91604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident Number: CA00959045 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. Deficiencies were issued for Facility Reported Incident number: CA00959045 at F689, F684, F837, and F842. On 4/25/2025 at 5:49 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s non-compliance with one or more requirements of participations has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) in the presence of the Administrator and the Director of Nursing (DON) due to the facility ' s failure to provide supervision to Resident 1 and to prevent the elopement of Resident 1 on 4/24/2025 at 6:48 p.m. On 4/27/2025 at 2:34 p.m., the DON provided an acceptable IJ removal plan (a detailed plan to address the IJ findings) for the facility ' s failure to provide supervision to Resident 1 and to prevent the elopement of Resident 1 on 4/24/2025 at 6:48 p.m. On 4/27/2025 at 6:19 p.m., while onsite at the facility, the SSA verified and confirmed the facility ' s full implementation of the IJ Removal Plan	F 000	Disclaimer: The signing of this plan of correction is not an admission or agreement of this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction constitutes Facility's written credible allegation of compliance for the deficiencies noted.	9/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/15/25

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 000	Continued From page 1 through observations, interviews, and record reviews, and determined the IJ situation regarding elopement due to lack of supervision was no longer present. The SSA removed the IJ on 4/27/2025 at 6:48 p.m., in the presence of the Administrator and the DON. The acceptable IJ Removal Plan included the following summarized actions: 1. On 4/25/2025, the Administrator gave a disciplinary action (a reprimand or corrective action in response to employee misconduct, rule violation, or poor performance) and suspended RNA 1 pending investigation. 2. On 4/25/2025 at 5 p.m., Registered Nurse (RN) 1, Licensed Vocational Nurse (LVN) 1, and 2 local police officers located Resident 1 in Resident 1 ' s apartment, approximately 7.8 miles (unit of measurement) away from the facility. 3. On 4/25/2025 at 5:56 p.m., RN 1, LVN 1, and 2 local police officers accompanied Resident 1 back to the facility. RN 2 completed Resident 1 ' s skin assessment and noted a scab (a dry, rough protective crust that forms over a cut or wound during healing) on Resident 1 ' s left knee. 4. On 4/25/2025 at 8:30 p.m., Resident 1 was transferred to General Acute Care Hospital (GACH) 1 for further evaluation. 5. From 4/25/2025 to 4/26/2025, the DON, the Quality Assurance (QA) Nurse Consultant (a registered nurse specializing in improving resident care quality, ensuring compliance with regulations, and enhancing healthcare practices), and the Director of Staff Development (DSD),	F 000		

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F 000	Continued From page 2 conducted a series of in-services (a planned, workplace-based training program designed to enhance staff competency, improve job performance, and keep staff up to date with current best practices and new techniques) to staff regarding "Safety and Supervision of Residents," "Elopement," "Missing Person," and "Resident Identification" policies, emphasizing the following: a. The purpose and importance of identifying and confirming with the Licensed Nurses (LNs), RNs, the Administrator, or Receptionist, that the person leaving the facility is a visitor and not a resident of the facility before allowing anyone to leave the (facility ' s secured) premises. b. The purpose and importance of supervising residents while in the facility and always being mindful of their (residents) whereabouts to ensure residents ' safety. c. The purpose and importance of identifying residents by checking if they are wearing an Identification (ID) wristband [a bracelet-like band, often worn on the wrist, contain at the minimum two identifiers (name and birthday) used for identification purposes] or having another form of identification such as a photograph. d. The purpose and importance of immediate action and interventions such as initiating a code to initiate search immediately once a resident was found missing. e. The purpose and importance of seeking assistance from the Local Police Department in searching for a missing resident.	F 000		

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F 000	Continued From page 3	F 000		

6. On 4/26/2025, LN, Medical Records Director, and Designee checked all residents to see if in-house residents were wearing ID wristbands. There were four residents (Residents 3, 6, 12, and 13) who were found not wearing ID wristbands due to refusal. An Interdisciplinary meeting (IDT meeting, involves professionals from different fields or specialties collaborating to address a shared problem or achieve a common goal) was conducted to discuss Residents 3, 6, 12, and 13 ' s noncompliance. The residents ' refusal to wear ID wristbands was addressed in the residents ' care plans.

7. On 4/26/2025, the Social Service Director (SSD) or designee and LNs evaluated all residents to see if the residents feel safe while in the facility using the safety/wellness evaluation tool. No other resident was found to be affected by the deficient finding.

8. On 4/26/2025, the IDT members comprising of the Administrator, the DON, and the DSD reviewed a new policy pertaining to secured unit/facility integrating the guidelines on admission process, environment special consideration, and visitation.

a. The RN or Licensed Designee will immediately apply an ID wristband to a resident upon admission to help identify a resident while in the facility. A resident ' s photograph will also be taken, and the resident ' s picture will be uploaded in the resident ' s electronic health record (a digital version of a resident ' s medical history, stored on a computer and designed to be shared across different healthcare settings).

b. A green colored ID wristbands will be provided

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F 000	Continued From page 4 to residents who are ambulatory without assistance for identification purposes and to alert staff about the risk for elopement especially when the residents seek exit doors. c. The Administrator will assign Department Heads or IDT members to conduct room inspections and check residents to see if they are wearing ID wristbands. The Administrator will also assign a Department Manager to be a "Manager of the Day (MOD)" on the weekends (Saturday to Sunday) to conduct random room inspection, including but not limited to checking Residents if they are wearing ID wristbands. d. The LNs will be conducting visual monitoring every 30 minutes for 72 hours to check newly admitted residents ' whereabouts, activities, and behaviors. e. The facility will assign a staff member to monitor the reception area daily seven days a week to monitor the front lobby as well as monitoring individuals entering and exiting the facility. The assigned receptionist will inform the SSD and/or designee five times a week (Monday to Friday) and the "Manager of the Day" on the weekends as coverage if the assigned receptionist will go on a break. An alarm has been installed on the main entrance door to also alert staff when there is someone coming in and out of the facility, in the absence of the receptionist in the front lobby.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 5 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice to meet the physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior) needs for one of four sampled residents (Resident 1) by failing to measure Resident 1 ' s blood sugar when Resident 1 returned to the facility on 4/25/2025. This failure had the potential to delay Resident 1 ' s care and negatively affect Resident 1 ' s well-being. Findings: During a review of Resident 1 ' s "History and Physical (H&P)" from GACH 2, dated 3/9/2025, the "H&P" indicated Resident 1 was admitted to GACH 2 due to hypertensive urgency (a situation where blood pressure is significantly elevated, but there is no immediate evidence of organ damage), and had diagnoses of hypertension (high blood pressure), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities).	F 684	F- 684 Immediate Corrective Action: On 04/26/2025, the Director of Nurses followed up with General Acute Hospital regarding resident's condition. Obtained information that resident was medically clear at Emergency Department and was admitted at Gero-psychiatric floor for further evaluation as gravely disabled. Based on ER records resident blood sugar level was within normal range. Action taken to identify all other residents having the potential to be affected by the deficient practice and corrective action taken: On 04/27/2025, ADON and RN supervisor reviewed all diabetic resident' s chart who required blood sugar check via fingerstick. All residents' blood sugar via fingerstick were checked as ordered. No other residents were affected by the same deficiency practice. Process and action taken to ensure deficient practice does not reoccur: On 04/27/2025, the Director of Nurses conducted an in-service with the licensed nurses on importance of checking blood sugar level via fingerstick for residents with diagnosis of diabetes to prevent occurrence of hypoglycemia and to manage episodes of hyperglycemia.	5/15/25

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F 684	Continued From page 6 During a review of Resident 1 ' s "Admission Assessment," dated 4/24/2025, the "Admission Assessment" indicated Resident 1 was admitted to the facility on 4/24/2025 at 5 p.m. The "Admission Assessment" indicated Resident 1 was alert and oriented to time, place, with slow comprehension and required assistance with showers, bed baths, oral hygiene, grooming, and dressing. During a review of Resident 1 ' s Change of Condition (COC - when there is a sudden significant change in a resident ' s health status) Assessment Form, dated 4/24/2025, the COC indicated on 4/24/2025 at 6:50 p.m., Resident 1 walked out of the facility after RNA 1 opened the facility ' s locked gate. The COC indicated LVN 2 noticed an unfamiliar person leaving the facility after RNA 1 used the code to open the locked gate. During a concurrent interview and record review on 4/25/2025 at 1:17 p.m. with the Director of Nursing (DON), Resident 1 ' s "Discharge Reconciliation Report," from the Center for Behavioral Health (CBH), dated 4/24/2025 was reviewed. The DON stated the facility had not located Resident 1 (as of this time of the interview) and as a result Resident 1 was at risk to experiencing negative effects from missing her medications, including hypoglycemia (a condition in which the body ' s blood sugar level drop below the normal range) or hyperglycemia (a condition in which the there is too much sugar in the blood). A concurrent review of the "Discharge Reconciliation Report" with the DON indicated Resident 1 was prescribed the following medications:	F 684	Continued from page 6. On 04/27/2025 DON conducted a 1:1 In-service to RN1 regarding the emphasis of checking blood sugar via finger stick for residents with diagnosis of diabetes to prevent episodes of hypoglycemia and manage episodes of hyperglycemia. Monitoring performance to ensure that correction is achieved and sustained: The ADON/RN supervisor randomly will review residents' charts with diagnoses of diabetes to ensure that blood sugar check via fingerstick is done as ordered by MD. ADON/RN supervisor to check charts of residents with diagnosis of Diabetes every week for 3 months to ensure that all orders for fingerstick are done as ordered by MD. As part of the facility CQI program, the DON will present a recapitulation of the RN supervisor, and findings will be reviewed to the QAA committee monthly for next three month for review and action as indicated. The DON will monitor to compliance through review of monthly report by RN supervisor and ADON.	

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F 684	Continued From page 7 - Insulin Lispro (Humalog - a rapid-acting insulin used to manage high blood sugar levels) 3 units (unit of measurement) before meals for diabetes mellitus. - Repaglinide (Prandin, a medication used to treat high blood sugar levels) 0.5 mg three times a day with meals for diabetes mellitus. During an interview on 4/27/2025 at 1:07 p.m. with Registered Nurse (RN) 1, RN 1 stated on 4/25/2025 at "approximately" 5 p.m. RN 1 located Resident 1 in Resident 1 ' s apartment. RN 1 stated Resident was accompanied back to the facility on 4/25/2025 at approximately 24 hours, at 6 p.m. on 4/25/2025 with the assistance of 2 local police officers. RN 1 stated Resident 1 ' s readmission assessment was completed by RN 2 after Resident 1 ate 100 percent (% - per one hundred) of her meal provided by the facility. RN 1 stated licensed staff should have measured Resident 1 ' s blood sugar level before her meal because Resident 1 was at risk of experiencing hypoglycemia (a condition in which blood sugar levels fall below normal level and can cause confusion and loss of consciousness) or hyperglycemia (a condition where the level of blood sugar in the blood is elevated above the normal range and can cause confusion, blurred vision, loss of consciousness) after being absent from the facility for approximately 24 hours. During an interview on 4/27/2025 at 5:15 p.m. with the DON, the DON stated facility should have measured Resident 1 ' s blood sugar when Resident 1 returned to the facility on 4/25/2025 since Resident 1 was at risk of experiencing hypoglycemia or hyperglycemia and might have	F 684		

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F 684	Continued From page 8 required treatment. During a review of current facility-provided policy and procedure titled, "Nursing Care of Older Adults with Diabetes Mellitus," last reviewed on 7/2024, the policy and procedure indicated, "Blood Glucose Monitoring ... For resident receiving insulin who is well controlled: c. monitor as indicated if the individual is fasting before a medical procedure, has returned to the facility after a significant absence, or has an acute infection or illness."	F 684	F- 689 Immediate Corrective Action: On 04/24/2025, the facility, under Administrator and Director of Nurses instruction, initiated the missing resident protocol. The staff called local hospitals. The facility searched facility premises and close surroundings. Local Law enforcement was called for support. MD was informed. Resident's representative was informed. The facility continued	5/6/25
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision (refers to the ongoing monitoring and guidance provided by staff to ensure the safety and well-being of a resident) to one of three sampled residents (Resident 1), who was cognitively impaired (refers to difficulties with thinking, learning, remembering, and using judgment, among other mental abilities) and was admitted to a secured facility (specialized healthcare setting that restricts patient movement and access to promote safety with measures such as locked doors and surveillance). On 4/24/2025 at 6:48	F 689	sear on 04/25/2025. On 4/25/2025 at around 5:00pm, Resident 1 was located and found in her apartment approximately 7.8 miles away from the facility, by RN 1 and LVN 1 and 2 Local police officers. On 4/25/2025 at around 5:56pm, Resident 1 returned to the facility accompanied by RN 1, LVN 1 and 2 local police officers. Resident 1's vital signs were checked by RN 2 B/P - 154/52, Temperature - 98.5, Respiration - 17, Pulse - 73 (regular) and oxygen saturation was 96% on room air. Resident 1 was alert/ oriented x2. Resident denied pain and no emotional distress noted. Resident 1's skin condition was also checked upon return by RN 2 and noted to have a scab on LT knee and discoloration on LT gluteal area which were already identified on admission on 4/25/2025.	

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F 689	Continued From page 9 p.m., Restorative Nurse Aide (RNA - focuses on helping residents regain or maintain their physical abilities and independence through restorative program and activities) 1 without verifying Resident 1 ' s identity, opened the facility ' s locked gate due to RNA 1 thought Resident 1 was a "visitor," and allowed Resident 1 to exit the facility ' s building. This deficient practice resulted in Resident 1 ' s elopement (the act of leaving a facility unsupervised and without prior authorization) on 4/24/2025 at 6:48 p.m., placing Resident 1 at risk for vehicular accidents since the facility is located in a busy street with many cars passing by, negative outcome from not receiving Resident 1 ' s medication, and exposure to extreme temperatures (heat during the day and cold during the night) that could lead to serious injury, serious harm, or death. On 4/26/2025 at 5:49 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s non-compliance with one or more requirements of participations has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) in the presence of the Administrator and the Director of Nursing (DON) due to the facility ' s failure to provide supervision to Resident 1 and to prevent the elopement of Resident 1 on 4/24/2025 at 6:48 p.m. On 4/27/2025 at 2:34 p.m., the DON provided an acceptable IJ removal plan (a detailed plan to address the IJ findings) for the facility ' s failure to provide supervision to Resident 1 and to prevent the elopement of Resident 1 on 4/24/2025 at 6:48 p.m.	F 689	continued From page 9 Resident 1 ate at around 6:50pm and consumed 100% of her meals. On 4/25/2025, Resident 1's attending physician was notified of her return at around 6:00pm and known emergency contact was also notified and aware of her return at around 6:00pm. On 4/25/2025 at around 8:30pm, Resident 1 was transferred to general acute care hospital (GACH) for further evaluation. On 4/26/2025, Resident 1's blood sugar level was 186 taken at the general acute care hospital (GACH) at around 11:50pm. On 4/25/2025, RNA 1 was given a disciplinary action and was suspended by the Administrator till further notice pending investigation. Resulting in immediate termination on 04/25/2025. On 4/25/2025 at around 6:30am to 4/26/2025, Director of Nursing/ QA Nurse Consultant/ Director of Staff Development conducted a series of in-service/ training and re-education to staff about Safety and Supervision of Resident policy/ Elopement/ Missing Person and Resident Identification policies, emphasis on the following:	

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F 689	Continued From page 10 On 4/27/2025 at 6:19 p.m., while onsite at the facility, the SSA verified and confirmed the facility ' s full implementation of the IJ Removal Plan through observations, interviews, and record reviews, and determined the IJ situation regarding elopement due to lack of supervision was no longer present. The SSA removed the IJ on 4/27/2025 at 6:48 p.m., in the presence of the Administrator and the DON. The acceptable IJ Removal Plan included the following summarized actions: 1. On 4/25/2025, the Administrator gave a disciplinary action (a reprimand or corrective action in response to employee misconduct, rule violation, or poor performance) and suspended RNA 1 pending investigation. 2. On 4/25/2025 at 5 p.m., Registered Nurse (RN) 1, Licensed Vocational Nurse (LVN) 1, and 2 local police officers located Resident 1 in Resident 1 ' s apartment, approximately 7.8 miles (unit of measurement) away from the facility. 3. On 4/25/2025 at 5:56 p.m., RN 1, LVN 1, and 2 local police officers accompanied Resident 1 back to the facility. RN 2 completed Resident 1 ' s skin assessment and noted a scab (a dry, rough protective crust that forms over a cut or wound during healing) on Resident 1 ' s left knee. 4. On 4/25/2025 at 8:30 p.m., Resident 1 was transferred to General Acute Care Hospital (GACH) 1 for further evaluation. 5. From 4/25/2025 to 4/26/2025, the DON, the Quality Assurance (QA) Nurse Consultant (a	F 689	continued From page 10 - Purpose/ importance of identifying and confirming with Licensed Nurse/ RN Supervisor/DON or Administrator/ Receptionist to see whether the person leaving is a visitor and not a Resident of the facility first and foremost before allowing anyone to leave the premises for safety. – Purpose/ importance of keeping Resident safe and well-being particularly in a secured setting by supervising Resident(s) while in the facility as needed and be mindful of their whereabouts at all times to ensure their safety. – purpose/ importance of identifying Residents to see by checking if they are wearing an ID wristband or having another form of identification (e.g., photographs) to help identify Resident to ensure that Resident will be receiving appropriate care and services they need. – Purpose/ importance of immediate action/ interventions such as initiating a code (GREEN) to initiate search immediately once a Resident was found missing. – Purpose/ importance of seeking out assistance from Local PD on a search.	

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IMPERIAL CARE CENTER	11441 VENTURA BLVD STUDIO CITY, CA 91604

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F 689	Continued From page 11 registered nurse specializing in improving resident care quality, ensuring compliance with regulations, and enhancing healthcare practices), and the Director of Staff Development (DSD), conducted a series of in-services (a planned, workplace-based training program designed to enhance staff competency, improve job performance, and keep staff up to date with current best practices and new techniques) to staff regarding "Safety and Supervision of Residents," "Elopement," "Missing Person," and "Resident Identification" policies, emphasizing the following: a. The purpose and importance of identifying and confirming with the Licensed Nurses (LNs), RNs, the Administrator, or Receptionist, that the person leaving the facility is a visitor and not a resident of the facility before allowing anyone to leave the (facility ' s secured) premises. b. The purpose and importance of supervising residents while in the facility and always being mindful of their (residents) whereabouts to ensure residents ' safety. c. The purpose and importance of identifying residents by checking if they are wearing an Identification (ID) wristband [a bracelet-like band, often worn on the wrist, contain at the minimum two identifiers (name and birthday) used for identification purposes] or having another form of identification such as a photograph. d. The purpose and importance of immediate action and interventions such as initiating a code to initiate search immediately once a resident was found missing.	F 689	continued from page 11 As of 4/25/2025, there are 113 employees who had given an in-service/ training and reeducation and on 4/26/2025, an additional 10 employees received in-service/training, which concluded a total of 95% of current employees who have completed their required in-services/ reeducation regarding above mentioned topics, excluding 7 of employees who are currently on leave of absence (LOA)/ vacation. This training and reeducation are ongoing and will continue until all 130 active staff/ employees are captured. On 05/14/2025 through 5/15/2025 re-education/ in-servicing/ training was conducted by a Licensed Psychologist. Facility has 130 current employees at which 123 completed their required in-services/ re-education/ post- test regarding above mentioned topics concluded a total of 95%. Out of the 130 current employees 7 of employees are excluded who are currently on leave of absence (LOA)/ vacation. This training and reeducation are ongoing and will continue until all 130 active staff/ employees are captured.	5/15/25

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F 689	Continued From page 12 e. The purpose and importance of seeking assistance from the Local Police Department in searching for a missing resident. 6. On 4/26/2025, LN, Medical Records Director, and Designee checked all residents to see if in-house residents were wearing ID wristbands. There were four residents (Residents 3, 6, 12, and 13) who were found not wearing ID wristbands due to refusal. An Interdisciplinary meeting (IDT meeting, involves professionals from different fields or specialties collaborating to address a shared problem or achieve a common goal) was conducted to discuss Residents 3, 6, 12, and 13 ' s noncompliance. The residents ' refusal to wear ID wristbands was addressed in the residents ' care plans. 7. On 4/26/2025, the Social Service Director (SSD) or designee and LNs evaluated all residents to see if the residents feel safe while in the facility using the safety/wellness evaluation tool. No other resident was found to be affected by the deficient finding. 8. On 4/26/2025, the IDT members comprising of the Administrator, the DON, and the DSD reviewed a new policy pertaining to secured unit/facility integrating the guidelines on admission process, environment special consideration, and visitation. a. The RN or Licensed Designee will immediately apply an ID wristband to a resident upon admission to help identify a resident while in the facility. A resident ' s photograph will also be taken, and the resident ' s picture will be uploaded in the resident ' s electronic health record (a digital version of a resident ' s medical history, stored on a computer and designed to be	F 689	Continued From page 12 Staff members who were unavailable to attend the in-service/ training, for any reason, will be given an in-service before returning to work in the facility. Post-test was also provided to determine the attendees understanding and knowledge of the topics of the in-services. Effective 4/25/2025, This in-service/ training and re-education will be provided monthly x 4 months then annually and as needed thereafter. On 4/25/2025, Medical Director was notified of the incident and QAPI was initiated by the Administrator to analyze and investigate the root-cause of the deficient practice(s). On 4/26/2025, a new policy pertaining to Secured Unit/ Facility was reviewed with Interdisciplinary team (IDT) members, which comprise of, but not limited to, Administrator, Director of Nursing Administrator and Director of Staff Development. New policy was reviewed and approved by quality assurance meeting on 05/12/2025 and will be integrating the following guidelines: – Admission process – Environment special consideration – Visitation	

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

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F 689	Continued From page 13 shared across different healthcare settings). b. A green colored ID wristbands will be provided to residents who are ambulatory without assistance for identification purposes and to alert staff about the risk for elopement especially when the residents seek exit doors. c. The Administrator will assign Department Heads or IDT members to conduct room inspections and check residents to see if they are wearing ID wristbands. The Administrator will also assign a Department Manager to be a "Manager of the Day (MOD)" on the weekends (Saturday to Sunday) to conduct random room inspection, including but not limited to checking Residents if they are wearing ID wristbands. d. The LNs will be conducting visual monitoring every 30 minutes for 72 hours to check newly admitted residents ' whereabouts, activities, and behaviors. e. The facility will assign a staff member to monitor the reception area daily seven days a week to monitor the front lobby as well as monitoring individuals entering and exiting the facility. The assigned receptionist will inform the SSD and/or designee five times a week (Monday to Friday) and the "Manager of the Day" on the weekends as coverage if the assigned receptionist will go on a break. An alarm has been installed on the main entrance door to also alert staff when there is someone coming in and out of the facility, in the absence of the receptionist in the front lobby. Findings:	F 689	Action taken to identify all other residents: On 4/25/25, RN Supervisor /Social Service Director checked all Residents and conducted a head count, identifying Residents based on census to see if all Residents accounted in the census and present in the facility, excluding the Resident(s) in hospital on bed-hold. No Residents was found to be affected by the deficient practice. On 4/26/2025, Licensed Nurses/ Medical Records Director and Designee checked all Residents to see if Residents (in-house) are wearing identification wristband. There are 4 Residents who found not wearing ID wristbands due to refusal. IDT meeting was conducted discussed Resident's non-compliance, their rights was respected, and their respective physician and responsible party was made aware. Refusals to wear ID wristband is addressed in the care plan. On 4/26/2025, Social Service Director or Designee and Licensed Nurses evaluated all Residents to see if they are and feel safe while in the facility using safety/ wellness evaluation tool. No Resident was found to be affected by this deficient finding.	

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F 689	Continued From page 14 During a review of Resident 1 ' s "History and Physical (H&P)" from GACH 2, dated 3/9/2025, the "H&P" indicated Resident 1 was admitted to GACH 2 due to hypertensive urgency (a situation where blood pressure is significantly elevated, but there is no immediate evidence of organ damage), and had diagnoses of hypertension (high blood pressure), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1 ' s GACH 2 Progress Notes, dated 4/2/2025, the Progress Notes indicated Resident 1 had a history of involvement from Adult Protective Services (APS - program to promote the safety, independence, and quality of life for adults who are unable to protect themselves) for self-neglect. The Progress Notes indicated Resident 1 had altered mental status (any significant change in a resident ' s normal mental state, encompassing a range of conditions from mild confusion to complete unconsciousness) with episodes of agitation (a condition in which a resident is unable to relax and be still), delirium (a sudden change in a resident ' s mental state, characterized by confusion and difficulty focusing), and had high concern for falls. The Progress Notes indicated it was not safe for Resident 1 to return home. During a review of Resident 1 ' s "H&P" from the Center of Behavioral Health (CBH), dated 4/11/2025, the "H&P" indicated Resident 1 had cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions) and was gravely disabled	F 689	Process and action taken to ensure deficient practice does not reoccur: 1. The facility will assign a staff member to monitor the reception area daily 7days/week to monitor the front lobby as well as monitoring individuals entering and exiting the facility. The assigned receptionist will inform the Social Service Director and/ or Designee 5x/week (Monday-Friday) (and/ or "Manager of the Day" on the weekends) as coverage in the event that the assigned receptionist will go on a break. The alarm has been installed on the main entrance door to also alert staff when there is someone coming in/ out of the facility, in the absence of the receptionist, or someone manning the front lobby. 2. Visitor(s) will sign-in and record the date/ time of the visit, reason for the visit (destination) prior to entering the facility and will sign-out be indicating the date/time when they left the facility prior to exit. Visitor(s) may be required to present a form of identification with picture, if needed, to be identified before entering the premises.	

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F 689	Continued From page 15 (refers to a condition where a resident, because of a mental health disorder, is unable to provide for the basic personal needs for food, clothing, shelter, personal safety, or necessary medical care) with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 1 ' s "Admission Assessment," dated 4/24/2025, the "Admission Assessment" indicated Resident 1 was admitted to the facility on 4/24/2025 at 5 p.m. The "Admission Assessment" indicated Resident 1 was alert and oriented to time, place, with slow comprehension and required assistance with showers, bed baths, oral hygiene, grooming, and dressing. During a review of Resident 1 ' s Change of Condition (COC - when there is a sudden significant change in a resident ' s health status) Assessment Form, dated 4/24/2025, the COC indicated on 4/24/2025 at 6:50 p.m., Resident 1 walked out of the facility after RNA 1 opened the facility ' s locked gate. The COC indicated LVN 2 noticed an unfamiliar person leaving the facility after RNA 1 used the code to open the locked gate. The COC indicated on 4/24/2025 at 7:55 p.m., the police was notified of Resident 1 ' s elopement. During a concurrent observation, interview, and record review on 4/25/2025 at 11:15 a.m., the facility ' s video surveillance footage of Station 1 and Reception area with the recording date and time of 4/24/2025 at 6:28:40 p.m. (adjusted to reflect the 12-hour clock) was observed and reviewed with the Administrator. The video	F 689	Continued From page 16 3. Visitor(s) will wear a visitor sticker for identification purpose(s) for the duration of their visit. Visitor(s) may be required to show a form of identification with picture, in the event, they refuse or loose the " visitor" sticker or will confirm with a second staff member vs. visitor's log and Resident identification system (e.g., ID wristband) to ensure that the individual is a "visitor" not a resident before allowing them to leave the facility. 4. Effective 4/25/2025, Administrator installed a buzzer at the gate that the staff will use to alert the Receptionist that assistance is needed at the gate area to assist and/ or identify the individual wanting to leave the premises prior to exiting the facility from 8:00am to 8:30pm daily 7x/week. Administrator/ Designee will check the buzzer's function randomly 2x/week x 3 months then monthly thereafter. In case of the buzzer's malfunction, Maintenance Supervisor/ Administrator will replace the device immediately. In case the buzzer malfunctions after-hours, RN Supervisor will be informed immediately for assistance.	

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F 689	Continued From page 16 footage showed RNA 1 opened the facility ' s locked gate, and a person (Resident 1) walked toward the open gate and exited the facility. The Administrator stated Resident 1 was the person in the video surveillance. The Administrator stated the following: a. On 4/24/2025 at 6:46:56 p.m., Resident 1 came out of Resident 1 ' s room and walked towards Station 1. b. On 4/24/2025 at 6:47:34 p.m., Resident 1 was ambulating (walking) near Station 1 while LVN 3 was standing in front of Station 1, in the hallway leading to the locked gate. RN 1 was inside Station 1, while RNA 1 was walking towards the locked gate. Resident 1 passed by LVN 3 who was standing near Station 1 and walked towards the locked gate, behind RNA 1. c. On 4/24/2025 at 6:47:56 p.m., LVN 3 was walking behind Resident 1 towards the locked gate. d. On 4/24/2025 at 6:47:57 p.m., Resident 1 was walking towards the locked gate and talked to RNA 1. e. On 4/24/2025 at 6:48:10 p.m., RNA 1 opened the locked gate and Resident 1 walked outside the locked gate towards the reception area. f. On 4/24/2025 at 6:48:29 p.m., Resident 1 opened the front door (in the reception area) and exited the facility building. The Administrator stated there was no facility staff present in the lobby.	F 689	Continued From page 16 5. Staff Members will also utilize the buzzer to alert Licensed Nurse/ RN Supervisor that assistance is needed at the gate area to identify and/ or assist the individual wanting to leave the premises prior to allowing to exit (after hours) daily 7x/week. Resident(s) leaving the premises with supervision will be verified with the physician to see if out-on-pass is allowed and whether Resident is going out-on-pass with authorized individual prior to allowing Resident to leave the premises. 6. Administrator will randomly review the visitor's log to ensure that visitors signed in/out and purpose of their visit is recorded properly 2x/week x 3 months then weekly thereafter. 7. RN Supervisor/ Licensed Designee will apply an identification (ID) wristband upon admission on newly admitted/ readmitted Resident(s) immediately to help identify Resident while in the facility. A photograph will also be taken, and picture will be uploaded in the Resident's electronic records (PCC).	

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F 689	Continued From page 17 During a concurrent interview and record review on 4/25/2025 at 1:17 p.m. with the DON, Resident 1 ' s "Discharge Reconciliation Report," from the CBH, dated 4/24/2025 was reviewed. The Discharge Reconciliation Report indicated Resident 1 was gravely disabled. The DON stated Resident 1 was admitted to the facility as gravely disabled. The DON stated the facility was in a high traffic area, with an occasionally homeless population and Resident 1 was at risk of being hit by a car and at risk of physical and sexual abuse from the homeless individuals. The DON stated Resident 1 was at risk of hypothermia (a significant and potentially dangerous drop in body temperature caused by prolonged exposure to cold) at night and hyperthermia (a condition characterized by abnormally high body temperatures) during the day when the temperature would go up. The DON stated Resident 1 could potentially experience any type of injury while outside of the facility including death. The DON stated the facility did not have a policy and procedure addressing supervision and access of the locked gate. The DON stated the facility was a secured facility and all the exit doors were kept locked and required a special key or code to open to prevent residents from wandering outside the building without supervision. The DON stated residents could exit the locked area only with staff supervision. The DON stated RNA 1 should not have opened the locked gate for Resident 1. The DON stated RNA 1 failed to identify Resident 1 as a resident of the facility resulting in Resident 1 ' s elopement. The DON stated the facility had not located Resident 1 (as of this time of the interview) and as a result Resident 1 was at risk to experiencing negative effects from missing her medications, including hypoglycemia (a condition in which the body ' s	F 689	Continue From page 17 8. A GREEN (COLOR WRISTBAND) will be provided to Residents who are known ambulatory without assistance for identification purpose (s) and to alert staff about the risk for elopement especially when they seek exit doors. 9. Administrator will schedule room rounds randomly 5x/week (M-F) x 3 months then 3x/week randomly, thereafter, assigning at least 3 rooms for each Department Heads and/ or Interdisciplinary Team (IDT) member to conduct room inspections and check Resident to see if they are wearing identification wristband. Administrator will also assign a Department Manager to be a " Manager of the Day (MOD)" on the weekends (Saturday- Sunday) to conduct random room rounds/ inspection, including but not limited to, checking Resident(s) if they are wearing ID wristbands. 10. Licensed Nurses will be conducting every 30- minutes visual monitoring x 72H to check newly admitted Resident's whereabouts/ activity/ behavior.	

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F 689	Continued From page 18 blood sugar level drop below the normal range) or hyperglycemia (a condition in which the there is too much sugar in the blood). A concurrent review of the "Discharge Reconciliation Report" with the DON indicated Resident 1 was prescribed the following medications: - Olanzapine (Zyprexa, a medication to treat several mental health conditions including psychosis) 2.5 milligram (mg - unit of measurement for weight/mass) twice daily for severe psychosis. - Divalproex Sodium (Depakote, a medication to improve mood, thoughts, and behavior) 125 mg three times daily for mood changes (sudden changes in how you feel). - Aspirin (a medication used to treat pain, fever, inflammation and blood clots) 81 mg daily for the prevention of myocardial infarction (a medical condition where blood flow to the heart muscle is suddenly blocked). - Furosemide (Lasix, a medication used to treat excessive fluid accumulation) 20 mg every Monday, Wednesday, and Friday for edema (swelling caused by the accumulation of excess fluid in the body). - Nebivolol HCL (Bystolic, a medication used to treat high Blood Pressure) 20 mg daily for hypertension. - Repaglinide (Prandin, a medication used to treat high blood sugar levels) 0.5 mg three times a day with meals for diabetes mellitus. - Insulin Lispro (Humalog - a rapid-acting insulin	F 689	Monitoring performance to ensure that correction is achieved and sustained: Findings from monitoring reports will be reviewed and presented to QA monthly for further resolutions and recommendations. Any issues of non-compliance shall be reviewed by the QA Committee for additional actions and recommendations until no negative trends noted and/ or 100% compliance has been achieved consistently x 3 months. Administrator and/ or Director of Nursing will monitor this corrective action for continued compliance.	

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F 689	Continued From page 19 used to manage high blood sugar levels) 3 units (unit of measurement) before meals for diabetes mellitus. - Nifedipine (Procardia, a medication used to treat high Blood Pressure and chest pain) 90 mg daily for the prevention of anginal pain (chest pain) associated with coronary artery disease (a condition where the arteries that supply blood to the heart become narrowed or blocked). During an interview on 4/25/2025 at 2:40 p.m. with RNA 1, RNA 1 stated on 4/24/2025 at "approximately" 6:50 p.m. while walking towards the locked gate, Resident 1 asked RNA 1 to open the door stating, "I have to leave now. I need to buy stuff. I will be back soon." RNA 1 stated she (RNA 1) did not ask Resident 1 if Resident 1 was a visitor or a resident and did not check to see if Resident 1 was wearing an ID wristband. RNA 1 stated because Resident 1 looked nice and well-dressed RNA 1 concluded Resident 1 was a "visitor" and opened the locked gate allowing Resident 1 to leave the facility without supervision. RNA 1 stated RNA 1 should have verified Resident 1 ' s identity prior to letting Resident 1 leave the facility. During an interview on 4/25/2025 at 5:02 p.m. with RN 2, RN 2 stated RN 2 was the RN assigned to care for Resident 1 on 4/24/2025. RN 2 stated, on 4/24/2025 at approximately 5 p.m., RN 2 initiated Resident 1 ' s admission assessment. RN 2 stated Resident 1 was transferred from the CBH where Resident 1 was admitted due to being gravely disabled. RN 2 stated Resident 1 was cognitively impaired, required frequent reminders on Resident 1 ' s location and situation. RN 2 stated during the	F 689		

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F 689	Continued From page 20 admission, Resident 1 was not provided with an ID wristband since the facility does not utilize ID wristbands. RN 2 stated on 4/24/2025 at approximately 7:10 p.m., she (RN 2) was informed by Certified Nursing Assistant (CNA) 1 that Resident 1 was missing after which staff (unable to identify) initiated a facility search but were not able to locate Resident 1. RN 2 stated RNA 1 should not have opened the locked gate before confirming Resident 1 ' s identity. RN 2 stated Resident 1 had diabetes and was at risk of experiencing hypoglycemia or hyperglycemia without diabetes medication and possibly without food. RN 2 stated Resident 1 could potentially experience negative effects from missing Resident 1 ' s medications and was at risk of being hit by a car. During an interview on 4/26/2025 at 10:14 a.m. with the DON, the DON stated all residents in the facility should be wearing ID wristbands for identification. The DON stated that upon admission social services staff or RNs were required to provide ID wristbands to new residents. The DON stated the facility had a policy addressing the identification of residents during medication administration but did not have a policy regarding provision of ID wristbands and verification of residents' or visitors' identity prior to allowing them (residents and visitors) to leave the facility. During an interview on 4/26/2025 at 12:20 p.m. with CNA 1, CNA 1 stated on 4/24/2025 CNA 1 was the CNA assigned to care for Resident 1. CNA 1 stated Resident 1 was admitted "around" 5 p.m. on 4/24/2025. CNA 1 stated when Resident 1 was admitted to the facility, CNA 1 introduced self to Resident 1 and with RN 1, they completed	F 689		

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	555707	A. BUILDING _____ B. WING _____	C 04/27/2025

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F 689	Continued From page 21 Resident 1 ' s inventory list after which CNA 1 left to assist with dinner. CNA 1 stated she last saw Resident 1 (on 4/24/25) between 6:30 p.m. to 7 p.m., walking in the hallway of Station 1. CNA 1 stated at "approximately" 7:35 p.m. CNA 1 went to check on Resident 1 but was not able to locate Resident 1. CNA 1 stated CNA 1 then notified RN 1 that Resident 1 was missing. CNA 1 stated facility staff (unable to identify) searched for Resident 1 inside and outside of the facility building but were not able to locate Resident 1. During an observation on 4/26/2025 at 3:19 p.m. in front of the facility entrance, the facility was located on a busy street in a commercial area (designated location used for business, retail, and offices) and a large number of cars are moving along the road. During an interview on 4/27/2025 at 1:07 p.m. with RN 1, RN 1 stated on 4/25/2025 at "approximately" 5 p.m. RN 1 located Resident 1 in Resident 1 ' s apartment. RN 1 stated Resident 1 was accompanied back to the facility after approximately 24 hours, at 6 p.m. on 4/25/2025 with the assistance of 2 local police officers. RN 1 stated Resident 1 ' s elopement incident could have been prevented if the facility had a system in place for the identification of residents and monitoring of the locked gate. RN 1 stated Resident 1 could have potentially experience physical harm, abuse, and negative effects from missing Resident 1 ' s medications such as low or high blood sugar levels, and behavioral issues from missing Resident 1 ' s psychotropic medications (used to treat mental health disorders). During an interview on 4/27/2025 at 5:15 p.m.	F 689		

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F 689	Continued From page 22 with the DON, the DON stated the facility did not have a system in place for the monitoring of the locked gate and identification of the residents and visitors. The DON stated Resident 1 ' s elopement incident could have been prevented if the facility had a system in place for the monitoring of the locked gate and identification of the residents and visitors. During a review of the current facility-provided policy and procedure titled, "Wandering and Elopement," last reviewed on 7/2024, the policy and procedure indicated, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. ... 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises." During a review of the current facility-provided policy and procedure titled, "Safety and Supervision of Residents," last reviewed on 7/2024, the policy and procedure indicated, "Facility-Oriented Approach to Safety: 1. Our facility-oriented approach to safety addresses risk for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes ... and a facility-wide commitment to safety at all levels of the organization .... Individualized, Resident-Centered Approach to Safety: 1. Our individualized, resident-centered	F 689		

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F 689	Continued From page 23 approach to safety addresses safety and accident hazards for individuals together to implement a systems approach to safety, which considers the hazards identified in the environment and individual risk factors and then adjust interventions accordingly. 2. Resident supervision is a core component of the system ' s approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and overtime for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment ...." F 837 SS=D Governing Body CFR(s): 483.70(d)(1)-(3) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f).	F 689 F 837	F- 837 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Administrator on 04/27/2025 completed 40 CEU units for the renewal of license. On 04/28/25 application for renewal and payment was mailed out to CDPH Licensing department. Pending review and approval. How the facility will identify other residents having the potential to be affected by the same deficient practice and corrective action will be taken: All the residents within the facility have the potential to be affected by deficient practice. All residents residing in the facility were identified to be possible affected by the deficient practice. On 04/28/2025 Regional Director of Operations gave Administrator an Inservice on the importance of upkeeping and maintaining licensure up to date.as well as providing Disciplinary actions towards deficient practice.	5/27/25

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F 837	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a licensed Administrator (ADM) held a current and active license from the State to serve in the capacity of a nursing home administrator (NHA). This deficient practice resulted in the facility operating without a licensed ADM that had the potential to negatively affect the facility's functions. Findings: During an observation on 4/272025 at 9:05 a.m. in the hallway, ADM' s license was posted at the facility's lobby. The ADM ' s license indicated the license expired on 4/26/2025. During an interview on 4/27/2025 at 3:07 p.m. with the ADM, the ADM stated the ADM ' S license had expired on 4/26/2025 and the application for the renewal of the license had not been submitted yet. The ADM stated the application for the renewal of license should have been submitted 60 days prior to the expiration of the license. During a review of the current facility-provided policy and procedure titled, "Administrator," last reviewed on 7/2024, the policy and procedure indicated, "A licensed administrator is responsible for the day-to-day functions of the facility ....1. The governing board of this facility has appointed an administrator who is dully licensed in accordance with current federal and state requirements."	F 837	What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not reoccur: Senior Director of Operations will do random rounds to the facility and check/ monitor communication board to ensure that Administrator license is posted and up to date. How the facility plans to monitor performance to make sure solutions are sustained: Findings from monitoring reports will be reviewed and presented to QA monthly for further resolutions and recommendations. Any issues of non-compliance shall be reviewed by the QA Committee for additional actions and recommendations until no negative trends noted and/ or 100% compliance has been achieved consistently x 3 months. Administrator and/ or Director of Nursing will monitor this corrective action for continued compliance.	

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F 842 SS=D	Continued From page 25 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842 F 842	F- 842 Immediate corrective action: On 04/27/2025, the Director of nurses assessed resident for use of Depakote. Resident has been receiving Depakote as ordered by MD and as it was verified by nurses with Resident Representative. Action taken to identify all other residents: On 04/27/2025, other residents' Consents were reviewed by Medical Record, but no other residents were affected by the same deficient practice. Process and action taken to ensure deficient practice does not reoccur: On 04/27/2025, the Director of Nurses conducted an in-service with the Medical Record Director regarding importance of signing consents timely that were verbally obtained from resident/resident representative by MD any were verified by nurses.	5/27/25

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F 842	Continued From page 26 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the medical records of two of four sampled residents (Resident 2 and 3) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to: 1. Ensure Resident 2 ' s Informed Consent (IC, voluntary agreement to accept treatment and/or	F 842	Monitoring performance to ensure that correction is achieved and sustained: The medical records will audit charts every month for 3 months to ensure that all informed consents are properly signed by MD. As part of the facility QAPI program, the DON will present a recapitulation of the Medical Record Director findings to the QAA committee monthly for next the month for review and action as indicated. The DON will monitor to compliance through review of monthly report by Medical Record Director. Immediate Corrective Action: On 04/27/2025, the Director of Nurses reviewed resident's medication summary. DON called and reviewed all medication with Primary Care provider. Received order to continue all medications as ordered. No changes at this time needed. Action taken to identify all other residents: On 04/27/2025, other residents' order summaries were reviewed by Medical Record and no other residents were affected by the same deficient practice.	

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F 842	Continued From page 27 procedures after receiving education regarding the risks, benefits, and alternatives offered) was signed by a physician. 2. Ensure Resident 3 ' s Attending Physician (MD) reviewed and signed the resident's Order Summary every month. These deficient practices had the potential for inaccurate documentation and inaccurate medical interventions for Resident 2 and Resident 3. Findings: a. During a review of Resident 2 ' s Admission Record on 4/26/2025, the Admission Record indicated Resident 2 was admitted to facility on 10/22/2021 and readmitted on 1/4/2023 with diagnoses including seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), diabetes mellitus (DM, disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 2 ' s cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were impaired. During a review of Resident 2 ' s Order Summary	F 842	On 04/27/2025, the Director of nurses conducted an in-service with the Medical Record Director regarding importance of doctors' signing order summaries in timely manner. Monitoring performance to ensure that correction is achieved and sustained: The Medical records will audit charts every month for 3 months to ensure that all ordered summaries are properly and timely signed by MD. As part of the facility CQI program, the DON will present a recapitulation of the medical record director findings to the QAA committee monthly for next three month for review and action as indicated. The DON will monitor to compliance through review of monthly report by Medical Record Director.	

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F 842	Continued From page 28 Report, the report indicated the following physician ' s order: - 2/28/2025: Divalproex Sodium (a medication used to treat certain types of seizures and bipolar disorder) Tablet Delayed Release (a type of medication that is designed to release its active ingredients at a slower rate) 500 milligram (mg-metric unit of measurement, used for medication dosage and/or amount) to give 1 tablet by mouth three times a day for mood disorder manifested by uncontrolled extreme mood swings causing anger outburst affecting daily living activities, and tally by hash-marks for its use. During a concurrent interview and record review on 4/26/2025 at 2:54 p.m. with the Medical Records Director (MDR), Resident 2 ' s IC for Depakote Sodium, dated 2/28/2025 was reviewed. The IC indicated the form was signed by Resident ' s responsible party and cosigned by a licensed nurse indicating Resident ' s Representatives had received information from the MD regarding the medication and have agreed to receive the treatment. The MDR stated she was responsible for ensuring the facility audits were done timely and the residents ' medical records were complete including physician signatures. The MDR stated the IC was not signed by the physician. The MDR stated she should have followed up with the physician to make sure the IC was signed for accurate documentation and to avoid inaccurate treatment. During a concurrent interview and record review on 4/27/2025 at 3:10 p.m. with Registered Nurse (RN) 1, Resident 2 ' s IC, dated 2/28/2025 was reviewed. The IC indicated the form was not signed by the physician. RN 1 stated the	F 842		

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F 842	Continued From page 29	F 842		

physician should have signed the form indicating that the medication information was discussed with the resident or resident representative and consent was obtained to receive the treatment for accurate documentation and accurate treatment.

During a review of the current facility provided policy and procedure titled, "Policy: Informed Consent," last reviewed on 7/2024, the policy and procedure indicated, " The physician and/or prescriber must sign an informed consent form after explaining all necessary information to the residents or their representatives.

b.During a review of Resident 3 ' Admission Record on 4/26/2025, the Admission Record indicated Resident 3 was admitted to the facility on 10/3/2024 with the following diagnoses including psychosis (a state where a person's perception of reality becomes distorted, leading to hallucinations, delusions, and disorganized thinking), muscle weakness, and dementia.

During a record review of Resident 3 ' s MDS, dated 4/15/2025, the MDS indicated Resident 3 ' s cognitive skills for daily decision making were impaired.

During a concurrent interview and record review on 4/26/2025 at 1:50 p.m. RN 3, Resident 3 ' s Order Summary dated 1/2025 to 4/2025 were reviewed. The Order Summary indicated the Order Summary Reports were not signed by the Attending Physician (MD). RN 3 stated MD should have reviewed and signed the Order Summary indicating that the order summary was reviewed and approved by the MD. RN 3 stated the failure had the potential for Resident 3 to receive inaccurate care.

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F 842	Continued From page 30 During a concurrent interview and record review on 4/26/2025 at 2:54 p.m. with the Medical Records Director (MDR), Resident 3 ' s Order Summary dated 1/2025 to 4/2025 were reviewed. The MDR stated MD should have signed Resident 3 ' s Order Summary every month to indicate the physician approved the orders required for Resident 3 ' s care. During an interview on 4/27/2025 at 5:15 p.m. with the Director of Nursing (DON), the DON stated MDR was responsible for ensuring the facility audits were done timely and the residents ' medical records were complete. The DON stated the MDs should have reviewed and signed the Order Summary for Resident 3 during follow up visits, at least every 60 days. The DON stated Resident 3 was at risk of receiving inaccurate medications or incorrect medication dosages negatively effecting Resident 3 ' s well-being. During a record review of the facility-provided policy and procedure titled, "Charting and Documentation," last reviewed on 7/2024, the policy and procedure indicated, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition shall be documented in the resident ' s medical record.... 3. Documentation in the medical record will be objective (not opiniated or speculative), complete, and accurate." During a record review of the facility-provided policy and procedure titled, "Physician Services," last reviewed on 7/2024, the policy and procedure indicated, "The attending physician must perform relevant tasks at the time of each visit, including a	F 842		

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F 842	Continued From page 31 review of the resident ' s total program of care and appropriate documentation."	F 842		