STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING _____ B. WING _____	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MESA GLEN CARE CENTER	638 E COLORADO AVENUE GLENDORA, CA 91740

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of two complaints and two Facility Reported Incidents (FRI) during the Annual Recertification Survey. Complaint numbers: CA00947740 and CA00949374 FRI numbers: CA00947747 and CA00949839 Total Census - 91 Sample Size -27 Closed Records - 3 Highest Scope and Severity: G No deficiency was issued for CA00947740. One deficiency was issued for CA00949374 (Refer to F880). One deficiency was issued for CA00947747 (Refer to F609). Two deficiencies were issued for CA00949839 (Refer to F600 and F656).	F 000	Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies will be correct as specified and they will be monitored to prevent recurrent no later than March 28, 2025. Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed as required by statute set forth in Code of Federal Regulations, Title 42, Section 489.12; and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed under Federal and State Law.	3/29/2025
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	F 550	**F550: Resident Rights/ Exercise of Rights** **CORRECTIVE ACTION** On 3/4/25, the Treatment Nurse for Resident 16s placed the indwelling catheter drainage bag in a dignity privacy (a discreet cover designed to conceal a urine drainage bag). On dates: 3/4/25 to 3/7/25 the Licensed Staff monitored any changes of condition particularly behavior changes as it relates to resident 16's dignity, privacy, and comfort, Resident 16 did not have any changes of condition at the time and all needs were met.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 03/29/25

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	Continued From page 1 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 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat one of 19 sampled residents (Resident 16) with respect and dignity by failing to ensure facility staff placed Resident 16's indwelling catheter (medical device that helps drain urine from your bladder) inside a privacy bag (a discreet cover designed to conceal a urine drainage bag) as indicated in the facility's policy and procedure titled, "Quality of	F 550	**OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/21/25, the Treatment Nurses (TN) checked all residents with orders for indwelling catheter to ensure that all have privacy dignity bags, no other residents were affected this alleged deficient practice. All resident with Indwelling/ Condom catheter orders have privacy dignity bag as of 3/21/25. **MEASURES AND SYSTEMIC CHANGES** In-service was conducted by DON/ Designee to Nursing Staff from 3/21/5 to 3/25/25 regarding placement of privacy dignity bag for all residents with indwelling catheter ensure that quality of life, care tasks, toileting, and promote dignity and respect. The TNs shall monitor daily placement of privacy dignity bag for all residents with indwelling catheter. On 3/21/25, the DSD/Designee provided education to CNAs to ensure that all residents with urinary catheter shall have a privacy dignity bag in place QS. **PERFORMANCE MONITORING** The Department Managers during daily rounds Monday to Friday shall monitor placement of privacy dignity bags for residents with indwelling catheter, any negative findings shall be escalated to the license staff for correction and reported during daily stand up meeting to the DON/Designee.	

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F 550	Continued From page 2 Life-Dignity." This failure resulted in a breach of the facility's standard protocol designed to preserve the resident's privacy and dignity. Findings: During a review of Resident 16's Admission Record (AR), the AR indicated the facility admitted Resident 16 on 10/22/2024, and readmitted Resident 16 on 1/21/2025, with diagnoses including, metabolic encephalopathy (a change in how your brain works due to an underlying condition), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and pressure ulcer (damage to the skin and underlying tissue caused by prolonged pressure on the skin, often over bony areas, which restricts blood flow and can lead to open sores)of sacral (at the bottom of the spine and lies between the fifth segment of the lumbar spine [L5] and the coccyx [tailbone]) region. During a review of Resident 16's physician order dated 1/23/25, the physician order indicated Resident 16 had an order for an indwelling foley catheter for wound management. During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 16's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to	F 550	**PERFORMANCE MONITORING (CONTINUED)** The Administrator/Designee will present the results to the QA Committee for monthly review for the next 3 months and quarterly thereafter or until substantial compliance is achieved.	3/28/2025

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F 550	Continued From page 3	F 550		

self-care activities) and was dependent (helper does all of the effort) on staff for mobility.

During an observation on 3/4/2025 at 10:29 AM, Resident 16 had an indwelling catheter with no privacy bag covering the catheter bag.

During an interview on 3/4/2025 at 10:40 AM, with the Treatment Nurse (TN), the TN stated that Resident 16 did not have a privacy bag that concealed Resident 16's catheter drainage bag. The TN stated that the privacy bag helped maintain the patient's dignity by concealing the drainage bag and catheter, especially in public or shared spaces. The TN stated that a privacy bag was part of ensuring a safe, respectful, and hygienic environment for the patient while they were managing the indwelling catheter.

During an interview on 3/7/2025 at 11:08 AM, with the Director of Nursing (DON), the DON stated that ensuring that a resident had a privacy bag over their foley catheter was essential for maintaining the resident's dignity, privacy, and comfort. The DON stated that the catheter bag could be seen as an intrusive medical device, and for residents, especially those who might have already felt vulnerable, it was important to preserve their sense of privacy. The DON stated that a privacy bag helped cover the catheter bag, reducing its visibility to others and minimizing the embarrassment a resident might feel.

During a review of the facility's P&P titled, "Quality of Life-Dignity," revised 8/2009, the P&P indicated, "Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by:

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F 550	Continued From page 4 a. Helping the resident to keep urinary catheter bags covered."	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its policy and procedure (P&P) titled, "Psychoactive Medication Informed Consent," for the use of for Olanzapine (Zyprexa- antipsychotic medication that used to treat mental disorders) and Lorazepam (Ativan- medication to treat anxiety) for one of one sampled resident (Resident 5). This failure violated Resident 5's right and placed Resident 5 at risk for psychological distress due to unnecessary medication.	F 552	**CORRECTIVE ACTION** On 3/21/25, the SSD validated that the informed consent for Resident's 5 the use of Olanzapine and Lorazepam has been obtained. The informed consent verification was done on 3/21/25. The DON/Designee initiated education to licensed staff on 3/21/25 to ensure that any residents receiving psychotropic medications shall have an informed consent verified **OTHER RESIDENTS AFFECTED IDENTIFICATION** The DON/Designee audited all residents on 3/21/25 to 3/28/25 receiving Psychotropic medications if a valid informed consent has been verified. There are 72 residents receiving Psychotropic medications - all informed consents for residents on Psychotorpics have been verified from 3/21/25 to 3/28/25.	

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F 552	Continued From page 5 Cross reference: F758 Findings: During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted to the facility on 12/18/2024 and readmitted on 2/25/25 with diagnoses that included end stage renal disease (kidneys lose the ability to remove waste and balance fluids), Type 1 diabetes mellitus (pancreas makes little or no insulin\ leading to high sugar levels), and non-ST elevation myocardial infarction (partial blockage of coronary [heart] artery). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 12/24/24, the MDS indicated Resident 5 was cognitively intact (ability to understand and process thoughts), and required partial/moderate assistance with personal hygiene and upper body dressing and substantial/maximal assistance with lower body dressing. During a review of Resident 5's History & Physical (H&P), dated 2/28/25, the H&P indicated Resident 5 had the capacity to make medical decisions. During a record review of Resident 5's Physician Orders (PO), the PO indicated Resident 5 was given Olanzapine oral tablet 2.5 milligrams (mg), one tablet, by mouth, two times a day (BID) for schizoaffective disorder (schizophrenia- [a disorder affecting a person's ability to think, feel, and behave] and mood disorder [psychiatric conditions causing intense and persistent changes in mood, energy, and behavior])	F 552	**MEASURES AND SYSTEMIC CHANGES** On 3/21/25, The DON/Designee provided a reeducation to Licensed staff and IDT regarding residents' rights to have an informed consent prior to initiation of antipsychotics and ensure that informed consent is available to all resident with order of psychotropics medications. Upon admission any residents receiving antipsychotics shall be audited by the Medical Records if the verification of the informed consent has been completed. During weekly Behavior Management Meeting, the IDT shall monitor and audit the compliance of informed consent verification, and the copy of the audit will be provided to the administrator, DON and the IDT. Findings on the audit will be address by the SSD and IDT immediately. **MONITORING PERFORMANCE** Medical Records to audit of Psychotropic medications 1xweekly x 3months or until substantial compliance is achieved for nursing follow up and report any deficits to DON for follow up. Issues and trends and copy of the report will be forwarded to the DON/ Administrator for further review and perform immediate corrective action as necessary.	

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F 552	Continued From page 6 manifested by (m/b) verbal aggression toward others. During an interview on 3/7/25, at 10:00 a.m., Resident 5 stated facility staff "tried to give her a pill this morning," and Resident 5 refused to take the pill. Resident 5 stated Resident 5 "has not signed nothing about medication." Resident 5 stated Resident 5 does not have schizophrenia and does not need the medication. During a concurrent interview and record review on 3/7/25, at 2:42 p.m., with Registered Nurse (RN 4), Resident 5's Informed Consent was reviewed. Resident 5's Informed Consent for antipsychotic medication did not have Resident 5's signature. RN 4 stated Informed Consent is completed upon admission. RN 4 stated if the resident has anti-psychotropic medication facility staff would obtain consent from the resident or the resident's responsible party (RP). RN 4 stated Resident 5's Informed Consent for Olanzapine and Lorazepam medication was not signed by Resident 5. RN 4 stated if the Informed Consent was not signed, there was no consent. RN 4 stated, "It is important to obtain an Informed Consent because medication is considered a chemical restraint (a form of medication restraint in which a drug is used to restrict freedom or movement of a patient)." LVN 4 stated facility staff needed to have permission to administer antipsychotic medication due to the resident may have side effects from the medication. LVN 4 stated, "Chemical restraint cannot be done against their (the residents) will." During a record review of the facility's Policy & Procedure (P&P) titled, "Psychoactive Medication Informed Consent," dated, March 2024, indicated	F 552	**MONITORING PERFORMANCE (CONTINUED)** The DON/Designee will present the results to the QA Committee for monthly review for the next 3 months and quarterly thereafter or until substantial compliance is achieved.	**3/28/2025**

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F 552	Continued From page 7 before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. The P&P indicated before initiating treatment with psychotherapeutic drugs, facility staff shall verify that the resident's health record contains written informed consent with the required signatures.	F 552		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide for one of one sampled resident (Resident 20) reasonable accommodation to meet the resident's needs by failing to ensure the call light was within reach. This deficient practice had the potential to negatively impact the psychosocial well-being of the resident and result in delayed provision of care and services. Findings: During a review of Resident 20's Admission Record (AR), the AR indicated Resident 20 was readmitted to the facility on 9/17/2023 with	F 558	**F558: REASONABLE ACCOMMODATIONS/ NEEDS/ PREFERENCE** **CORRECTIVE ACTION** Resident 20's call light is within reach on 3/4/2025 immediately after staff was notified. **OTHER RESIDENTS AFFECTED IDENTIFICATION** All active residents including residents newly admitted residents have the potential to be affected buy this deficient practice The facility conducted an interview of 7 alert, oriented residents on 3/21/25 to 3/28/25.all 7 (# of alert) resident indicated their call light is within reach, and their needs were met timely by the facility staff. No other residents were affected by the deficient practice at this time.	

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F 558	Continued From page 8 diagnoses that included epilepsy (a brain disorder that causes recurring, unprovoked seizures) and osteoporosis (weak and brittle bones). During a review of Resident 20's History and Physical (H&P), dated 3/4/2024, the H&P indicated Resident 20 had a fluctuating capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 1/22/2025, the MDS indicated Resident 20 had intact cognition (ability to understand) and needed substantial/maximal assistance (helper does more than half the effort; helper lifts or holds trunk or limbs and provides more than half the effort) for upper body dressing (to dress and undress above the waist). During an observation on 3/4/2025 at 11:23 am in Resident 20's room, Resident 20 was sitting up in bed with the call light wire behind a pillow and the call light touching the floor. During a concurrent observation and interview on 3/4/2025 at 11:27 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 20's room, the call light was observed touching the floor. LVN 2 stated, the resident's call light should not be under the pillow or touching the ground because Resident 20 needed it close by to call for assistance. During an interview on 3/7/2025 at 9:21 am with the Director of Nursing (DON), the DON stated, Resident 20's call light should be within reach, in case the resident needs to call for help. The DON further stated if the resident cannot reach the call	F 558	**MEASURES AND SYSTEMIC CHANGES** In-service was conducted by DON/ Designee to staff between 3/7/2025 to 3/28/2025 regarding improvement of call light management to enhance quality of life, care tasks, toileting, and promote dignity and respect. Department Managers shall perform daily from Monday to Friday, RN Supervisor/ Designee on Saturday and Sunday, room rounds to ensure that call light is within reach of the resident when on bed and sitting in the wheelchair in his room. Any negative findings from the room rounds will be corrected immediately and be reported during stand up meeting. **MONITORING PERFORMANCE** Administrator or his designee and the DSD will conduct quality room rounds weekly to ensure that call light is within reach of the resident when on bed and sitting in the wheelchair in his room. Any negative findings from the room rounds will be corrected immediately and will be presented to the QA Committee monthly for the first three months for further evaluation and recommendations; quarterly thereafter if no negative trends are found. This correction will be monitored by the facility administrator /Designee for continuous compliance.and will be presented to the Monthly QAA Committee for the first three months for further evaluation and recommendations; quarterly thereafter if no negative trends are found.	3/28/2025

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F 558	Continued From page 9 light, they may not get the help they need, putting them at risk for injury. During a review of the facility's Policy and Procedure (P&P) titled, "Answering the Call Light," last revised 9/2022, the P&P indicated, the purpose was to ensure timely responses to the resident's requests and needs. The P&P indicated as a general guideline; the call light was accessible to the resident when in bed.	F 558		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578	**F578: Request/Refuse/Discontinue Treatment; Formulate Adv Dir** **CORRECTIVE ACTION** From 3/21/25 to 3/25/25, the SSD and SSA added an accurately completed copy of Advance Directive Acknowledgement Form (ADAF) and Physician Orders for Life-Sustaining Treatment POLST to the medical records of Residents 5,6,11,35,37,41 and 75 signed by residents or appropriate Responsible Party depending on residents' capacity to make decisions. On 3/21/25 the DON conducted an in-service for Licensed Staff, SSD, Medical records regarding importance of completing the Advance Directive Acknowledgement Form and Physician Orders for Life-Sustaining Treatment (POLST) accurately signed by resident or appropriate Responsible Party depending on residents' capacity to make decisions upon admission.	

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F 578	Continued From page 10 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the residents and/or responsible parties (RP) were provided information regarding the resident's right to formulate an Advance Directive (AD, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual is incapacitated) and the resident's Physician Orders for Life-Sustaining Treatment (POLST-medical form that documents a patient's wishes regarding end-of-life care) was accurate and complete for seven of seven sampled residents (Residents 5, 6, 11, 35, 37, 41, and 75). This deficient practice had the potential to result in Residents 5, 6, 11, 35, 37, 41, 75 receiving unwanted care and treatment and/or unnecessary life-sustaining treatment. Findings: a. During a review of Resident 6's Admission	F 578	**OTHER RESIDENTS AFFECTED IDENTIFICATION** From 3/21/25 to 3/25/25, the SSD and SSA conducted a comprehensive review of all active residents to ensure they had been provided with information on formulating an Advance Directive and that any completed POLST forms were accurate. Upon completion of the review, no additional residents were found to be affected by this deficient practice. **MEASURES AND SYSTEMIC CHANGES** Upon admission, new residents will be provided with information on how to formulate an Advance Directive. If an Advance Directive is already in place, a copy will be obtained from the resident or their representative and promptly placed in the resident's medical record upon receipt. The SSD/SSA, in coordination with the Medical Records (MR) department, will ensure that all residents receive information on Advance Directives and that a copy is obtained from the resident or their representative, if applicable, and placed in their medical record. The SSD/SSA, in coordination with the Medical Records Director (MRD), will ensure that the Advance Directive Acknowledgment Form (ADAF) is completed and that residents' POLST forms are accurately completed upon admission.	

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F 578	Continued From page 11 Record (AR), the AR indicated Resident 6 was readmitted to the facility on 12/29/23, with diagnoses that included fracture (crack or break in bone), unspecified protein-calorie malnutrition (inadequate intake of protein and calories), and hypertensive heart disease. The AR indicated Resident 6's RP was Family (FAM) 1. During a review of Resident 6's History & Physical (H&P), dated 1/2/25, the H&P indicated Resident 6 did not have the capacity to make medical decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 12/11/24, the MDS indicated Resident 6 was severely cognitively impaired (ability to understand and process thoughts), and was dependent on staff for activities of daily living (ADLs) and transferring from bed-to-chair. During a concurrent interview and record review on 3/6/25, at 3:12 p.m., with the Social Services Designee (SSD), Resident 6's POLST dated 12/29/23 and Advance Directive Acknowledgement Form (ADAF) dated 12/31/23 was reviewed. The SSD stated the person that signed Resident 6's POLST dated 12/29/23 and ADAF dated 12/31/23 was FAM 2 (instead of FAM 1 who was Resident 6's RP documented in Resident 6's AR). The SSD stated Resident 6's POLST did not indicate FAM 2 was Resident 6's RP. During an interview on 3/7/25, at 10:52 a.m., with the SSD, the SSD stated after speaking with FAM 1, FAM 1 stated FAM 2 is Resident 6's RP and FAM 1 was just a visitor and was not authorized to sign Resident 6's POLST or ADAF. The SSD	F 578	**MONITORING PERFORMANCE** The Social Service Director (SSD) and Administrator will ensure that the above process is consistently maintained. The SSD or designee will report any trends or issues related to providing residents with information on creating an Advance Directive and completing a POLST, as well as confirming whether a copy of the ADAF and POLST is included in the resident's medical record. These reports will be submitted to the QAA Committee monthly for a period of three months or until compliance is achieved, for further review and any additional recommendations.	3/28/2025

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stated FAM 1 was the RP and not FAM 2 as indicated in Resident 6's AR.

b. During a review of Resident 41's AR, the AR indicated Resident 41 was readmitted to the facility on 10/7/24, with diagnoses that included acute respiratory failure (lungs can't properly exchange gases), acute systolic congestive heart failure (weakened left ventricle), and hypertensive heart disease (high issues due to long term high blood pressure).

During a review of Resident 41's History & Physical (H&P), dated 10/9/24, the H&P indicated Resident 41 had the capacity to make medical decisions.

During a review of Resident 41's MDS, dated 1/7/25, the MDS indicated Resident 5 was cognitively intact and required substantial/maximal assistance with personal hygiene and lower body dressing and dependent on staff for bed-to-chair transfers.

During an interview 3/6/25 at 1:48 p.m., with the SSD, the SSD stated the SSD had worked as the facility SSD for seven months. The SSD stated whoever admitted the resident would complete the ADAF and the POLST. The SSD stated when the facility met for the Interdisciplinary Team (IDT- a group of professionals from different disciplines who work together collaboratively to achieve a common goal) meeting within 72 hours of admission/readmission, the IDT reviewed the chart for completeness. The SSD stated that quarterly chart checks were done for completeness and accuracy. The SSD stated Resident 41's ADAF was missed. The SSD stated the ADAF was important in case the facility sent

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out the resident to the hospital, had a change of condition, or needed treatment; the form should be accurate.

c. During a review of Resident 5's AR, the AR indicated Resident 5 was originally admitted to the facility on 12/18/24, and readmitted on 2/25/25, with diagnoses that included end stage renal disease (kidneys lose the ability to remove waste and balance fluids), Type 1 diabetes mellitus (the body makes little or no insulin [hormone that lowers blood sugar]leading to high sugar levels), and non-ST elevation myocardial infarction (partial blockage of coronary [heart] artery).

During a review of Resident 5's MDS, dated 12/24/24, the MDS indicated Resident 5 was cognitively intact and required partial/moderate assistance with personal hygiene and upper body dressing and substantial/maximal assistance with lower body dressing.

During a review of Resident 5's History & Physical (H&P), dated 2/25/25, the H&P indicated Resident 5 had the capacity to make medical decisions.

During a concurrent interview and record review on 3/6/25 at 11:50 a.m. with Registered Nurse (RN 4), Resident 5's ADAF dated 2/25/25 and POLST dated 2/28/25 were reviewed. RN 4 stated RN 4 completed Resident 5's ADAF Resident 5 upon readmission (on 2/25/25). RN 4 stated RN 4 overlooked the AD selection on the ADAF indicating if Resident 5 had executed an AD or not. RN 4 stated Resident 5's POLST dated 2/28/25 was not signed and dated by Resident 5.

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During an interview on 3/5/25 at 1:43 p.m., with LVN 3, LVN 3 stated residents' ADAFs were completed upon admission by a licensed nurse, either RN or LVN.

During an interview on 3/6/25 at 1:48 p.m., with the SSD, the SSD stated Resident 5's ADAF dated 2/25/25 and POLST dated 2/28/25 were not accurate because the POLST was not signed and dated by the resident and the ADAF was not complete because the box was not checked indicating whether Resident 5 had an AD or Resident 5 did not have an AD.

During a subsequent interview on 3/6/25, at 2:12 p.m., with RN 4, RN 4 stated RN 4 spoke to Resident 5 that day and this triggered RN 4's memory that RN 4 completed a POLST for Resident 5. RN 4 was not able to provide the POLST completed by RN 4.

d. During a review of Resident 75's AR, the AR indicated Resident 75 was admitted on 10/3/2024 with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees and paraplegia (loss of movement and/or sensation, to some degree, of the legs).

During a review of Resident 75's H&P dated 10/4/2024, the H&P indicated Resident 75 had the capacity to understand and make decisions.

During a review of Resident 75's MDS dated 1/6/2025, the MDS indicated Resident 75 had intact cognition.

During a review of Resident 75's Advance Directive Acknowledgement Form (ADAF) dated

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10/3/2024, the ADAF indicated no option was checked by the resident or responsible party for the resident to have executed or not have executed an AD.

During a concurrent interview and record review on 3/5/2025 at 11:08 am with the Social Services Director (SSD), Resident 75's ADAF was reviewed. The ADAF indicated no option was checked by the resident or responsible party for the resident to have executed or not have executed an AD. The SSD stated the ADAF was incomplete, and a box should have been checked to indicate Resident 75's AD status.

During an interview on 3/7/2025 at 9:14 am with the Director of Nursing (DON), the DON stated the ADAF was used to check if residents have executed a pre-planned AD and was necessary to have the document completely filled out to allow staff to know what was planned for the resident in the event of an emergency situation.

e. During a review of Resident 35's AR, the AR indicated Resident 35 was admitted on 1/27/2025 with diagnoses that included respiratory failure (a condition caused by inadequate supply of oxygen in the body) and seizures.

During a review of Resident 35's H&P dated 1/31/2025, the H&P indicated Resident 35 had the capacity to understand and make decisions.

During a review of Resident 35's MDS dated 2/3/2025, the MDS indicated Resident 35 had moderately impaired cognition.

During a review of Resident 35's ADAF dated 1/27/2025, the ADAF indicated no option was

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checked by the resident or responsible party for the resident to have executed or not have executed an AD.

During a concurrent interview and record review on 3/5/2025 at 11:08 am with the SSD, Resident 35's ADAF was reviewed. The ADAF indicated, no option was checked by the resident or responsible party for the resident to have executed or not have executed an Advance Directive. SSD stated, the ADAF was incomplete, and a box should have been checked to indicate Resident 35's AD status.

During an interview on 3/7/2025 at 9:14 am with the Director of Nursing (DON), the DON stated the ADAF was used to check if residents have executed a pre-planned AD and was necessary to have the document completely filled out to allow staff to know what was planned for the resident in the event of an emergency situation.

During a review of the facility's policy and procedure (P&P) titled, "Advance Directives," last revised 9/2022, the P&P indicated, prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.

f. During a review of Resident 11's Admission Record (AR), the AR indicated Resident 11 was admitted to the facility on 8/16/2024 with diagnoses that included major depressive disorder (MDD, persistent feelings of sadness, loss of interest in activities, and difficulty functioning in daily activities for at least two weeks).

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During a review of Resident 11's MDS dated 11/22/2024, the MDS indicated Resident 11's cognitive abilities (ability to think, learn, and process information) were moderately impaired.

During a review of Resident 11's history and physical (H&P) dated 1/21/2025, the H&P indicated Resident 11 had the capacity to understand and make decisions.

g. During a review of Resident 37's Admission Record (AR), the Admission Record indicated Resident 37 was admitted to the facility on 10/11/2024 and readmitted on 2/1/2025 with diagnoses that included Huntington's Disease (HD, genetic brain disorder that causes slow progressive decline in movement, thinking, and emotional abilities), Human Immunodeficiency Virus (HIV, virus that attacks the body's immune system) and dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks).

During a review of Resident 37's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 2/3/2025 indicated Resident 37 can make needs known but cannot make medical decisions.

During a review of Resident 37's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 2/7/2025, indicated Resident 37's had moderately impaired cognitive abilities (ability to think, learn, and process information).

During a concurrent interview and record review on 3/5/2025 at 9:32 AM with the Social Services

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F 578	Continued From page 18 Director (SSD), Resident 11 and 37's Advance Directive Acknowledgement (ADA) form was reviewed. The SSD stated Resident 11 and 37's ADA forms were not filled out completely and stated the form should be filled completely within 24 hours of admission. The SSD stated by not having the ADA forms filled out completely would place residents at risk of receiving the incorrect emergency treatment. During an interview on 3/7/2025 at 1:46 PM with the Director of Nursing (DON), the DON stated the ADA form should be filled out immediately upon admission. The DON stated by not filling out the form completely places the resident at risk of providing the wrong emergency treatment and not honoring the resident's wishes. During a review of the facility's policy and procedure (P&P) titled, "Advance Directives" revised 9/2022, the P&P indicated prior to admission of a resident, the SSD or designee will inquire about the existence of any written advance directives.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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. The facility must provide- §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.	F 584	**F 584: Safe/Clean/Comfortable/ Homelike Environment** **CORRECTIVE ACTION** Resident 11's personal wheelchair was reported missing to the Social Services Director (SSD), and on 3/7/2025, a replacement wheelchair was provided for Resident 11. On 3/7/2025, Maintenance Director secured and fully attached the toilet seat in Resident 63's bathroom. On 3/10/2025, Maintenance Director repaired Resident 68's patio door to ensure it could be fully closed.	

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F 584	Continued From page 19 (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. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §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 ensure a safe, clean, homelike environment for three of three sampled residents (Residents 11, 63, and 68) by failing to: a. Ensure Resident 11's personal wheelchair was reported as missing to the Social Services Director (SSD). b. Ensure Resident 63's toilet seat was fully	F 584	**OTHER RESIDENT AFFECTED IDENTIFICATION** On 3/7/2025, the administrator and maintenance supervisor conducted environmental rounds to ensure all residents had a clean and safe environment. They confirmed that all patio doors could be fully closed and toilet seats were securely attached. No other residents were found to be impacted by the alleged deficiencies. On 3/7/2025, the SSD performed an inventory of residents with personal wheelchairs. No other residents were found to be affected by the alleged deficiency. **MEASURES AND SYSTEMIC CHANGES** Department heads will perform daily room rounds from Monday to Friday, ensuring that equipment in residents' rooms is in good working condition. Findings will be communicated to the leadership team during the daily standup. Maintenance staff will conduct monthly room rounds for all residents' rooms to verify that doors and toilet seats are in proper working condition. Upon a resident's new admission or issuance of a personal wheelchair, licensed staff must inventory the wheelchair and ensure it is marked for the resident's use only. Any missing or lost personal wheelchairs must be documented in the theft and loss log by the SSD/SSA for resolution.	

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F 584	Continued From page 20 attached to the toilet bowl. c. Ensure Resident 68's patio door was able to fully close. These failures had the potential to result in negatively impacting Resident 11, 63 and 68's quality of life and had the potential for an unsafe environment for the residents Findings: a. During a review of Resident 11's Admission Record (AR), the Admission Record indicated Resident 11 was admitted to the facility on 8/16/2024 with diagnoses that included major depressive disorder (MDD, persistent feelings of sadness, loss of interest in activities, and difficulty functioning in daily activities for at least two weeks). During a review of Resident 11's Resident's Clothing and Possessions form (RCP) dated 8/16/2024, the RCP form indicated Resident 11 was admitted with one wheelchair. During a review of Resident 11's MDS dated 11/22/2024, the MDS indicated Resident 11's cognitive abilities (ability to think, learn, and process information) were moderately impaired and indicated Resident 11 used a wheelchair. During a review of Resident 11's History and Physical (H&P) dated 1/21/2025, the H&P indicated Resident 11 had the capacity to understand and make decisions. During an interview on 3/4/2025 at 1:25 PM with Resident 11, Resident 11 stated Resident 11 had a wheelchair, but it went missing two to three	F 584	**MONITORING PERFORMANCE** The Maintenance Supervisor will present the findings from maintenance logs, specifically regarding the environmental inspections of patio doors and toilet seats, to the monthly Safety Committee for three months or until compliance is achieved for further review and recommendations. The Administrator is responsible for ensuring the continuity and sustainability of this process. The SSD will report any instances of lost or missing personal wheelchairs to the monthly QAA Committee for monitoring.	3/28/2025

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weeks ago and was reported to an unnamed Certified Nursing Assistant (CNA). Resident 11 stated Resident 11 was unable to go outside and smoke because Resident 11's wheelchair was missing.

During a concurrent observation and interview on 3/5/2025 at 3:21 PM with CNA 9 in Resident 11's room, no wheelchair was noted in Resident 11's room. CNA 9 stated Resident 11's personal wheelchair was not in Resident 11's room. CNA 9 stated if it had gone missing it should've been reported to Social Services. CNA 9 stated the risk of not having a resident's personal belongings at the bedside side, for example the wheelchair, would limit the resident's ability to move around freely in the facility. CNA 9 stated it would make the resident feel upset that the personal belongings have gone missing.

During an interview on 3/5/2025 at 3:22 PM with Resident 11, Resident 11 stated Resident 11's wheelchair had Resident 11's first and last name on it. Resident 11 stated an unnamed CNA placed it outside into the hallway and Resident 11 has not seen it since.

During an interview on 3/5/2025 at 3:32 PM with the SSD, the SSD stated if there was a missing item, the SSD would need to do a theft and loss report. The SSD stated no one reported Resident 11's missing wheelchair to the SSD. The SSD stated it should've been reported to the SSD and stated depending on the item, by not reporting can limit the resident from performing activities of daily living (ADL's) and would make the resident feel upset or depressed.

During an interview on 3/7/2025 at 1:47 PM with

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the DON, the DON stated personal belongings, like a wheelchair, should be with the resident. The DON stated if the wheelchair was missing it would make the resident feel depressed because it would limit the resident's ability to move around the facility.

During a review of the facility's policy and procedure (P&P) titled, "Personal Property" revised 9/20112, the P&P indicated the facility will promptly investigate any complaints of misappropriation of a resident's property.
b. During a review of Resident 63's AR, the AR indicated Resident 63 was admitted to the facility on 7/15/2024 with diagnoses that included arthritis (swelling and tenderness of one or more joints that causes stiffness and joint pain) and lack of coordination.

During a review of Resident 63's History and Physical (H&P) dated 7/16/2024, the H&P indicated Resident 63 had the capacity to understand and make decisions.

During a review of Resident 63's untitled Care Plan (CP) dated 11/27/2024, the CP indicated Resident 63 was at risk for injury due to a fall that occurred when the resident transferred from the commode. The CP interventions indicated educating on the importance of maintaining a safe environment, free of potential fall hazards with a goal of Resident 63 remaining free from further falls.

During a review of Resident 63's MDS dated 1/16/2025, the MDS indicated Resident 63 had severe cognitive impairment (ability to think). The MDS indicated Resident 63 required setup or clean-up assistance (Helper sets up or cleans up;

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resident completes activity. Helper assists only prior to or following the activity) for toilet hygiene and supervision with toilet transferring (ability to get on or off a toilet) and used a wheelchair.

During a review of Resident 63's Health Status Note (HSN) dated 3/2/2025 at 10:05 am, the HSN indicated Resident 63 was picked up and went out of the facility (on pass) with family that day.

During an interview on 3/5/2025 at 9:20 am with Resident 63's Responsible Party (RP), the RP stated the toilet seat was broken in Resident 63's bathroom and it was reported to the staff at the nearest nursing station after returning from taking Resident 63 out of the facility on 3/2/2025.

During an interview on 3/6/2025 at 1:34 pm with Certified Nurse Assistant 11 (CNA 11), CNA 11 stated Resident 63 uses the toilet in the bathroom with CNA 11's assistance.

During a concurrent observation and interview on 3/6/2025 at 3:18 pm with the Maintenance Supervisor (MS) in Resident 63's bathroom, the toilet seat was loose and missing a screw on the left side, leaving it detached from the toilet rim. MS stated, there was a screw that he could replace and stated the toilet seat should be stable for the resident.

During an interview on 3/7/2025 at 9:28 am with the facility's Director of Nursing (DON), the DON stated Resident 63 used a wheelchair, needed the assistance of one person, and required assistance when using the bathroom. The DON stated, the toilet seat should not be broken and should have been fixed. The DON further stated, there's a risk the resident could fall when the toilet

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seat moved off the toilet.

During a review of the facility's P&P titled, "Maintenance Service," revised 12/2009, the P&P indicated, maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P indicated, the Maintenance Department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The P&P indicated, functions of maintenance personnel included, but were not limited to maintaining the building in good repair and free from hazards and maintaining the plumbing fixtures in good working order.

c. During a review of Resident 68's AR, the AR indicated Resident 68 was admitted to the facility on 9/28/2024 with diagnoses that included respiratory failure (a condition caused by inadequate supply of oxygen in the body), a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), and dementia (a progressive state of decline in mental abilities) with an onset date of 9/28/2024.

During a review of Resident 68's H&P dated 1/21/2025, the H&P indicated Resident 68 did not have the capacity to understand and make decisions and was dependent (a helper does all of the effort, resident does none of the effort to complete the activity) for basic activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).

During a review of Resident 68's MDS dated 2/19/2025, the MDS indicated Resident 68 had

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severe cognitive impairment.

During a concurrent observation and interview on 3/5/2025 at 10:25 am with Certified Nurse Assistant 10 (CNA 10) inside Resident 68's room, the patio sliding door near Resident 68's bed was open by approximately one inch and cold air was coming inside. CNA 10 stated, the door couldn't be closed and was stuck on the track. CNA 10 further stated, CNA 10 did not know how long the door had been left open and was unable to contact the Maintenance Department earlier to fix it.

During a concurrent observation and interview on 3/5/2025 at 10:30 am with the Maintenance Supervisor (MS) inside of Resident 68's room, the patio sliding door near Resident 68's bed was open by approximately one inch, there was no screen door, and cold air was coming inside the room. The MS stated the patio was not being used by the residents and may have been opened by the housekeeping staff. The MS further stated, there was dirt in the door track and the MS was unable to fully close the door. The MS stated, the patio sliding door should not remain open and stated it was going to rain that day.

During an interview on 3/7/2025 at 9:24 am with the Director of Nursing (DON), the DON stated a homelike environment should be comfortable and similar to a resident's home. The DON stated a patio sliding door that couldn't close needed to be repaired or replaced immediately to prevent the resident from getting sick, especially if it rained. The DON further stated, there was a possibility insects could also come inside the room if the door was left open and these were not homelike

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F 584	Continued From page 26 conditions. During a review of the facility's policy and procedure (P&P) titled, "Homelike Environment," last revised 2/2021, the P&P indicated, residents were provided with a safe, clean, comfortable and homelike environment. The P&P indicated, staff provided person-centered care that emphasized the resident's comfort and the characteristics of the facility that reflect a personalized, homelike setting that included a clean, sanitary, and orderly environment.	F 584		
F 609 SS=D	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: §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. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609	**F609: Reporting of Alleged Violations** **CORRECTIVE ACTIONS** The reported allegation of abuse involving resident 51 and resident 10 was documented on 1/22/25. On 3/7/25 upon identification of the incident being sent to the wrong fax number of CDPH for reporting allegations, Administrator in collaboration with SSD updated the contact numbers of CDPH visible by the main fax machine. Resident 10 was reassessed on 1/22/25, with no injuries or signs of emotional distress observed related to the alleged incident. On 3/25/25, the Director of Staff Development conducted an in-service training for facility staff on the facility's policies and procedures for abuse reporting including correct contact number posted on facility's main fax machine. The Director of Nursing (DON) also provided in-service training on 3/25/25 for licensed nurses, focusing on the facility's abuse reporting procedures and proper use of the SOC-341 form and sending it to the correct contact number.	

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F 609	Continued From page 27 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 report alleged abuse within two hours to the California Department of Public Health (CDPH) on 1/22/2025 for one of one sampled resident (Resident 51). This failure had the potential to expose Resident 10 to further abuse from Resident 51. Findings: a. During a review of Resident 51's Admission Record (AR), the Admission Record indicated Resident 51 was admitted to the facility on 9/13/2024 with diagnoses that included Alzheimer's disease (brain disorder that gradually destroys memory and thinking skills). During a review of Resident 51's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated12/20/2024, the MDS indicated Resident 51's cognitive abilities (ability to think, learn, and process information) were moderately impaired and indicated Resident 51 used a wheelchair. During a review of Resident 51's Change of Conditions (COC) dated 1/22/2025 at 3:09 PM, the COC indicated Resident 51 accidentally hit Resident 10 on the left side of the face.	F 609	**OTHER RESIDENTS AFFECTED IDENTIFICATION** All active residents, including newly admitted residents, may be impacted by this deficiency. The IDT conducted a Resident QA survey/interview with 7 alert and oriented residents from 3/21/25 to 3/27/25. All 7 residents reported that they had never experienced any inappropriate contact or interaction that made them feel unsafe. No negative effects or adverse outcomes have been reported or observed as a result of this deficiency. **MEASURES AND SYSTEMIC CHANGES** All reported allegations of abuse will be thoroughly investigated and discussed during the stand-up meeting with the IDT. Department Heads will continue conducting the Resident QA interview survey for residents who can participate. For those unable to participate, the responsible party or family will be contacted during room rounds once per week for three months to gather feedback on the interview questions. The results of the QA satisfaction interviews will be reported to the Administrator for timely follow-up and reporting. The Director of Staff Development conducted follow-up in -service for facility staff from 3/21/25 to 3/25/25 on abuse prohibition and management, with additional training provided quarterly thereafter.	

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F 609	Continued From page 28 During review of Resident 51's untitled care plan (CP) dated 1/23/2025, the CP indicated CDPH, law enforcement, and the Ombudsman were notified of the incident between Resident 10 and Resident 51. b. During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on 3/9/2024 and readmitted on 9/16/2024 with diagnoses that included anxiety and personality disorder (mental health condition where the individual has inflexible pattern of thinking, feeling, and behaving that interferes with daily life and relationships). During a review of Resident 10's MDS dated 12/24/2024, the MDS indicated Resident 10's cognitive abilities were intact. During an interview on 3/7/2025 at 8:21 AM with Resident 10, Resident 10 stated Resident 10 was hit by Resident 51 in the face when moving past Licensed Vocational Nurse 3 (LVN 3) during the medication pass. Resident 10 stated Resident 10 felt traumatized from the incident between Resident 10 and Resident 51. During a concurrent interview and record review on 3/7/2025 at 9:55 AM with the Social Services Director (SSD), the facility's fax cover sheet dated 1/22/2025 was reviewed. The SSD stated it was faxed to the wrong number. The SSD stated by not faxing the alleged abuse allegations to CDPH within two hours as required by law could delay the investigation. During an interview on 3/7/2025 at 2:09 PM with the Director of Nursing (DON), the DON stated	F 609	As part of the new employee orientation program and the annual skills competency evaluation, the DON/DSD will review the facility's Abuse Prevention and Prohibition Program. This includes policies and procedures on timely reporting of abuse to the Abuse Coordinator, DON, or Supervisor, ensuring resident protection, implementing immediate interventions, and initiation investigation to safeguard resident safety. **MONITORING PERFORMANCE** The administrator shall ensure the ongoing and sustained execution of the above process. Additionally, the administrator shall report any identified trends from the resident/family QA satisfaction interviews to the QAA committee monthly for three months or until compliance is achieved, for further review and additional recommendations.	3/28/2025

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F 609	Continued From page 29 the alleged physical altercation between Resident 10 and Resident 51 was not reported to the correct CDPH number. The DON stated by not reporting the incident to the correct number placed the safety of both residents at risk as CDPH would not be able to investigate the abuse allegation in a timely manner. During a review of the facility's policy and procedure (P&P) titled, "Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigation" revised 9/2022, the P&P indicated the administrator will immediately report allegations of abuse to the state licensing and certification agency within two hours of an allegation involving abuse.	F 609		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident	F 640	**F640: ENCODING/ TRANSMITTING RESIDENT ASSESSMENTS** **CORRECTIVE ACTION** The MDS assessment for Resident 2 was completed on 3/7/2025 and transmitted the same day to reflect accurate patient's status. **OTHER RESIDENTS AFFECTED IDENTIFICATION** A comprehensive MDS audit was conducted by MDS team on 3/21/25, no other resident noted to be affected by this deficient practice. **MEASURES AND SYSTEMIC CHANGES** The MDS coordinator was reeducated on the importance of timely and accurate completion and submission of MDS assessments on 3/21/2025. This education included the training on the regulatory requirements and the potential impact of delayed assessments.	

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F 640	Continued From page 30 contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to transmit the Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) for one of one sampled resident (Resident 2) within 14 days of Resident 2's death. This failure had the potential to result in inaccurate resident information.	F 640	**MEASURES AND SYSTEMIC CHANGES (CONTINUED)** The facility will implement regular, ongoing education to ensure that the current MDS coordinator and new staff members are trained on MDS requirements upon hire. c. The DON/Designee will be assigned to monitor MDS deadlines weekly x3months ensuring that assessments are scheduled, completed, and submitted in a timely manner. **PERFORMANCE MONITORING** This plan of correction will be integrated into our performance improvement process through a review of the plan of correction during our monthly quality assurance meeting monthly x3 or until deficient practice is resolved. During which the Admin/Designee will report any findings specific to sustaining compliance and recommendations from the QAA committee to identify outcomes and trends ensuring plan of action is achieved, sustained, and evaluated for effectiveness.	3/28/2025

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Findings:

During a review of Resident 2's Admission Record (AR), the Admission Record indicated Resident 2 was admitted to the facility on 9/27/2024 with diagnoses that included malignant neoplasm (cancerous growth of cells) of the stomach and prostate (small gland in male reproductive system).

During a review of Resident 2's Health Status Note (HSN) dated 11/27/2024 at 10:08 PM, the HSN indicated Resident 2 expired on 11/27/2024 at 11:08 PM.

During a review of the MDS 3.0 NH Final Validation Report (FVR) dated 3/7/2025, the FVR indicated Resident 2's MDS was submitted on 3/7/2025 and indicated it was submitted past 14 days after Resident 2's death.

During an interview on 3/7/2025 at 12:02 PM with the MDS Assistant (MDS A), the MDS A stated Resident 11 expired on 11/27/2024 and stated the MDS was not submitted until 3/7/2025. MDS A stated the purpose of submitting the MDS timely was to ensure information was accurate and to follow Medicare guidelines.

During an interview on 3/7/2025 at 2:07 PM with the Director of Nursing (DON), the DON stated a resident's MDS needs to be submitted within 14 days. The DON stated if it was not submitted within the 14 days it would put the facility at risk of not being compliant with regulations.

During a review of the facility's policy and procedure (P&P) titled, "CMS's RAI Version 3.0

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F 640	Continued From page 32 Manual" dated 10/2023, the P&P indicated for a death in the facility tracking record needs to be transmitted within 14 calendar days.	F 640	**F656: DEVELOP/ IMPLEMENT COMPREHENSIVE CARE PLAN** **CORRECTIVE ACTIONS** Resident 5's was reassessed on 3/13/25, no decline from baseline noted and comprehensive care plan was updated reflecting resident's current status. Resident 196 was transferred to Acute hospital on 3/6/25 for evaluation and treatment per MD order. Resident readmitted to the facility and comprehensive care plan was updated reflecting resident's current status. Resident 37's was reassessed on 3/4/25, no decline from baseline noted and comprehensive care plan was updated reflecting the resident to resident altercation and resident's current status. Resident 68's was reassessed on 3/5/25 no decline from baseline noted and comprehensive care plan was updated reflecting resident's current status. Resident 47 was reassessed on 3/5/25, no decline form baseline noted and comprehensive care plan was updated reflecting resident's current status.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		

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F 656	Continued From page 33 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive plan of care for four of four sampled residents (Resident 5, Resident 47, Resident 68, and Resident 196). These failures resulted in Residents 5, 47, 68, and 196 not receiving individualized care and had the potential for Residents 5,47, 68, and 196 not able to maintain the residents' highest practical physical and mental well-being. Findings: a. During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted to the facility on 12/18/24 and readmitted on 2/25/25 with diagnoses that included end stage renal disease (kidneys lose the ability to remove waste and balance fluids), Type 1 diabetes mellitus (pancreas makes little or no insulin\ leading to high sugar levels), and non-ST elevation myocardial infarction (partial blockage of coronary [heart] artery). During a review of Resident 5's Minimum Data	F 656	**OTHER RESIDENTS AFFECTED IDENTIFICATION** IDT conducted chart review on 3/25/25 and 3/28 to all active residents including newly admitted residents to ensure that the plan of care is current and updated to met the resident needs. 2 other residents were found to have been affected by the deficient practice. Comprehensive care plan was reviewed and updated for the affected residents on 3/28/25. DON and/or designee provided in-service to the RNs and LVNs on 3/21/25 about the importance of initiating care plan timely upon admission and updating resident's care plan for any change of conditions. **MEASURES AND SYSTEMIC CHANGES** Resident's clinical records will be review by the IDT within 48hrs of admission to check for care plan completion and if special care issues reported by the endorsing hospital are addressed in the care plan. MDS staff will complete comprehensive care plan within 7 days of a resident's comprehensive assessment to outlines the resident's needs, goals, and interventions to promote their well-being.	

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F 656	Continued From page 34 Set (MDS, a resident assessment tool), dated 12/24/24, the MDS indicated Resident 5 was cognitively intact (ability to understand and process thoughts), and required partial/moderate assistance with personal hygiene and upper body dressing and substantial/maximal assistance with lower body dressing. During a review of Resident 5's History & Physical (H&P), dated 2/28/25, the H&P indicated Resident 5 had the capacity to make medical decisions. During a concurrent interview and record review on 3/7/25, at 4:29 p.m., with Licensed Vocational Nurse (LVN) 3. Resident 5's care plans were reviewed. A comprehensive, individualized Care Plan for the administration of an anti-psychotropic medication was not found in Resident 5's clinical record. LVN 3 stated LVN 3 was not able to provide a Care Plan for Olanzapine (Zyprexa-anti-psychotropic medication, medication used to treat mental disorders, including schizophrenia and bipolar disorder) for Resident 5. LVN 3 stated, "it is important to have a Care Plan for anti-psychotropic medication." LVN 3 stated the purpose of the care plan was for staff to identify the goal and interventions of the psychotropic medication because the goal was to decrease the symptoms of schizophrenia (a disorder affecting a person's ability to think, feel, and behave) and psychosis (mental disorder causing disconnection from reality). During a record review of the facility's Policy & Procedure (P&P) titled, "Care Plans-Comprehensive," revised September 2010, the P&P indicated an individualized comprehensive care plan that includes measurable objectives	F 656	**MEASURES AND SYSEMIC CHANGES (CONTINUED)** Licensed nurse will update resident's plan-of-care within 24hrs for any Resident's COC and special needs lists. **PERFORMANCE MONITORING** The IDT will conduct care plan meetings within 7days after admission to discuss resident's overall care and level of assistance required, then quarterly and as needed for any unusual occurrence The DON/designee will review the special needs list for accuracy and completeness weekly and as needed. The DON/designee will monitor the corrective action for continuous compliance. Finding will be reviewed by the Director of Nursing/Designees weekly for the first three months and will be presented to the QA committee monthly for three months for further evaluation and recommendations.	3/28/2025

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and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. The P&P indicated the resident's comprehensive care plan is developed within (7) days of the completion of the resident's comprehensive assessment (MDS).
b. During a review of Resident 196's Admission Record, the Admission Record indicated Resident 196 was admitted to the facility on 3/3/2025.

During a review of Resident 196's H&P dated 2/26/2025, the H&P indicated Resident 196 had a history of hyperlipidemia (high cholesterol in the blood), dementia, and a cerebral infarct (blood clot block blood vessel in the brain preventing oxygen to reach brain cells).

During a review of Resident 196's Alert Note (AN) dated 3/4/2025 at 11:22 AM, the AN indicated Resident 37 alleged Resident 196 punched Resident 37 several times.

During a review of Resident 196's Skin Observation Tool (SOT) dated 3/4/2025 at 9:22 AM, the SOT indicated Resident 196 kept walking away from staff when staff attempted to assess Resident 196's skin after the resident-to-resident altercation.

During an observation on 3/4/2025 at 11:57 AM, Resident 196 was observed in the south hallway without a shirt on attempting to exit through the south hallway double doors. Resident 196 was observed to be agitated and exited through the double doors triggering the door alarms and staff members following Resident 196 outside to the parking lot.

During a review of Resident 196's Health Status

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Note (HSN) dated 3/4/2025 at 12:09 PM, the HSN indicated Resident 196 exited out of the south station entrance and exited towards the parking lot.

During a concurrent interview and record review on 3/7/2025 at 11:06 AM with Licensed Vocational Nurse 3 (LVN 3), Resident 196's untitled care plans (CP) dated 3/2025 were reviewed. LVN 3 stated there was no CP created for the resident-to-resident altercation on 3/4/2025 between Resident 196 and Resident 37. LVN 3 stated by not creating a CP for the incident would place the resident at risk of the incident to happen again because interventions have not been placed to prevent the incident. LVN 3 stated a CP should've been created for Resident 196's attempt to elope on 3/4/2025. LVN 3 stated the risk of not creating a CP for elopement was putting the resident at risk for future elopements because interventions would not have been implemented to prevent future attempts. LVN 3 stated the care team would also not be aware of previous elopement attempts.

During an interview on 3/7/2025 at 1:51 PM with the Director of Nursing (DON), the DON stated Resident 11 should have a CP for elopement and stated by not having a CP for elopement can place the resident at risk for elopement in the future.

During a review of the facility's policy and procedure titled, "Care Plans, Comprehensive Person-Centered" revised 3/2022, the P&P indicated a comprehensive person-centered CP will be developed and implemented to include measurable objectives and timetables to meet the resident's physical, psychosocial and functional

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needs.

c. During a review of Resident 68's AR, the AR indicated Resident 68 was admitted to the facility on 9/28/2024 with diagnoses that included respiratory failure (a condition caused by inadequate supply of oxygen in the body), a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), and dementia (a progressive state of decline in mental abilities) with an onset date of 9/28/2024.

During a review of Resident 68's H&P dated 1/21/2025, the H&P indicated Resident 68 did not have the capacity to understand and make decisions and was dependent (a helper does all of the effort, resident does none of the effort to complete the activity) for basic activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).

During a review of Resident 68's MDS dated 2/19/2025, the MDS indicated Resident 68 had severe cognitive impairment.

During a review of Resident 68's untitled CP initiated on 3/5/2025, the CP indicated Resident 68 had dementia.

During an interview with Licensed Vocational Nurse 3 (LVN 3) on 2/7/2024 at 2:27 pm, LVN 3 stated Resident 68 should have a CP for dementia which should have been created upon admission (9/28/2024) by a licensed nurse. LVN 3 further stated, without the CP, staff would not be able to help Resident 68 improve and staff would not know the goals and interventions for the

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F 656	Continued From page 38 diagnosis of dementia During an interview with the Director of Nursing (DON) on 3/7/2025 at 4:05 pm, the DON stated a CP was needed for Resident 68 who had a diagnosis of dementia and should be implemented as soon as it was identified on 9/28/2024. The DON further stated, without a CP, facility staff would not be able to accurately provide care and services the resident needed. During a review of the facility's P&P titled, "Care Plans, Comprehensive Person-Centered" revised 3/2022, the P&P indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet a resident's physical, psychosocial and functional needs was developed and implemented for each resident. d. During a review of Resident 47's Admission Record (AR), the AR indicated the facility admitted Resident 47 on 12/31/2024, and re-admitted the resident on 2/13/2025, with diagnoses including, sickle-cell disease (a genetic disorder that causes abnormal red blood cells), bipolar disorder (a mental illness that causes extreme mood swings, from mania [a state of intense, often euphoric or irritable, energy and activity, characterized by racing thoughts, rapid speech, and a decreased need for sleep, often accompanied by impulsive or risky behaviors] to depression), and PTSD. During a review of Resident 47's Minimum Data Set (MDS, a resident assessment tool), dated 1/6/2025, the MDS indicated Resident 47's cognition (the ability to think and process information) was intact. The MDS indicated Resident 47 required supervision or touching	F 656		

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assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required supervision or touching assistance with mobility.

During a concurrent interview and record review on 3/6/2025 at 4:37 PM with Licensed Vocational Nurse (LVN) 5, Resident 47's Care Plan Reports were reviewed. Resident 47's CP Reports did not indicate that the facility initiated an individualized person-centered care plan to address Resident 47's PTSD diagnosis. LVN 5 stated that she was unaware of Resident 47's PTSD diagnosis and the facility should have initiated an individualized person-centered care plan for Resident 47's PTSD diagnosis. LVN 5 stated that it was crucial for staff to be aware if a resident had PTSD because it directly affected how staff approached resident's care. LVN 5 stated that PTSD could impact a person's emotional and psychological well-being and knowing about the diagnosis helped staff tailor their approach to meet the resident's specific needs. LVN 5 stated that a PTSD care plan made sure that everyone involved in the resident's care was on the same page. LVN 5 stated that the care plan would outline strategies for managing triggers, communication techniques, and how to address any behavioral concerns. LVN 5 stated that the care plan ensured the healthcare team approached the care consistently and with the understanding that the resident's PTSD needs would be addressed in a compassionate and mindful way.

During an interview on 3/7/2025 at 11:08 AM with

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F 656	Continued From page 40 the Director of Nursing, the DON stated that identifying PTSD early allowed the facility to personalize care and develop interventions and strategies to prevent triggering episodes or heightened stress. The DON stated that initiating a PTSD care plan was essential because it ensured that all team members were aligned in their approach to the resident's care. The DON stated that PTSD affected each person differently, so having a tailored care plan allowed the facility to address the unique needs of the individual. The DON stated that the facility should have initiated a PTSD care plan for Resident 47 and should have included specific interventions, coping strategies, and triggers to avoid. During a review of the facility's policy and procedure (P&P) titled, "Care Plans, Comprehensive Person-Centered," revision 3/2022, the P&P indicated "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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	F 684	**F684: Quality of Care** **CORRECTIVE ACTION** On 3/27/2025 review of Resident 27 MAR regarding IV flushing and flushing is rendered by RN before and after IV medication administration per MD's order. On 3/19/2025 and 3/25/25 Treatment Nurse with the Nurse Practitioner assessed the skin of resident 49 and skin is improving with no complications noted.	

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F 684	Continued From page 41 by: Based on interview and record review, the facility failed to provide care in accordance with professional standards of practice for two of three sampled residents (Residents 27 and 49) by failing to: a. Ensure Resident 27's Peripherally Inserted Central Catheter (PICC, thin flexible tube that is inserted into a view in the upper arm to give fluids and other medications) line and Midline (long, thin, flexible tube that is inserted into a large vein in the upper arm) were flushed (to fill with normal saline [NS, mixture of salt and water concentration] solution to prevent clotting when not in use) per the Medical Doctor (MD) order. b. Ensure Treatment Nurse (TN) 1 assessed Resident 49's skin condition. These failures had the potential to result in Residents 27 and 49 to develop complications from a delay in care and services. Findings: a. During a review of Resident 27's Admission Record (AR) the AR indicated Resident 27 was admitted to the facility on 3/12/2023 and readmitted on 1/13/2025 with diagnoses that included acute osteomyelitis (bone infection caused by bacteria) of the left foot and ankle and cellulitis (serious bacterial skin infection). During a review of Resident 27's History and Physical (H&P) dated 2/20/2025, the H&P indicated Resident 27 had the capacity to understand and make decisions.	F 684	**OTHER RESIDENTS AFFECTED IDENTIFICATION** All resident with IV orders were reviewed on 3/10/2025 and no other residents were affected by the deficient practice identified. On 3/27/25, all residents with skin conditions were reviewed for appropriate assessment and documentation. No other residents were affected by the deficient practice. **MEASURES AND SYSTEMIC CHANGES** On 3/25/2025, In service was provided by DON to Licensed Nurses regarding the importance of flushing pre and post medication administration per MD's order for prevention of complications such as clotting and maintain patency of the access site. On 3/25/2025, In service was provided by DON/Designee to Licensed Nurses regarding importance of skin assessments weekly for residents with skin conditions. DON, ADON, RN Supervisor/Designee will monitor 3x weekly the IV MAR to ensure flushing before and after medication administration is rendered per Md's order and is documented promptly in the IV MAR. .	

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F 684	Continued From page 42 During a review of Resident 27's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 1/10/2025, the MDS indicated Resident 27's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 27's untitled orders (UO) dated 1/31/2025 timed at 9:11 PM, Resident 27 had a Medical Doctor (MD) order to flush the PICC line with NS before and after giving a medication and every 12 hours for maintenance. On 2/17/2025 timed at 7:46 PM the UO indicated to flush the Midline with NS 10 milliliters (mL, unit of measurement for volume) before and after giving a mediation and every eight (8) hours for maintenance. During a concurrent interview and record review with Registered Nurse Supervisor 4 (RN 4), Resident 27's Treatment Administration Record (TAR) dated 2/2025 to 3/2025 was reviewed. The TAR indicated blank spaces on the following dates: 2/1/2025 2/2/2025 2/3/2025 2/4/2025 2/5/2025 2/6/2025 2/7/2025 2/11/2025 2/13/2025 2/14/2025 2/15/2025 2/16/2025 2/18/2025 2/21/2025	F 684	**MEASURES AND SYSTEMIC CHANGES (CONTINUED)** DON/Wound IDT on a weekly basis during wound meeting will conduct an audit ensuring all residents with skin conditions have skin assessments completed documented on residents' medical records **MONITORING PERFORMANCE** ADON/RN Supervisor will do a weekly monitoring x 4 weeks then monthly thereafter of IV flushing and skin assessments until 100% compliance is obtained. These reports will be submitted to the QAA committee monthly for a period of three months or until compliance is achieved, for further review and any additional recommendations.	3/28/2025

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F 684	Continued From page 43 2/23/2025 2/25/2025 2/26/2025 2/28/2025 3/1/2025 RN 4 stated if it was blank then Resident 27's PICC and Midline was not flushed per the MD order. RN 4 stated if staff are not flushing the PICC and Midline per the MD order then staff would not be able to maintain the patency of the intravenous (IV, within a vein) line and staff would not be able to check if the IV site was red, swollen, or if it was in place. During an interview on 3/7/2025 at 1:36 PM with the Director of Nursing (DON), the DON stated if staff have an MD order to flush the PICC and Midline then they must flush it. The DON stated if it was not documented then it was not done. The DON stated by not flushing the PICC and Midline, it would place the resident at risk of clogging the IV line. During a review of the facility's policy and procedure (P&P) titled, "Charting and Documentation" revised on 7/2017, the P&P indicated the following information is to be documented in the resident medical record including treatments or services performed. b. During a review of Resident 49's Admission Record (AR), the AR indicated Resident 49 was readmitted to the facility on 12/9/24 with diagnoses that included pain, and hypertensive heart disease. During a review of Resident 49's History & Physical (H&P), dated 12/25/24, the H&P	F 684		

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indicated Resident 49 did not have the capacity to make medical decisions.

During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 12/30/24, the MDS indicated Resident 49 was severely cognitively impaired (ability to understand and process thoughts), and was dependent for activities of daily living (ADLs) and transferring from bed-to-chair.

During an interview on 3/05/25, at 12 PM, Resident 49 stated Resident 49 has a sore on her bottom.

During an observation of Resident 49 on 3/06/25 12:10 PM, Resident 49 was sleeping in bed in a supine position.

During in interview on 3/6/25, at 12:15 PM with the Director of Nurse (DON) there was no weekly skin assessments for Resident 49. The DON stated it is the facility policy to complete weekly assessment and as needed for residents.

During an interview on 3/07/25, at 11:24 AM TN 1, TN 1 stated all licensed nurses could perform a head-to-toe assessment, but "It is the treatment nurse primary responsibility." TN 1 stated the last skin assessment for Resident 49 dated 12/27/24 following the resident's readmission. TN 1 stated It is important to follow facility policy and complete regular skin assessments so that staff know if the treatment is effective.

During an interview on 3/07/25, at 12:00 PM, TN 1 stated she was unable to provide monitoring documentation about Resident 49's skin conditions.

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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 treatments to prevent the development of pressure ulcer (PU- an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure) and promote healing for four of six sampled residents (Residents 1, 16, 20 and 36) by failing to: a. Ensure the low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure injuries) for Resident 36 was set to alternating pressure. b. Ensure the low air loss mattress for Resident 20 was set to alternating pressure. c. Ensure Resident 1's heel boots for offloading purposes were applied. d. Ensure Resident 16's LALM was set at the correct weight setting. These failures had the potential to cause	F 686	**F686: Treatment/ Service to prevent/ heal Pressure ulcer** **CORRECTIVE ACTION** On 3/7/2025, LALM setting was corrected for residents 36, 20, and 16. On 3/7/2025, offloading boots were put on resident 1's feet **OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/7/2025, the treatment nurse and licensed nurses checked all residents with LALM and offloading boots to verify that they are being utilized as ordered. No other residents were affected by the deficient practice. **MEASURES AND SYSTEMIC CHANGES** On 3/21/2025 DON/Treatment nurse provided an in-service training to licensed nurses on how to operate air loss mattress for correct setting. DON/designee will randomly check residents' LALM setting weekly to verify that they are correctly set per MD orders. DON/designee will randomly check residents with offloading boots orders if they are properly carried out.	

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F 686	Continued From page 46 pressure ulcers, worsen and prevent healing for residents with skin and pressure injuries. Findings: a. During a review of Resident 36's Admission Record (AR), the AR indicated Resident 36 was readmitted to the facility on 1/28/2024 with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 36's History and Physical (H&P) dated 2/4/2024, the H&P indicated Resident 20 had the capacity to understand and make decisions. During a review of Resident 36's Physician Orders (PO) dated 3/1/2024, the PO indicated Resident 36 had an order for LALM for wound management and prevention. The PO indicated, LALM settings needed to be checked every shift. During a review of Resident 36's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/27/2024, the MDS indicated Resident 36 had intact cognition (ability to understand), was at risk of developing pressure ulcers and a pressure reducing device was in use for Resident 36's bed. During a review of Resident 36's Braden Scale for Predicting Pressure Sore Risk (BS - a resident assessment tool that identifies residents at risk for pressure ulcers) dated 2/26/2025, the BS indicated Resident 36 was at risk for developing a PU.	F 686	**MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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During a concurrent observation and interview on 3/4/2025 at 11:04 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 36's room, Resident 36 was asleep in bed and the LALM static pressure indicator was lit. LVN 2 stated, the LALM was on static pressure which kept the mattress fully inflated at all times and prevented the air from fluctuating inside the mattress, which could prevent wound healing. LVN 2 further indicated, static pressure was used while providing bedside and wound care.

During an interview on 3/7/2025 at 9:53 am with the Treatment Nurse (TN), the TN stated Resident 36's LALM was used for wound management and prevention and stated Resident 36 had a history of pressure ulcers. TN further stated, when the LALM was left on static mode and the resident was unable to reposition themselves, there's a possibility of skin breakdown. The TN stated LALM settings were checked and documented on the Treatment Assessment Record (TAR) by the licensed vocational nurse and included checking if the LALM was on static pressure.

During a concurrent interview and record review on 3/7/2025 at 4:08 pm with the Director of Nursing (DON), Resident 36's TAR dated 3/1/2025 to 3/31/2025 was reviewed. The TAR indicated the settings for LALM for wound management and prevention to be checked and was not documented it was checked on March 1 during day shift and March 2 during the evening shift. The DON stated it was missing documentation. The DON stated, the LALM was used for PU prevention and the licensed nurse should have documented and ensured the

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settings were correct. The DON stated the only time the LALM should have remained on static pressure was when staff was performing resident care. The DON further stated, a mattress left on static pressure could be hard and could cause injury to the resident's skin.

b. During a review of Resident 20's AR, the AR indicated Resident 20 was readmitted to the facility on 9/17/2023 with diagnoses that included epilepsy (a brain disorder that causes recurring, unprovoked seizures) and osteoporosis (weak and brittle bones).

During a review of Resident 20's History and Physical (H&P) dated 3/4/2024, the H&P indicated Resident 20 had fluctuating capacity to understand and make decisions.

During a review of Resident 20's MDS dated 1/22/2025, the MDS indicated Resident 20 had intact cognition and was at risk of developing pressure ulcers and a pressure reducing device was in use for Resident 20's bed and chair.

During a review of Resident 20's PO dated 6/24/2024, the PO indicated Resident 20 had an order for LALM for wound management and prevention. The PO indicated, LALM settings needed to be checked every shift.

During a review of Resident 20's Wound Consult (WC) dated 11/19/2024, the WC indicated recommendations for Resident 20's care which included following facility pressure injury and relief protocols and the use a LALM.

During a review of Resident 20's untitled Care Plan (CP), dated 2/5/2025, the CP indicated

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Resident 20 had a potential for PU development related to incontinence, fragile skin and was only ambulating with Restorative Nurse Assistants (RNAs- staff who provide rehabilitative care). The CP interventions included to follow facility policies and protocols for the prevention and treatment of skin breakdown.

During a concurrent observation and interview on 3/4/2025 at 11:30 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 20's room, Resident 20 was lying in bed and the LALM static control button was lit. LVN 2 stated, Resident 20 had a history of PU and when the LALM was on static pressure the mattress remained fully inflated, stopping air from fluctuating inside the mattress, which could prevent wound healing. LVN2 further stated, static pressure was used while providing bedside and wound care.

During an interview on 3/7/2025 at 9:59 am with the Treatment Nurse (TN), the TN stated Resident 20's was at risk for PU and that Resident 20 always laid on her back. The TN further stated, when the LALM was left on static mode and the resident was unable to reposition themselves, there's a strong possibility of skin breakdown. The TN stated, LALM settings were checked and documented on the Treatment Assessment Record (TAR) by the licensed vocational nurse and included checking if the LALM was on static pressure.

During a concurrent interview and record review on 3/7/2025 at 4:10 pm with the Director of Nursing (DON), the TAR dated 3/1/2025 to 3/31/2025 was reviewed. The TAR indicated the settings for LALM for wound management and prevention to be checked and was not

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documented it was checked on March 1 during day shift and March 2 during the evening shift. The DON stated it was missing documentation. The DON stated, the LALM was used for PU prevention and the licensed nurse should have documented and ensured the settings were correct. The DON stated the only time the LALM should have remained on static pressure was when staff was performing resident care. The DON further stated, a mattress left on static pressure could be hard and could cause injury to the resident's skin.

During a review of "Drive: Med-Aire Alternating Pressure Mattress Replacement System with Low Air Loss User Manual Item #14027," (undated), the LAL mattress manual indicated the Med Aire 8", 14027 System was specifically designed for the prevention and treatment of pressure injuries while optimizing patient comfort and should be operated as instructed. The manual indicated, the static control button was used to shift between alternating and static mode and when in static mode, the static indicator will turn on and the mattress will become a firm surface.

During a review of the facility's Policy and Procedure (P&P) titled, "Support Surface Guidelines," revised September 2013, the P&P indicated redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. The P&P indicated, elements of support surfaces that are critical to pressure ulcer prevention and general safety also include pressure redistribution.
c. During a review of Resident 1's Admission Record (AR), the AR indicated the facility

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admitted Resident 1 on 10/19/2018, and readmitted Resident 1 on 11/5/2024, with diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and cellulitis (a bacterial skin infection that causes inflammation, redness, pain, and swelling) of right lower limb.

During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/1/2025, the MDS indicated Resident 1's cognition (the ability to think and process information) was intact. The MDS indicated Resident 1 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility.

During review of Resident 1's physician order (PO) dated 3/3/2025, the PO indicated that Resident 1 had an active order for heel boots to both feet for offloading purposes, monitor placement every shift.

During an observation on 3/4/2025 at 10:49 AM, Resident 1 was noted lying in bed with head of the bed elevated without heel protecting boots in place.

During a concurrent interview and record review on 3/4/2025 at 3:30 PM with Licensed Vocational Nurse (LVN) 6, Resident 1's Order Summary Report dated 3/6/2025 was reviewed. LVN 6 stated that Resident 1 had an active order dated 3/3/2025 for heel boots to both feet for offloading purposes, and to monitor placement every shift. LVN 6 stated that following physician orders was

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vital for maintaining the Resident 1's health and safety. LVN 6 stated that physician orders were based on the physician's medical expertise and were tailored to the individual needs of each resident. LVN 6 stated that in the case of heel protectors, these were prescribed to prevent pressure ulcers, which could have been a major health concern, especially for Resident 1 who had limited mobility and was at risk for skin breakdown. LVN 6 stated that not applying the heel boots could lead to unnecessary complications.

During an interview on 3/7/2025 at 11:08 AM, with the Director of Nursing (DON), the DON stated that physician orders was non-negotiable in healthcare. The DON stated that these orders were based on the professional medical judgement of the physician, who had assessed the resident's needs. The DON stated that heel protectors were made to prevent pressure ulcers. The DON stated that the heel was a particularly vulnerable area, and without the protectors, the resident could be at risk for skin breakdown, pain, or infection.

During a review of the facility's policy and procedure (P&P) titled, "Prevention of Pressure Ulcers", revised 9/2013, the P&P indicated, "The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors." The P&P indicated, "Interventions and Preventive Measures: ...Risk Factor - Immobility ... When in bed, every attempt should be made to "float heels" (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by clinical staff or by the physician.

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d. During a review of Resident 16's Admission Record (AR), the AR indicated the facility admitted Resident 16 on 10/22/2024, and readmitted Resident 16 on 1/21/2025, with diagnoses including, metabolic encephalopathy (a change in how your brain works due to an underlying condition), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and pressure ulcer (damage to the skin and underlying tissue caused by prolonged pressure on the skin, often over bony areas, which restricts blood flow and can lead to open sores) of sacral (at the bottom of the spine and lies between the fifth segment of the lumbar spine [L5] and the coccyx [tailbone]) region.

During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 16's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent (helper does all of the effort) with mobility.

During an observation on 3/4/2025 at 10:29 AM, Resident 16 was noted lying on a low air loss mattress with setting set at 500 lbs.

During an interview on 3/4/2025 at 10:40 AM, with the Treatment Nurse (TN), the TN stated that the LALM was designed to help prevent pressure ulcers by redistributing the resident's weight and reducing pressure on vulnerable areas of the body. The TN stated that when the mattress was

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set to the exact weight of the resident, it optimally adjusted the air pressure to provide the right level of support. The TN stated that if the mattress was set too high or too low for resident's actual weight, it would not be effective in properly distributing pressure, which could increase the risk of skin breakdown and pressure sores.

During a review of Resident 16's Order Summary Report (OSR), dated 3/5/2025, the OSR indicated Resident 16 had an active physician order dated 1/23/25 for a bariatric (the branch of medicine that deals with the study and treatment of obesity) low air loss mattress for wound management, to monitor proper functioning, and placement every shift.

During a review of Resident 16's Weights and Vitals Summary (WVS), dated 3/5/2025, the WVS indicated Resident 16's weight was 244 lbs.

During an interview on 3/7/2025 at 11:08 AM, with the Director of Nursing (DON), the DON stated that the correct settings on a LALM was essential to providing the best care for residents, particularly those who were at higher risk for pressure ulcers or skin breakdowns. The DON stated that the LALM was designed to redistribute pressure, reduce friction, and provide constant airflow to the skin, which was particularly important for immobile or frail residents. The DON stated that if the settings was not accurate, the mattress might not provide the necessary support and airflow, which could lead to discomfort and, in some cases, exacerbate pressure related injuries.

During a review of the facility's user manual titled, "Med Aire 10 Alternating Pressure and Low Air

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F 686	Continued From page 55 Bariatric Mattress Replacement System," undated, the user manual indicated, "It is recommended to press Auto Firm on the panel when the mattress is first inflated. Users can then easily adjust the air mattress to desired firmness according to patient's weight and comfort."	F 686		
F 689 SS=G	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 a safe environment to prevent injuries for two of two sampled residents (Residents 37 and 294) by failing to: a. For Resident 37, the facility failed to: 1. Ensure Licensed Vocational Nurses (LVNs) implemented Resident 37's untitled Care Plan (CP), dated 2/26/2025, to provide interventions such as anticipating Resident 37's needs and providing opportunities for positive interaction/attention to Resident 37 to decrease or eliminate Resident 37's episodes of banging head on the walls/doors. 2. Ensure Certified Nursing Assistants (CNAs) provided hourly monitoring to Resident 37 who	F 689	**F 689: FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **CORRECTIVE ACTION** Resident #37 was transferred to a General Acute Hospital on 3/2/25 for evaluation following self-inflicted injuries. On 3/4/25, the resident was placed under 1:1 sitter supervision for close monitoring. A healthcare provider ordered a helmet for the resident to wear while out of bed to prevent further self-inflicted harm. The IDT convened on (date) to review and update Resident #37's comprehensive care plan. On 3/24/2025, the DSD/Designee provided nursing staff with education on the importance of hourly monitoring for Resident #37, emphasizing behavioral observations and self-inflicted injuries. Resident #294 attempted to retrieve his lunch tray from the bedside table independently and was found on the floor on 3/5/25. The resident was assessed for injuries and placed under Close Observation and Care (COC) monitoring from 3/5/25 to 3/8/25. No injuries were noted from the fall.	

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F 689	Continued From page 56 was assessed with aggressive behavior (any behavior or act aimed at harming a person or damaging physical property) as ordered by Resident 37's physician (Medical Doctor/MD 1) on 2/2/2025. As a result, Resident 37 sustained a self-inflicted (injury that person causes to themselves) laceration (cut, a wound that is produced by the tearing of soft body tissue) on the scalp (skin on top of the head) which measured one centimeter (cm, unit of measurement), and a head contusion (bruise) on 3/2/2025. Resident 37 was sent to General Acute Care Hospital 2 (GACH 2) where Resident 37 underwent a repair of laceration by application of skin tissue adhesive glue (a glue used to close wounds in the skin as an alternative to sutures [stitches]). In addition, on 3/4/2025 Resident 37 had a physical altercation (fight) with Resident 37's roommate (Resident 196) and Resident 37 was sent to GACH 2 for medical evaluation. Resident 37 sustained a displaced nasal septal fracture (break in the bone that separates the two nostrils), a frontal (front) scalp hematoma (pool of clotted blood) and complained of severe pain (10 out of 10 pain [10/10], on a pain scale from 0 to 10, 0 indicated no pain, and 10 indicated severe pain) on the face from the altercation with Resident 196. b. For Resident 294, the facility failed to ensure staff did not leave Resident 294's lunch tray in Resident 294's room until staff was ready to assist Resident 294 with feeding on 3/5/2024. Resident 294 was assessed with impairment on both upper extremities, severely impaired cognition (the ability to think and process information), and was dependent on staff for eating.	F 689	**CORRECTIVE ACTION (CONTINUED)** On 3/25/2025, the DON/Designee conducted an in-service training for licensed staff covering: •Comprehensive care planning for managing residents with self-inflicted injuries and aggressive behaviors •Abuse and neglect prevention and prohibition On 3/25/2025, the DSD/Designee provided CNAs with education on: •Abuse and neglect prevention and prohibition •Close supervision of residents during behavioral escalations and the immediate reporting of any behavioral changes to licensed staff •Safety and supervision during mealtimes, with a focus on residents requiring total assistance with eating **OTHER RESIDENTS AFFECTED IDENTIFICATION** All residents had the potential to be affected by the alleged deficient practice. From 3/21/25 to 3/25/25, licensed staff and the IDT conducted facility rounds to observe residents for any behaviors indicating self-inflicted injuries. No additional residents were observed with self-inflicted injuries.	

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F 689	Continued From page 57 As result, Resident 294 reached for his lunch tray on the bedside table by himself and fell on 3/5/2025. Cross Reference: F656 and F600 Findings: a. 1. During a review of Resident 37's Admission Record (AR), the AR indicated the facility initially admitted Resident 37 on 10/11/2024 and readmitted on 2/1/2025 with diagnoses that included Huntington's Disease (HD, a progressive and genetic [inherited] disorder that affects the brain), and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 37's History and Physical (H&P, formal document of a medical provider's examination of a resident) dated 2/3/2025, the H&P indicated Resident 37 was able to make needs known but cannot make medical decisions. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment and care planning tool) dated 2/7/2025, the MDS indicated Resident 37 had moderately impaired cognition (ability to think, learn, and process information). The MDS indicated Resident 37 required supervision (overseeing or watching someone do something) for toileting, bathing, sitting to standing, and partial/moderate assistance (helper does less than half the effort, helper helps lift, hold, or support trunk or limbs) for walking 10 feet.	F 689	**OTHER RESIDENT AFFECTED (CONTINUED)** On 3/28/25, the DSD/Designee monitored meal times to assess whether residents requiring total assistance with eating had their meal trays left on the bedside table before receiving assistance. No residents were observed experiencing the alleged deficient practice. **MEASURES AND SYSTEMIC CHANGES** On 3/21/25, the Director of Nursing (DON) or designee conducted an additional in-service training session for licensed staff, focusing on the following topics: •Comprehensive care planning for residents with self-inflicted injuries and aggressive behaviors •Strategies for preventing and prohibiting abuse and neglect •Licensed staff rounds during mealtimes to ensure resident safety and supervision From 3/21/25 to 3/25/25, the Director of Staff Development (DSD) or designee provided training to CNA staff, which included: •Close supervision during behavioral escalations, along with immediate reporting of concerns to licensed staff	

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F 689	Continued From page 58 During a review of Resident 37's untitled CP, dated 2/26/2025, the CP indicated Resident 37 had a behavior problem of "banging" head on the wall and punching the wall due to dementia. The CP goal indicated to ensure Resident 37 would not have incidence of behavior problem and fewer episodes of banging head on the wall. The CP interventions indicated for nursing staff to anticipate the needs of Resident 37 and provide opportunities for positive interaction and attention. During a review of Resident 37's Progress Notes (PN) dated 3/2/2025 timed at 2:04 PM, the PN indicated Resident 37 was walking in the hallway and suddenly threw a remote control from Resident 37's hand to the floor. The PN indicated Resident 37 turned around and hit the top of Resident 37's head on the door. The PN indicated Resident 37 had angry outburst (a sudden violent expression of strong feeling) for no reason. The PN indicated Treatment Nurse (TN) 1 assessed Resident 37 and Resident 37 had minimal bleeding from the top of the center of Resident 37's head. The PN indicated Resident 37 sustained a laceration on the head which measured 2.5 cm in length by 0.3 cm in width by 0.3 cm in depth. During a review of Resident 37's Change of Condition Evaluation (COCE) dated 3/2/2025 timed at 2:34 PM, the COCE indicated Resident 37 was walking in the hallway and hit Resident 37's head on the door causing bleeding on the top of Resident 37's head. During a review of Resident 37's GACH 2 Emergency Department General (EDG) form dated 3/2/2025 at 3:27 PM, the EDG form	F 689	•Accurate documentation for residents requiring close monitoring •Safety and supervision during mealtimes, specifically for residents who need total assistance with eating. On 3/29/25, facility will initiate a hallway monitoring program where a monitoring aide will do rounds every two hours to identify residents with potential escalating or self-inflicting injuries behaviors. Findings will be logged on a Hallway Monitor Form and will be reported and addressed accordingly. As part of new hire orientation and annual performance evaluation, the DSD/Designee shall provide ongoing staff training and competency development in safety, supervision, and abuse prevention. **PERFORMANCE MONITORING** The safety committee will perform monthly audits of behavioral incident reports, staff training compliance, and the effectiveness of the hallway monitor program. Findings will be received during monthly safety QAPI meetings, where necessary adjustments to training and monitoring programs will be made based on recommendations.	

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F 689	Continued From page 59 indicated Resident 37 was brought in the Emergency Department from the facility by ambulance for evaluation of head injury. The EDG form indicated Resident 37 had head contusion and one cm laceration to the scalp. The EDG form indicated Resident 37 underwent a repair of the scalp laceration with application of skin tissue adhesive glue. During a review of Resident 37's PN dated 3/2/2025 timed at 7:32 PM, the PN indicated Resident 37 returned back to the facility from GACH 2. The PN indicated Resident 37's laceration on the head was glued with skin tissue adhesive glue at GACH 2. During a review of Resident 37's Order Summary Report (OSR) dated 3/4/2025, the OSR indicated for nursing staff to monitor Resident 37's top of the head laceration with surgical glue status post (S/P-after) banging head to the wall for any wound dehiscence (separation of wound edges), bleeding or unusual changes every shift and to report to MD 1 promptly. During a concurrent interview with LVN 3 on 3/6/2025 at 1:39 PM, LVN 3 stated on 3/2/2025 (could not remember exact time) Resident 37 hit Resident 37's head on the shower door in the hallway. LVN 3 stated Resident 37 sustained a laceration on top of Resident 37's head. LVN 3 stated Resident 37 was sent to GACH 2 and received treatment for the laceration (laceration was glued together). LVN 3 stated she did not know Resident 37 had an order to monitor Resident 37 for episodes of hitting head on walls/doors.	F 689	The Administrator/Designee will oversee the continued effectiveness of these systemic interventions and allocate additional resources as needed.	3/29/2025

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a. 2. During a review of Resident 37's OSR, dated 2/2/2025, the OSR indicated an order for hourly monitoring of Resident 37 for aggressive behavior every shift.

During a review of Resident 37's COCE dated 3/4/2025 timed at 7:13 AM, the COCE indicated Resident 37 had a physical altercation with another resident (Resident 196). The COCE indicated Resident 196 hit Resident 37 on the face and head. The COCE indicated Resident 37 sustained a bloody mouth, a bloody nose, and a small bump on the forehead.

During a review of Resident 37's Situation, Background, Assessment, Recommendation Communication (SBARC, communication form used to share information about the condition of a resident), dated 3/4/2025, timed at 7:20 AM, the SBARC indicated Resident 37 sustained a bloody mouth, bloody nose, and a small bump on the forehead. The SBARC form indicated Resident 37 was punched by Resident 37's roommate (Resident 196).

During a review of Resident 37's GACH 2 EDG form dated 3/4/2025 timed at 11:50 AM, the EDG form indicated Resident 37 was brought in the Emergency Department from the facility by ambulance due to head and nose pain (pain level was not indicated) after a physical altercation at the facility on 3/4/2025 at 7 AM. The EDG form indicated there was no treatment given for Resident 37 at GACH 2.

During a review of Resident 37's GACH 2 Computer Tomography (CT, imaging procedure that produces images of the inside the body) of Resident 37's face, dated 3/4/2025, timed at

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11:53 AM, the CT scan result indicated a mildly displaced nasal septal fracture and a frontal scalp hematoma.

During an interview with Certified Nursing Assistant 8 (CNA 8) on 3/4/2025 at 4:15 PM, CNA 8 stated Resident 37 returned from GACH 2 on 3/4/2025 (unable to recall time) with a bump on Resident 37's forehead.

During a concurrent observation of Resident 37 in Resident 37's room and interview with Resident 37 on 3/4/2025 at 4:17 PM, Resident 37 was calm and had a small bump on the forehead. Resident 37 stated Resident 37 had a 10/10 pain on Resident 37's face as the result of the altercation with Resident 196 on 3/4/2025.

During an interview with the facility's Director of Staff Development (DSD) on 3/7/2025 at 12:18 PM, the DSD stated, on 3/4/2025 in the early morning (unable to recall the time) the DSD entered Resident 37's room and saw blood around Resident 37's nose and mouth. The DSD stated Resident 37 told the DSD that Resident 196 punched Resident 37 in the face. The DSD stated the incident was not witnessed by facility staff.

During a concurrent interview and record review with CNA 7 on 3/7/2025 at 12:29 PM, Resident 37's OSR dated 2/2/2025 was reviewed. The OSR indicated an order for hourly monitoring to Resident 37 for aggressive behavior every shift. CNA 7 stated there were no Hourly Behavioral Monitoring Sheet (HBMS) created for Resident 37 on 3/2/2025 and 3/3/2025 and the HBMS on 3/4/2025 was created after the physical altercation incident happened between Resident

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37 and Resident 196 on 3/4/2025. CNA 7 stated CNA 7 was not aware or informed that Resident 37 required hourly monitoring. CNA 7 stated Resident 37 needed hourly monitoring when the resident was aggressive and had behavior of hurting himself. CNA 7 stated hourly monitoring was a physician's order and needed to be followed. CNA 7 stated CNAs (all CNAs) were responsible for hourly monitoring and documenting the hourly monitoring on the HBMS. CNA 7 stated CNA 7 did not see any HBMS completed for Resident 37 prior to the incidents on 3/2/2025 and 3/4/2025.

During a concurrent interview and record review with LVN 3 on 3/7/2025 at 2:21 PM, Resident 37's OSR dated 2/2/2025 was reviewed. The OSR dated 2/2/2025 indicated an order for hourly monitoring of Resident 37 for aggressive behavior every shift. LVN 3 stated hourly monitoring for Resident 37 was not done as ordered by the physician. LVN 3 stated the purpose of monitoring Resident 37 hourly was to ensure Resident 37 was safe. LVN 3 stated prior to the incident on 3/2/2025 and 3/4/2025 nursing staff did not provide hourly monitoring/supervision to Resident 37 as MD 1 ordered.

During an interview with the facility's Director of Nursing (DON) on 3/7/2025 at 3:15 PM, the DON stated hourly monitoring for Resident 37 was not done prior to the incidents on 3/2/2025 and 3/4/2025. The DON stated Resident 37 was not supervised/monitored because the physician's order for hourly monitoring was not implemented. The DON stated, "The incidents on 3/2/2025 and 3/4/2025 could have been prevented if hourly monitoring was done (on Resident 37)."

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During a review of the facility's Policy and Procedure (P&P) titled, "Safety and Supervision of Residents," revised 7/2017, the P&P indicated the care team shall target interventions to reduce individual related risks related to hazards in the environment including adequate (enough, acceptable in quality or quantity) supervision and monitoring of residents.

b. During a review of Resident 294's Admission Record (AR), the AR indicated the facility admitted Resident 294 on 2/4/2025, with diagnoses including, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), toxic encephalopathy (brain dysfunction caused by exposure to toxic substances, resulting in symptoms like altered consciousness, memory loss, and cognitive impairment), and lack of coordination.

During a review of Resident 47's Fall Risk Evaluation (FRE) and Assessment Outcomes (AO), dated 2/24/2025, timed at 8:36 PM, the FRE and AO indicated Resident 294 was a moderate fall risk.

During a review of Resident 294's Multidisciplinary Care Conference (MCC), dated 2/26/2025, timed at 11:11 AM, the MCC indicated Resident 294's cognition was severely impaired.

During a review of Resident 294's Functional Abilities and Goals (FAAG), dated 2/26/2025, timed at 5:17 AM, the FAAG indicated Resident 294 was dependent (helper does all of the effort) on staff for activities of daily living (ADL, term used in healthcare that refers to self-care activities) including eating and mobility, and had

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functional impairment on both sides of his upper extremities.
During an observation on 3/5/2025 at 12:15 PM, Resident 294 was lying in bed asking to be fed in frustration. Licensed Vocational Nurse (LVN) 1 approached Resident 294 and took his vital signs (measurements of your body's basic functions, like your heart rate, breathing rate, temperature, and blood pressure). Resident 294 denied pain when asked by LVN 1.

During an interview on 3/5/2025 at 12:21 PM, with LVN 1, LVN 1 stated that he had just returned from lunch and was conducting rounds to ensure residents were receiving their lunch trays. LVN 1 stated that (on 3/5/2025) when he entered the south unit, the maintenance supervisor (MS) informed him that there was a resident on the floor in room 31. LVN 1 stated that he immediately went to room 31 and found Resident 294 sitting on the floor with his back against the bed and facing the window. LVN 1 stated that Resident 294's food tray had been placed on the bedside table, positioned between the window and the bed. LVN 1 stated that Resident 294 was observed reaching for his lunch tray. LVN 1 stated that Resident 294 was then assisted back into bed and assessed for injuries. LVN 1 stated that Resident 294 denied any injuries, and no physical injuries were noted. LVN 1 stated that Resident 294 was dependent with eating, had been identified as a fall risk, was cognitively impaired, and had episodes of confusion. LVN 1 stated that staff should not have delivered Resident 294's lunch tray until staff were ready to assist with feeding the resident, which could have prevented the fall. LVN 1 stated Resident 294 likely attempted to reach for the tray, which was placed on the bedside table next to the bed and fell. LVN

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1 stated that, due to the resident's condition and for his safety, staff should have ensured that the tray was not delivered or placed on the bedside table until they were ready to feed the resident.

During an interview on 3/5/2025 at 12:29 PM, with Certified Nursing Assistant (CNA) 4, CNA 4 stated that Resident 294 was confused and dependent on staff for eating. CNA 4 stated that she was notified of Resident 294's fall but did not witness the fall as she was passing out meal trays at the time. CNA 4 stated that Resident 294's meal tray should not be placed on Resident 294's bedside table, given the resident's confusion and fall risk. CNA 4 stated that Resident 294's tray should not be delivered to Resident 294's room until staff were ready to assist Resident 294 with his meal, as this would have helped prevent the fall.

During an interview on 3/7/2025 at 11:08 AM, with the Director of Nursing (DON), the DON stated that residents who were cognitively impaired often lacked the awareness of their surroundings or their physical capabilities. The DON stated if the meal tray was within reach and a cognitively impaired resident was not being supervised or assisted, they may attempt to grab it, which could lead to a fall, as the facility unfortunately experienced with Resident 294. The DON stated that Resident 294's confusion and inability to recognize the potential hazard were significant factors in the fall incident. The DON stated that staff should not deliver a meal tray to a confused and dependent resident unless staff were ready to assist with feeding. The DON stated the meal tray should only be placed in the resident's vicinity when staff were present to help the resident with the meal. The DON stated this would ensure that the resident was not left in a vulnerable state

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F 689	Continued From page 66 where the resident might reach for the tray on his/her own. During a review of the facility's P&P titled, "Safety and Supervision of Residents," revise 7/2017, the P&P indicated, "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities." The P&P indicated, "The facility-oriented approach and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly ... Resident supervision is a core component of the systems 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." The P&P indicated, "The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in resident's condition."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690	**F690: Bowel/Bladder Incontinence, Catheter, UTI** **CORRECTIVE ACTION** On 3/10/25, licensed nurse assessed Resident 27 and no complication from foley catheter use was snoted and Foley catheter care was performed.	

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F 690	Continued From page 67 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement the facility's policy titled "Catheter (thin flexible tube used to drain fluids from the body or deliver fluids into it) Care, Urinary" for one of one sampled resident (Resident 27) by failing to perform foley catheter (FC, thin, flexible tube inserted into the bladder through the urethra to drain urine) care every shift per the physician's order for Resident 27.	F 690	**OTHER RESIDENTS AFFECTED IDENTIFICATION** All residents had the potential to be affected by the alleged deficient practice, no other resident was affected. On 3/10/25, Treatment nurse reviewed all resident with orders of indwelling catheter and foley catheter care were rendered as ordered and no other residents were found affected of the deficient practice. **MEASURES AND SYSTEMATIC CHANGES** On 3/21/25 DON/Designee provided inservice regarding the importance of rendering indwelling catheter care including documentation in the TAR. DON/Designee will perform review and audit of MAR/TAR 3x/wk x 90days or until 100% of compliance is achieved. **MONITORING PERFORMANCE** Any discrepency and non compliance with documentation on the MAR/TAR will reviewed in the monthly QAA meeting for further recommendations.	3/28/2025

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This failure had the potential to result in Resident 27 to experience complications from indwelling catheter use.

Findings:

During a review of Resident 27's Admission Record (AR), the AR indicated Resident 27 was admitted to the facility on 3/12/2023 and readmitted on 1/13/2025 with diagnoses that included neuromuscular dysfunction of the bladder (unable to control the bladder due to injury to the spinal cord).

During a review of Resident 27's untitled care plan (CP) dated 10/9/2024, the CP indicated for staff to check the indwelling catheter tubing for kink every shift.

During a review of Resident 27's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 1/10/2025 indicated Resident 27's cognitive abilities (ability to think, learn, and process information) were intact and indicated the presence of an indwelling catheter.

During a review of Resident 27's Order Summary Report (OSR) dated 2/18/2025, the OSR indicated an active physician's order to provide indwelling catheter care every shift.

During a review of Resident 27's History and Physical (H&P) dated 2/20/2025, the H & P indicated Resident 27 had the capacity to understand and make decisions.

During a concurrent interview and record review

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F 690	Continued From page 69 on 3/6/2025 at 10:02 AM with the Treatment Nurse (TN), Resident 27's Treatment Administration Record (TAR) dated 2/2025 to 3/2025 was reviewed. The TAR indicated there were spaces that were left blank on the following dates: 2/18/2025 2/20/2025 2/22/2025 2/23/2025 2/24/2025 2/28/2025 3/1/2025 3/3/2025 3/4/2025 The TN stated there are blanks spaces on those dates and stated if it was blank then Foley Catheter care was not done. The TN stated the TNs check the bags and change as needed to ensure the FC is clean. The TN stated if it was not done per the physician's order then the resident would be at risk of developing a urinary tract infection (UTI, infection of the urinary system that includes the bladder, kidneys, and urethra that is caused by bacteria) because staff was not monitoring the FC. During an interview on 3/7/2025 at 1:40 PM with the Director of Nursing (DON), the DON stated nursing staff are to monitor the patency of the FC and check for placement and sediments every shift. The DON stated if it was not done then it would put the resident at risk for developing an infection. During a review of the facility's policy and procedure (P&P) titled, "Catheter Care, Urinary" revised 8/2022, the P&P indicated the date and	F 690		

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F 690	Continued From page 70 time catheter care was given will be recorded into the resident's medial record.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the Medical Doctor and create a Change of Condition (COC) for one of one sampled resident (Resident 28), when Resident 28 lost 17 pounds (lbs., unit of measurement for weight) on 1/9/2025. This failure had the potential to result in Resident 28 to experience further weight loss.	F 692	**F692: Nutrition/Hydration Status Maintenance** **CORRECTIVE ACTION** On 3/27/25 the Primary MD was notified of the 17lbs weight loss and COC was initiated. OTHER RESIDENT AFFECTED IDENTIFICATION All residents had the potential to be affected by the alleged deficient practice. On 3/27/2025, the RD checked all residents with significant weight change since 2/1/2025 until 3/28/2025 and found 3 residents that did not have a COC and MD was not notified of the significant change. On 3/28/2025, the charge nurse started a COC and notified the physician. **MEASURES AND SYSTEMIC CHANGES** DON/Designee provided in-service to license nurses 3/25/25 Re: importance of notifying MD and initiating a change of condition when weight changes (weight loss/weight gain) were identified on residents including notification of RP and RD for proper interventions to prevent further weight loss.	

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F 692	Continued From page 71 Findings: During a review of Resident 28's Admission Record (AR), the Admission Record indicated Resident 28 was admitted to the facility on 4/22/2019 and readmitted on 11/24/2024 with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks) and dysphagia (difficulty swallowing). During a review of Resident 28's History and Physical (H&P) dated 11/28/2024, the H&P indicated Resident 28 was alert and oriented to self. During a review of Resident 28's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 11/29/2024, the MDS indicated Resident 28 had severe impairments in Resident 28's cognitive abilities (ability to think, learn, and process information) and indicated Resident 28 required set up assistance with eating. During a review of Resident 28's Weights and Vitals Summary (WVS) dated 12/10/2024 to 1/9/2025, the WVS indicated Resident 28 weighed 160 pounds (lbs., unit of measurement for weight) on 12/10/2024 timed at 6:44 AM and on 1/9/2025 timed at 10:08 AM indicated a weight of 143 lbs. During a review of Resident 28's Progress Notes (PN) dated 1/7/2025 timed at 11:50 AM, the PN indicated Resident 28 lost 17 lbs. in one month and indicated the decline suggested a nutritional or medical issue requiring intervention.	F 692	DON/Designee provided in-services 3/25/25 to License nurse/RNA, dietary Staff re: importance of obtaining weight including timeliness of MD/RP notification and initiating change of condition. Re: weight loss. During the weekly weight meeting, RD will discuss any significant weight changes with the IDT and the nursing representative will verify and start the COC and notify the MD for further orders as needed. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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During a review of Resident 28's untitled care plan (CP) dated 1/14/2025, the CP indicated Resident 28 had an unplanned/unexpected weight loss related to an acute illness and included an intervention to contact the physician and dietician immediately if weight declines.

During a concurrent interview and record review on 3/5/2025 at 9:44 AM with Registered Nurse Supervisor 5 (RN 5), Resident 28's medical record was reviewed. RN 5 stated there was no COC created or MD notification for the unplanned weight loss on 1/9/2025. RN 5 stated if a resident lost a substantial amount of weight of about ten (10) percent (%) or more, staff are to notify the MD. RN 5 stated by not notifying the MD it placed Resident 28 at risk for losing more weight and malnutrition because interventions would not be ordered to address the weight loss.

During an interview on 3/5/2025 at 10:30 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated LVN 1 was not aware of Resident 28's weight loss on 1/9/2025. LVN 1 stated there was no COC created to indicate the MD or resident representative (RP) was made aware of the weight loss. LVN 1 stated the MD was probably not aware of the weight loss and stated it would place Resident 28 at risk for malnutrition, delayed healing of wounds, and weakness if the MD was not notified for proper interventions.

During an interview on 3/7/2025 at 1:42 PM with the Registered Dietitian (RD), the RD stated the RD was made aware of Resident 28's weight loss but did not notify the MD. The RD stated nursing staff are responsible to report weight losses to the MD.

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F 692	Continued From page 73 During an interview on 3/7/2025 at 1:42 PM with the Director of Nursing, the DON stated if a resident was losing weight staff are to notify the MD. The DON stated if the MD was not notified, it would place the resident at risk of further weight loss because interventions would not be ordered to address the weight loss if it was medically related. During a review of the facility's policy and procedure (P&P) titled, "Weight Assessment and Intervention" revised 9/2008, the P&P indicated the physician, and multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss, or increasing weight loss. During a review of the facility's P&P titled, "Change in a Resident's Condition or Status" revised 2/2021, the P&P indicated the nurse will notify the MD when there has been a significant change in the resident's physical, emotional, and or mental condition.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695	**F695: Respiratory/ Tracheostomy Care and Suctioning** **CORRECTIVE ACTION** Oxygen 2LPM via Nasal Canula was ordered on 3/5/25. On 3/5/25, “No Smoking/Oxygen in Use” sign was placed on resident 293’s door by the IP Nurse.	

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F 695	Continued From page 74 Based on observation, interview, and record review, the facility failed to ensure that a precautionary signage indicating "No Smoking/Oxygen in Use" was placed on the door of the room and there was a physician's order for oxygen therapy for one of two sampled residents (Resident 293) who was on oxygen therapy. This deficient practice had the potential for unnecessary oxygen therapy use for Resident 293 and increased risk of harm to residents, staff, and visitors in the facility. Findings: During a review of Resident 293's Admission Record (AR), the AR indicated the facility admitted Resident 293 on 1/28/2025, with diagnoses including, end stage renal disease (End Stage Renal Disease-irreversible kidney failure), chronic obstructive pulmonary disease (COPD-a chronic lung disease that makes it hard to breathe), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (a sore or break in the skin or lining of an organ). During a review of Resident 293's Minimum Data Set (MDS, a resident assessment tool), dated 2/13/2025, the MDS indicated Resident 293's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 293 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and substantial/maximal assistance with mobility.	F 695	**OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/5/2025, the DON/IP nurse checked and reviewed residents with oxygen to verify that there are orders and “No Smoking/Oxygen in use” sign was placed on the door of residents’ rooms. No other resident was affected by the deficient practice. **MEASURES AND SYSTEMIC CHANGES** On 3/25/2025, the DON/DSD in-service was provided to LN/CNA re: importance of obtaining physician order for resident receiving oxygen therapy; provide signage on residents’ door indicating “No Smoking/Oxygen in use”. During the daily (Monday to Friday) room rounds, the department heads will check rooms for “No smoking/ Oxygen in use” signs on rooms with residents that use oxygen and report findings during the standup meeting. DON/designee will check residents that are using oxygen weekly to verify that they have orders. **MONITORING COMPLIANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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During an observation on 3/4/2025 at 11:30 AM, Resident 293 was observed on oxygen therapy at 2 liters per minute (LPM- unit of measurement for volume) via nasal cannula (a medical device used to deliver oxygen into the nose). Resident 293's room did not have a "no smoking/oxygen in use" signage posted on the door.

During an interview on 3/4/2025 at 11:41 AM, with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that there was no "No Smoking/Oxygen in Use" sign posted on the door of Resident 293's room. LVN 3 stated that Resident 293 was receiving oxygen therapy and should have had a sign indicating "no smoking/oxygen in use." LVN 3 stated that the "no smoking/oxygen in use" sign was critical for safety. LVN 3 stated that oxygen was a highly flammable substance, and when a person was on oxygen therapy, they were at a much higher risk of sustaining serious burns or injuries from something as simple as a spark. LVN 3 stated that the signs helped remind both residents and visitors of the immediate danger.

During an interview and concurrent record review on 3/5/2025 at 4:23 PM, with LVN 5, Resident 293's Order Summary Report (OSR) dated 3/5/2025 was reviewed. Resident 293's OSR indicated no physician order for oxygen therapy. LVN 5 stated that Resident 293 was receiving oxygen therapy without a physician's order. LVN 5 stated that a physician's order for oxygen therapy helped guide the healthcare team in properly administering oxygen therapy, ensured proper monitoring and documentation, and helped provide individualized, coordinated care for residents with respiratory conditions. LVN 5 stated that without a physician's order, the facility could not guarantee that the oxygen therapy was

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being used effectively and safely, which could lead to adverse outcomes for the resident.

During an interview on 3/7/2025 at 11:08 AM, with the Director of Nursing (DON), the DON stated that the "no smoking/oxygen in use" sign served as a clear and immediate reminder to everyone - staff, residents, and visitors that the area was a potential fire hazard. The DON stated that the goal was to reduce the risk of any accidents related to open flames or sparks, especially from cigarettes or other sources of ignition. The DON stated that oxygen could support combustion, meaning a small spark from a lit cigarette or other heat source could have quickly escalated into a dangerous situation. The DON stated that oxygen therapy was a medical treatment, and like any treatment, it required proper authorization from a licensed physician. The DON stated that oxygen was a medication, and its use should have been based on specific guidelines and the patient's individual condition for Resident 293. The DON stated that a physician's order ensured that the facility was giving the right amount of oxygen, at the right time, and for the right reasons. The DON stated that administering oxygen therapy without a physician's order could have significant risks, such as oxygen toxicity. The DON stated that too much oxygen could lead to lung damage.

During a review of the facility's policy and procedure (P&P) titled, "Oxygen Administration," revised 10/2010, the P&P indicated, "The purpose of this procedure is to provide guidelines for safe oxygen administration." The P&P indicated, "The following equipment and supplies will be necessary when performing this procedure ... Place an "Oxygen in Use" sign on the outside

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F 695	Continued From page 77 of the room entrance door. The P&P indicated, "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." During a review of the facility's P&P titled, "Medication Orders," revised 11/2014, the P&P indicated, "When recording orders for oxygen, specify the rate flow, route and rationale. Example: oxygen 3L/min per nasal cannula as needed for shortness of breath."	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 facility failed to implement the facility's policy titled, "Pain Assessment and Management" for two of two sampled residents (Resident 5 and 25) by failing to: a. Communicate the Pain Specialist (PS) recommendations to the Medical Doctor (MD) for Resident 25 on 1/28/2025 and 2/25/2025. b. Notify Resident 5's Physician when the current pain management was not working for Resident 5's pain. These failures had the potential to result in Resident 5 and 25 to experience unnecessary pain affecting their quality of life and well being..	F 697	**F 697: Pain Management** **CORRECTIVE ACTION** On 3/6/25 Resident 25 pain medication was reviewed, and non-pharmacologic intervention prior to administering pain medication ordered was given by MD. On 3/27/25 Resident 5 returned to the facility and pain assessment was reviewed and completed. **OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/27/2025, DON reviewed all orders for residents with pain management to ensure pain medications and non-pharmacologic intervention were performed prior to pain medication administration No other resident was affected.	

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F 697	Continued From page 78 Findings: a. During a review of Resident 25's Admission Record (AR), the AR indicated Resident 25 was admitted to the facility on 2/1/2022 with diagnoses that included major depressive disorder (MDD, mood disorder characterized by at least two weeks of persistent feelings of sadness and loss of interest). During a review of Resident 25's Order Details (OD) dated 1/29/2025 timed at 8:23 AM, the OD indicated an order for Gabapentin (medication used to treat nerve pain) 300 milligrams (mg, unit of measurement) three times a day (TID) for neuropathy pain (nerve pain). During a review of Resident 25's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 2/7/2025, the MDS indicated Resident 25's cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 25 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs) with rolling left and right. During a review of Resident 25's History and Physical (H&P) dated 2/14/2024, the H&P indicated Resident 25 did not have the capacity to understand and make decisions. During a review of Resident 25's Progress Note (PN) dated 1/28/2025 timed at 2:53 PM, the PN indicated recommendations from the Pain Specialist to attempt nonpharmacological interventions before administering medications.	F 697	**MEASURES AND SYSTEMIC CHANGES** During the daily (Monday to Friday) clinical meeting, DON/designee will review new orders of pain medication to check if MD ordered non-pharmacologic interventions before the pain medication and verify with MD as needed. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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On 2/25/2025 at 7:22 PM the PS, indicated in the PN recommendations to discontinue Gabapentin 300 mg TID and to attempt nonpharmacological interventions prior to administering mediations. Both PNs indicated for staff to communicate all recommendations to the referring MD for approval.

During an interview on 3/4/2025 at 1 PM with Resident 25, Resident 25 stated staff did not attempt any nonpharmacological interventions for Resident 25's pain in both legs (bilateral) legs.

During a concurrent interview and record review on 3/6/2025 at 10:48 AM with Licensed Vocational Nurse 4 (LVN 4), Resident 25's PNs dated 1/28/2025 and 2/25/2025 were reviewed. LVN 4 stated Resident 25 has a PS for Resident 25's chronic back pain and stated there were no orders for nonpharmacological interventions. LVN 4 stated recommendations were not communicated to the MD and stated it should have been communicated. LVN 4 stated Resident 25 was receiving Gabapentin 300 mg TID and there was no documentation that nonpharmacological interventions were attempted. LVN 4 stated by not communicating the PS recommendations to the MD would place the resident at risk of unnecessary pain medication usage.

During an interview on 3/7/2025 at 1:58 PM with the Director of Nursing (DON), the DON stated the PS recommendations should have been communicated to the attending MD. The DON stated by not communicating the PS recommendations to the MD it placed the resident at risk of not reaching the maximal potential for pain relief. The DON stated by not

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attempting nonpharmacological interventions can place the resident at risk of overmedicating on pain medication.

During a review of the facility's policy and procedure (P&P) titled, "Pain Assessment and Management" revised 10/2022, the P&P indicated pain management was a multidisciplinary care process that includes developing and implementing approaches to pain management and monitoring effectiveness of interventions.

b. During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted to the facility on 12/18/24 and readmitted on 2/25/25 with diagnoses that included end stage renal disease (kidneys lose the ability to remove waste and balance fluids), Type 1 diabetes mellitus (pancreas makes little or no insulin\ leading to high sugar levels), and non-ST elevation myocardial infarction (partial blockage of coronary [heart] artery).

During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 12/24/24, the MDS indicated Resident 5 was cognitively intact (ability to understand and process thoughts), and required partial/moderate assistance with personal hygiene and upper body dressing and substantial/maximal assistance with lower body dressing.

During a review of Resident 5's History & Physical (H&P), dated 2/28/25, the H&P indicated Resident 5 had the capacity to make medical decisions.

During a record review of Resident 5's Physician Orders (PO), dated 3/7/25, the PO indicated

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F 697	Continued From page 81	F 697		

Resident 5 was given Hydrocodone-Acetaminophen (medication used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough) Oral Tablet 5-325 milligrams (mg), given one tablet by mouth, every six hours as needed for pain scale 5-10/10 (on a 0 to 10 pain scale, 0 indicated no pain, 10 indicated severe pain), and Gabapentin (medication used to treat epilepsy and it is also taken for nerve pain) Oral Tablet, give 300 mg by mouth, three times a day for neuropathy pain.

During an interview on 3/5/25, at 10:45 a.m., Resident 5 stated Resident 5 had a lot of back and hand pain, but the pain medication was not helping. Resident 5 stated Resident 5 had complained of pain to the nurses (unable to identify the nurses).

During a concurrent interview and a record review with Licensed Vocational Nurse (LVN) 3 on 3/7/25, at 11:35 a.m., Resident 5's Medication Administration Record (MAR), dated 2/1/25-2/28/25 and 3/1/25-3/31/25 were reviewed. The MAR indicated Resident 5's pain level was 6 out of 10 (6/10) on 2/11/25, 2/12/25, 2/13/25, 2/14/25, 2/16/25, 2/17/25, and 3/4/25. Resident 5's pain level on 2/26/25 was 8/10 and Resident 5's pain level on 2/27/25 was 9/10. The MAR indicated Resident 5 was not assessed for pain on 2/26/25 and 2/27/25 during the evening (3:00 p.m.-11:30 p.m.) and night shift (11:00 p.m.-7:30 a.m.). The MAR indicated Resident 5 had a pain level of 7-8/10 on 3/1/25, 3/2/25, 3/5/25, 3/6/25. Resident 5's pain level on 3/3/25 was 9/10. LVN 3 stated LVN 3 will reach out to the pain physician (MD 1) and let MD 1 know the Norco 5-325mg, every six hours was not working for Resident 5.

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F 697	Continued From page 82 LVN 3 stated Resident 5 told LVN 3 yesterday (3/6/2025) that Resident 5 had pain in the hands. LVN 3 stated LVN 3 asked Resident 5 if Resident 5 wanted pain medication and pain medication was given to Resident 5. LVN 3 stated LVN 3 did not contact MD 1 to notify Resident 5's pain was not controlled with the current pain medication (pain management) because LVN 3 was swamped (busy) and didn't have time to call MD 1. LVN 3 stated LVN 3 would contact MD 1 today. LVN 3 stated LVN 3 need to assess the effectiveness of pain medication after two hours of administration. During an interview on 3/7/2025 at 1:58 PM with the Director of Nursing (DON), the DON stated Resident 5's complaint of pain (pain scale) should have been communicated to the attending physician. The DON stated by not communicating Resident 5's concern to the physician placed Resident 5 at risk for not reaching the maximal potential for pain relief. During a review of the facility's policy and procedure (P&P) titled, "Pain Assessment and Management," revised 10/2022, the P&P indicated pain management was a multidisciplinary care process that includes developing and implementing approaches to pain management and monitoring effectiveness of interventions.	F 697		
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	F 698	**F698: Dialysis** **CORRECTIVE ACTION** On 3/8/25, resident 62 was assessed for any negative effects from not having the post dialysis assessment by the DON. No negative effects were noted.	

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F 698	Continued From page 83 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 facility failed to implement its policy and procedure (P&P) titled, "Hemodialysis (HD, use of machine to remove waste and extra fluids from the blood) Catheters (soft, flexible tube that is inserted into a large vein)-Access and Care of" for one of one sampled resident (Resident 62) when the post dialysis (treatment to remove waste and excess fluid in the body) process assessment form was not completed on 3/1/2025. This failure had the potential to result in Resident 62 to experience complications after dialysis. Findings: During a review of Resident 62's Admission Record (AR), the AR indicated Resident 62 was admitted to the facility on 11/13/2023 and readmitted on 7/18/2024 with diagnoses that included end stage renal disease (ESRD, occurs when kidney function has declined to the point the kidneys can no longer function on own) and dependence on dialysis. During a review of Resident 62's History and Physical (H&P) dated 11/14/2024, the H&P indicated Resident 62 had the capacity to understand and make decisions. During a review of Resident 62's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 12/14/2024, the MDS indicated Resident 62's	F 698	**OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/7/2025, DON reviewed all dialysis residents' post dialysis forms and found that 1 other resident had incomplete pre/ post dialysis form. The resident was assessed for any negative effects from not having the post dialysis assessment by the DON. No negative effects were noted. **MEASURES AND SYSTEMIC CHANGES** On 3/25/2025, the DON provided an in service was provided to Licensed Nurses Re: the importance of performing post dialysis assessments is completed. DON/Designee will review dialysis residents' pre/post dialysis assessment during the daily (Monday to Friday) clinical meeting for completion and correct them as needed. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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F 698	Continued From page 84	F 698		

cognitive abilities (ability to think, learn, and process information) was intact.

During a review of Resident 62's Order Summary Report (OSR) dated 1/31/2025 indicated Resident 62 had an active Medical Doctor (MD) order for dialysis on Tuesday, Thursday, and Saturday.

During a concurrent interview and record review on 3/5/2025 at 2:38 PM with Licensed Vocational Nurse 2 (LVN) 2, Resident 62's Post Dialysis Assessment (PDA) form dated 3/1/2025 was reviewed. The PDA form contained blank spaces for the PDA section. LVN 2 stated the pre and post assessments for dialysis need to be filled out when a resident goes out of the facility to receive dialysis. LVN 2 stated the PDA form was left blank. LVN 2 stated by not filling out the PDA form this placed Resident 62 at risk for not monitoring for unstable vital signs or risk of bleeding at the catheter site after dialysis.

During an interview on 3/7/2025 at 1:53 PM with the Director of Nursing (DON), the DON stated the pre and post dialysis assessment should be filled out to monitor for any complications before and after dialysis. The DON stated if the form was not filled out, the status of the resident would be unknown, and the staff would not have any documentation on the baseline vital signs or any monitoring of the access site.

During a review of the facility's P&P titled, "Hemodialysis Catheters-Access and Care of" revised 2/2023, the P&P indicated the nurse should document observations post dialysis every shift.

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F 699	Continued From page 85	F 699	**F699: Trauma informed care**	
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide trauma-informed care for one of one sampled resident (Resident 47) by not ensuring that Resident 47 received adequate care and services to address Resident 47's Post-Traumatic Stress Disorder (PTSD- a mental health condition that can develop after someone has experienced a deeply disturbing or frightening event). This deficient practice had the potential to result in inadequate attention to Resident 47's specific trauma-related needs. Cross Reference F656 and F726 Findings: During a review of Resident 47's Admission Record (AR), the AR indicated the facility admitted Resident 47 on 12/31/2024, and readmitted Resident 47 on 2/13/2025, with diagnoses including, sickle-cell disease (a genetic disorder that causes abnormal red blood cells), bipolar disorder (a mental illness that causes extreme mood swings, from mania [a state of	F 699	**CORRECTIVE ACTION** On 3/25/25 an IDT care plan was conducted with resident re: Post traumatic stress disorder to ensure that resident who are trauma survivors will receive competent trauma informed care, and resident's experiences and preferences in order to eliminate or mitigate re: trauma to residents. On 3/28/25, DSD provided an in-service to staff regarding resident 47's specific PTSD triggers and preferences **OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/7/2025, DON reviewed all residents to check for PTSD diagnosis and found 2 other residents with PTSD diagnosis. On 3/28/25, IDT met with both residents to discuss PTSD triggers and preferences. On 3/28/25, DON provided an in-service to staff regarding both residents' triggers for PTSD **MEASURES AND SYSTEMIC CHANGES** DON/Designee will review all new newly admitted resident with Post Traumatic Stress Disorder during the daily (Monday to Friday) clinical meeting to ensure that staff are aware of resident's experiences and preferences.	

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F 699	Continued From page 86 intense, often euphoric or irritable, energy and activity, characterized by racing thoughts, rapid speech, and a decreased need for sleep, often accompanied by impulsive or risky behaviors] to depression), and PTSD. During a review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/6/2025, the MDS indicated Resident 47's cognition (the ability to think and process information) was intact. The MDS indicated Resident 47 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required supervision or touching assistance with mobility. During an interview on 3/4/2025 at 11:48 AM, with Resident 47, Resident 47 stated that she had been living at the facility for a while, and overall, the care had been fine. Resident 47 stated there was something she had been struggling with, and that was the lack of understanding when it came to her PTSD diagnosis. Resident 47 stated that she had difficult experiences in her past, and her PTSD had affected the way she interacted with people or handled certain situations. Resident 47 stated that it felt like no one at the facility really understood her or knew how to respond to her triggers. Resident 47 stated that when staff approached her in a certain way or when someone came too close too quickly her body went into "fight or flight" (an automatic, instinctive reaction to perceived danger or stress, preparing the body to either confront the threat [fight] or escape [flight]) mode, and she could not control it.	F 699	Licensed nurses will discuss triggers and preferences of residents with PTSD during the shift huddle. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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Resident 47 stated that when she acted out, whether it was getting upset or withdrawing into herself, it seemed like the staff just thought she was being difficult or acting out for no reason. Resident 47 stated that if staff had a little more awareness of her condition, it would go a long way and make a significant difference.

During an interview on 3/6/2025 at 4:00 PM, with Certified Nursing Assistant (CNA) 13, CNA 13 stated that CNA 13 did not know exactly what PTSD was but had heard of it. CNA 13 mentioned that it was related to a traumatic event, such as a gunshot wound, but could not provide any further specifics. CNA 13 stated that CNA 13 was unaware of any residents in the facility who had a PTSD diagnosis. CNA 13 stated that CNA 13 did not recall ever receiving any in-service training related to PTSD.

During an interview on 3/6/2025 at 4:23 PM, with CNA 14, CNA 14 stated that CNA 4 did not know what PTSD was. CNA 14 stated that he could not recall receiving any in-service training on PTSD and was unaware of any residents in the facility with a PTSD diagnosis.

During an interview on 3/6/2025 at 4:37 PM, with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that PTSD stands for Post Traumatic Stress Disorder and can develop from a traumatic event that someone experienced. LVN 5 provided the example of a combat veteran who may have intrusive memories of a traumatic event, such as a nightmare. LVN 5 stated that LVN 5 was unaware of any residents in the facility who had a diagnosis or history of PTSD. LVN 5 emphasized the importance of staff being aware if a resident had PTSD, as it directly affected how care was

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approached. LVN 5 explained that PTSD can impact a person's emotional and psychological well-being, and understanding the diagnosis allows staff to tailor their approach to meet the specific needs of the resident. LVN 5 stated that LVN 5 was unaware of Resident 47's PTSD diagnosis and stated the facility should have initiated specific measures and interventions to address the Resident 47's PTSD diagnosis.

During an interview on 3/7/2025 at 10:08 AM, with the Director of Staff Development (DSD), the DSD stated that the DSD was unaware of any residents with a diagnosis of PTSD in the facility. The DSD emphasized the importance of staff awareness regarding PTSD, as it affected how individuals responded to their environment, processed emotions, and interacted with others. The DSD stated that without an understanding of the signs and triggers of PTSD, staff might misunderstand certain behaviors, which could lead to frustration or ineffective support. The DSD stated that being mindful of PTSD ensured that the facility approached each resident with empathy and patience, fostering a safe and supportive environment. The DSD stated that staff had not been in-serviced on specific PTSD related topics. The DSD stated that incorporating PTSD in the in-service lesson plan would help staff stay current with best practices and ultimately create an environment of understanding and compassion, benefiting everyone.

During an interview on 3/7/2025 at 11:08 AM, with the Director of Nursing, the DON stated that PTSD awareness was critical in the facility because it directly impacted the care provided to residents. The DON mentioned that many

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F 699	Continued From page 89 residents who entered the facility had experienced some form of trauma. The DON stated that PTSD could affect both the resident's emotional and physical health, and without awareness of the signs and symptoms, there was a risk of misinterpreting the resident's behavior. The DON stated that by offering regular, PTSD specific in-services, the facility would ensure that all staff members understood PTSD and how it manifested. The DON stated that this type of training, benefited everyone who had direct contact with residents, enabling staff to approach residents with sensitivity and compassion. The DON stressed the importance of creating an environment that supported healing and reduced potential triggers. During a review of the facility's policies and procedures titled, "Behavioral Assessment, Intervention and Monitoring," revised 3/2019, the P&P indicated, "1. The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. 3. Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents."	F 699		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725	**F725: Sufficient Nursing Staff**	

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F 725	Continued From page 90 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure sufficient nursing staff to provide care and services to meet the needs for three of four sampled residents (Resident 5, Resident 6, and Resident 41). These deficient practices had the potential to result in Residents 5, 6 and 41 did not receive adequate care to meet the residents' needs. Findings:	F 725	**CORRECTIVE ACTION** On 3/6/2025, staff answered the call lights timely. On 3/21/25 staff were provided in-service by the DON regarding the importance of answering call lights timely and the importance of endorsing resident care before going on breaks and/or leaving for the day. **OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/24/25 the SSD interviewed 7 alert residents to ask if the call lights are being answered timely. No other residents were affected by the deficient practice. **MEASURES AND SYSTEMIC CHANGES** During the shift huddle, staff will be reminded to answer call lights promptly and to endorse resident care before going on breaks and/or leaving for the day by the RN supervisor/designee. DON/designee will interview 5 random residents weekly to check if their lights are being answered timely. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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a. During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted to the facility on 12/18/24 and readmitted on 2/25/25 with diagnoses that included end stage renal disease (kidneys lose the ability to remove waste and balance fluids), Type 1 diabetes mellitus (pancreas makes little or no insulin leading to high sugar levels), and non-ST elevation myocardial infarction (partial blockage of coronary [heart] artery).

During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 12/24/24, the MDS indicated Resident 5 was cognitively intact (ability to understand and process thoughts), and required partial/moderate assistance with personal hygiene and upper body dressing and substantial/maximal assistance with lower body dressing.

During a review of Resident 5's History & Physical (H&P), dated 2/28/25, the H&P indicated Resident 5 had the capacity to make medical decisions.

b. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on 12/29/23 with diagnoses that included sepsis (life-threatening complication of an infection), pneumonia (infection that inflames air sacs in one or both lungs), and epilepsy (disorder in which nerve cell activity in the brain is disturbed).

During a review of Resident 6's MDS, dated 12/11/24, the MDS indicated Resident 5 was severely cognitively impaired, and required substantial/maximal assistance with toileting.

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During a review of Resident 6's History & Physical (H&P), dated 1/2/25, the H&P indicated Resident 6 did not have the capacity to make medical decisions.

c. During a review of Resident 41's AR, the AR indicated Resident 41 was readmitted to the facility on 10/07/24 with diagnoses that included dysphagia (difficulty swallowing), osteoporosis (bones become weak and brittle), and dementia (a group of thinking and social symptoms that interfere with daily functioning).

During a review of Resident 41's History & Physical (H&P), dated 10/9/24, the H&P indicated Resident 41 did not have the capacity to make medical decisions.

During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool), dated 1/7/25, the MDS indicated Resident 41 was moderately cognitively impaired and required substantial/maximal assistance with shower/bathe self and toileting.

During an interview, on 3/4/25, 11:40 a.m. with Resident 6, Resident 6 stated Resident 6 was legally blind. Resident 6 stated Resident 6 has to wait an hour or more for staff to change her and Resident 6 has a sore on Resident 6's bottom. Resident 6 stated Resident 6 used call light to call staff about forty minutes ago because Resident 6 needed her incontinence pad change. Resident 6 stated a staff member (unidentified) came in and told Resident 6 that this staff would let Certified Nurse Assistant (CNA) 15 know when CNA 15 comes back from lunch. Resident 6 stated Resident 6 waited up to one hour or more for staff assistance when Resident 6 activated the call

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light and needed help.

During an observation, on 3/4/25, at 12:02 p.m., Resident 6 was heard calling the name "E...e (name of Resident's 6 nurse" from Resident 6's bed. During a concurrent observation, there was staff observed in the hallway and staff did not acknowledge Resident 6.

During an interview, on 3/4/25, at 12:10 p.m., with CNA 15, CNA 15 stated CNA 15 was assigned to care for Resident 6, CNA 15 stated CNA 10 covered CNA 15's resident assignment during CNA 15's lunch. CNA 15 stated after lunch, CNA 15 helped other residents in the back of the facility. CNA 15 stated that unfortunately, CNA 15 stated CNA 15 did not let CNA 10 know that CNA 15 was back from lunch and needed to work in the back of the facility to assist other residents. CNA 15 stated according to the facility policy CNAs needed to inform another CNAs if they would be away from the assigned resident area.

During a concurrent interview on 3/4/25, at 1:15 p.m., with CNA 16 and CNA 17, CNA 16 and CNA 17 stated CNAs must always endorse resident care to another CNA when going to lunch or away from the unit. CNA 16 stated It is the facility's policy to let another CNAs know when they will be away from the unit.

During the Resident Council Meeting on 3/5/25, at 9:35 a.m., Resident 12 stated staff tried to do the best that they could, but they were short of staff. Resident 12 stated that Resident 12's roommate (Resident 6) waited for thirty minutes to one hour to get help from staff. Resident 12 stated Resident 12 tried to help Resident 6 as much as Resident 12 could.

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During an interview on 3/5/25, at 10:40 a.m., Resident 5 stated Resident 5 has to wait up to an hour for staff to assist Resident 5 with putting on Resident 5's nasal cannula (tube that delivers oxygen through nose) on for Resident 5's oxygen. Resident 5 stated Resident 5 has to wait a long time, up to an hour at night and up to thirty minutes during the day for staff to assist her. Resident 5 stated staff told her that she was asleep. Resident 5 stated "well yes I'm asleep because they (staff) take so long."

During an interview, on 3/6/25, at 4:53 p.m., with the Director of Nursing (DON), the DON stated any staff can answer the call light and even housekeeping were trained to answer the call light without providing care. The DON stated all staff were trained to endorse their residents' care when going on lunch or leaving the resident area during breaks. The DON stated CNAs were reminded by the Charge Nurse during shift change meeting. The DON stated timely manner is answering call light when staff see it and no more than ten minutes. The DON stated it is important for staff to answer call light timely because "you (staff) don't know what they (residents) need." The DON stated if staff have shortness of breath or emergency, staff must address the residents' needs as soon as possible.

During a concurrent observation and interview on 3/7/25, at 10:30 a.m., with Resident 41, Resident 41 was heard from the hallway yelling "Nurse" from Resident 14's bed. Resident 14 stated Resident 14 pressed the call light, and "they" never come. Resident 14 stated this morning Resident 14 had to wait for two hours for

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F 725	Continued From page 95 assistance to the restroom before the staff came. During a record review of the facility's Policy & Procedure (P&P) titled, "Staffing, Sufficient and Competent Nursing," revised August 2022, the P&P indicated our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing a related care and services for all residents in accordance with resident care plans and the facility assessment. During a record review of the facility's Policy & Procedure (P&P) titled, "Answering the Call Light," revised October 2010, the P&P indicated the purpose of this procedure is to respond to the resident's request and needs. The P&P indicated for staff to answer the resident's call light as soon as possible.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726	**F726: Competent Nursing Staff** **CORRECTIVE ACTION** Resident 47 is no longer a resident of the facility as of 3/26/25. Resident discharged safely and expressed gratitude for the help of staff members. **OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/25/25 and 3/28/25, MDS personnel audited residents with diagnosis of PTSD and 2 residents were identified. IDT met with the residents and both have no verbalization of any new onset of acute distress or poor handling/ interaction/care by staff.	

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F 726	Continued From page 96 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide in-service training (a type of professional training or staff development that is given to staff while they are employed) on Post-Traumatic Stress Disorder (PTSD- a mental health condition that can develop after someone has experienced a deeply disturbing or frightening event) for 106 of 106 nursing staff to adequately care for one of one sampled resident (Resident 47) with diagnosis of PTSD. This deficient practice had the potential to result in inadequate attention to Resident 47's specific trauma-related needs that could affect Resident 47's well-being. Cross Reference F656 and F699 Findings: During a review of Resident 47's Admission Record (AR), the AR indicated the facility admitted Resident 47 on 12/31/2024, and	F 726	**MEASURES AND SYSTEMIC CHANGES** On 3/28/25, DSD conducted an in-service to Staff regarding care of patients with PTSD DSD to ensure competency skills check on care for patients with PTSD are done upon hire and annually thereafter. Licensed nurses will discuss triggers and preferences of residents with PTSD during the shift huddle. DON/Designee will review all new newly admitted resident with Post Traumatic Stress Disorder during the daily (Monday to Friday) clinical meeting to ensure that staff are aware of resident's experiences **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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readmitted Resident 47 on 2/13/2025, with diagnoses including, sickle-cell disease (a genetic disorder that causes abnormal red blood cells), bipolar disorder (a mental illness that causes extreme mood swings, from mania [a state of intense, often euphoric or irritable, energy and activity, characterized by racing thoughts, rapid speech, and a decreased need for sleep, often accompanied by impulsive or risky behaviors] to depression), and PTSD.

During a review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/6/2025, the MDS indicated Resident 47's cognition (the ability to think and process information) was intact. The MDS indicated Resident 47 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required supervision or touching assistance with mobility.

During an interview on 3/4/2025 at 11:48 AM, with Resident 47, Resident 47 stated that she had been living at the facility for a while, and overall, the care had been fine. Resident 47 stated there was something she had been struggling with, and that was the lack of understanding when it came to her PTSD diagnosis. Resident 47 stated that she had difficult experiences in her past, and her PTSD had affected the way she interacted with people or handled certain situations. Resident 47 stated that it felt like no one at the facility really understood her or knew how to respond to her triggers. Resident 47 stated that when staff approached her in a certain way or when

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someone came too close too quickly her body went into "fight or flight" (an automatic, instinctive reaction to perceived danger or stress, preparing the body to either confront the threat [fight] or escape [flight]) mode, and she could not control it. Resident 47 stated that when she acted out, whether it was getting upset or withdrawing into herself, it seemed like the staff just thought she was being difficult or acting out for no reason. Resident 47 stated that if staff had a little more awareness of her condition, it would go a long way and make a significant difference.

During an interview on 3/6/2025 at 4:00 PM, with Certified Nursing Assistant (CNA) 13, CNA 13 stated that CNA 13 did not know exactly what PTSD was but had heard of it. CNA 13 mentioned that it was related to a traumatic event, such as a gunshot wound, but could not provide any further specifics. CNA 13 stated that CNA 13 was unaware of any residents in the facility who had a PTSD diagnosis. CNA 13 stated that CNA 13 did not recall ever receiving any in-service training related to PTSD.

During an interview on 3/6/2025 at 4:23 PM, with CNA 14, CNA 14 stated that CNA 4 did not know what PTSD was. CNA 14 stated that he could not recall receiving any in-service training on PTSD and was unaware of any residents in the facility with a PTSD diagnosis.

During an interview on 3/6/2025 at 4:37 PM, with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that PTSD stands for Post Traumatic Stress Disorder and can develop from a traumatic event that someone experienced. LVN 5 provided the example of a combat veteran who may have intrusive memories of a traumatic event, such as

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a nightmare. LVN 5 stated that LVN 5 was unaware of any residents in the facility who had a diagnosis or history of PTSD. LVN 5 emphasized the importance of staff being aware if a resident had PTSD, as it directly affected how care was approached. LVN 5 explained that PTSD can impact a person's emotional and psychological well-being, and understanding the diagnosis allows staff to tailor their approach to meet the specific needs of the resident. LVN 5 stated that LVN 5 was unaware of Resident 47's PTSD diagnosis and stated the facility should have initiated specific measures and interventions to address the Resident 47's PTSD diagnosis.

During an interview on 3/7/2025 at 10:08 AM, with the Director of Staff Development (DSD), the DSD stated that the DSD was unaware of any residents with a diagnosis of PTSD in the facility. The DSD emphasized the importance of staff awareness regarding PTSD, as it affected how individuals responded to their environment, processed emotions, and interacted with others. The DSD stated that without an understanding of the signs and triggers of PTSD, staff might misunderstand certain behaviors, which could lead to frustration or ineffective support. The DSD stated that being mindful of PTSD ensured that the facility approached each resident with empathy and patience, fostering a safe and supportive environment. The DSD stated that staff had not been in-serviced on specific PTSD related topics. The DSD stated that incorporating PTSD in the in-service lesson plan would help staff stay current with best practices and ultimately create an environment of understanding and compassion, benefiting everyone.

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F 726	Continued From page 100 During an interview on 3/7/2025 at 11:08 AM, with the Director of Nursing, the DON stated that PTSD awareness was critical in the facility because it directly impacted the care provided to residents. The DON mentioned that many residents who entered the facility had experienced some form of trauma. The DON stated that PTSD could affect both the resident's emotional and physical health, and without awareness of the signs and symptoms, there was a risk of misinterpreting the resident's behavior. The DON stated that by offering regular, PTSD specific in-services, the facility would ensure that all staff members understood PTSD and how it manifested. The DON stated that this type of training, benefited everyone who had direct contact with residents, enabling staff to approach residents with sensitivity and compassion. The DON stressed the importance of creating an environment that supported healing and reduced potential triggers. During a review of the facility's policies and procedures titled, "Behavioral Assessment, Intervention and Monitoring," revised 3/2019, the P&P indicated, "1. The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. 3. Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents."	F 726		

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F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732	**F732: Posted Nurse Staffing Informing** **CORRECTIVE ACTION** On 3/7/2025, the scheduler posted the daily staffing data in the lobby and south station. **OTHER RESIDENTS AFFECTED IDENTIFICATION** No other residents were affected by the deficient practice. **MEASURES AND SYSTEMIC CHANGES** The DSD/designee will check the nurse staffing posting daily to verify that the posting is current and will report findings to the daily (Monday to Friday) standup meeting On 3/14/2025, the DSD provided in-service to staff regarding the importance of updating the nurse staffing posting within 2 hours of the beginning of the shift. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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by:
Based on interview and record review, the facility failed to post the actual nursing hours for the night shift (NOC, 11PM to 7:30 AM) from 3/2/2025 to 3/7/2025 in two of two sampled locations (Lobby and South Station).

This failure had the potential to result in the residents and visitors to not know whether there is sufficient staff to provide quality care to the residents.

Findings:

During an interview on 3/7/2025 at 5:35 PM with the Director of Staff Development (DSD), the DSD stated the Staffer posts the actual nursing hours in the Lobby and South Station, however, the NOC shift was not posted. The DSD stated if the NOC shift actual hours were not posted staff, family members, visitors, and residents would not know how many staff members are working that day.

During an interview on 3/7/2025 at 5:41 PM with the Staffer, the Staffer stated the NOC shift was supposed to post the actual nursing hours for the NOC shift, but it was not done and would need training on how to post the actual nursing hours. The Staffer stated if the actual nursing hours are not posted for the NOC shift, nurses, residents, and families would not know how many staff members are working.

During a review of the facility's policy and procedure (P&P) titled, "Staffing, Sufficient and Competent Nursing" revised 8/2022, the P&P indicated direct care daily staffing numbers (the number of nursing personnel responsible for

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F 732	Continued From page 103 providing direct care to residents) are posted in the facility for every shift.	F 732		
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 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §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 §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:	F 755	**F755: Pharmacy Services/ Procedure/ Pharamacist/ Records** **CORRECTIVE ACTION** MD notified on the missed dosage of Daptomycin and Zosyn on 3/10/25 on Resident 27. MD's recommendation was to monitor adverse reaction and complication of the missed medication. Resident was assessed by RN on 3/10/25 and no new onset of acute distress noted. **OTHER RESIDENTS AFFECTED IDENTIFICATION** Review of the residents with IV medication orders was conducted on 3/10/2025 and no other deficient practice was noted. All IV medication orders were being administered as ordered. **MEASURES AND SYSTEMIC CHANGES** DON/ Designee to monitor IV documentation QD x2 weeks then 2x/ week x 2 weeks then monthly thereafter to ensure all IV medications are being administered as ordered by MD. Medical record will include in the daily audit the IV MAR for any missed dose of IV medications ordered by MD.	

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F 755	Continued From page 104 Based on interview and record review, the facility failed to ensure Zosyn (type of antibiotic) Intravenous (IV, route of administration that is directly inserted into the vein) and Daptomycin (type of antibiotic) IV were given per the physician's order for one of one sampled resident (Resident 27). These failures had the potential for Resident 27 to develop severe infections and complications from antibiotic use. Findings: During a review of Resident 27's Admission Record (AR), the Admission Record indicated Resident 27 was admitted to the facility on 3/12/2023 and readmitted on 1/13/2025 with diagnoses that included acute osteomyelitis (bone infection caused by bacteria) of the left foot and ankle and cellulitis (serious bacterial skin infection). During a review of Resident 27's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 1/10/2025, the MDS indicated Resident 27's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 27's Order Summary Report dated 2/19/2025 indicated Resident 27 had an MD order for Zosyn 3.375 gram IV every eight hours for osteomyelitis to the left third toe and status post Incision and Drainage (I&D, medical procedure used to relieve pressure and treat infections to drain out pus or fluids in an infected area) until 3/26/2025. On 2/20/2025 the	F 755	DON conducted an in service on 3/25/2025 to Registered Nurses regarding importance of administration of IV Medication as ordered by MD. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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OSR indicated an active MD order for Daptomycin 700 milligrams (mg, unit of measurement) IV once a day for osteomyelitis of the left third toe until 3/26/2025.

During a review of Resident 27's History and Physical (H&P) dated 2/20/2025, the H&P indicated Resident 27 had the capacity to understand and make decisions.

During a concurrent interview and record review on 3/6/2025 at 11:34 AM with Registered Nurse Supervisor 4 (RN 4), Resident 27's Intravenous Medication Administration Record (IMAR) dated 2/2025 to 3/2025 was reviewed. RN 4 stated there were blank spaces for Zosyn administration on 2/21/2025, 2/25/2025, and 3/1/2025. RN 4 stated there were blank spaces for Daptomycin administration on 2/23/2025, 2/26/2025, and 3/1/2025. RN 4 stated if it was blank then the medication was not given as ordered. RN 4 stated if antibiotics were not given as ordered it would place the resident at risk of worsening the current infection or develop a new infection.

During an interview on 3/7/2025 at 1:38 PM with the Director of Nursing (DON), the DON stated if the IMAR was blank then it was missed. The DON stated the resident needs to receive antibiotics as ordered to treat the current infection and prevent future infections. The DON stated if the resident did not receive the antibiotics as prescribed it can place the resident at risk of worsening the current infection or the infection can become resistant to the antibiotic.

During a review of the facility's policy and procedure (P&P) titled, "Medication Administration-General Guidelines" dated 3/2024,

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F 755	Continued From page 106 the P&P indicated the individual who administered the medication dose shall record the administration in the resident's MAR directly after the medication was given.	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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; §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 drugs; §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	F 758	**F758: Free from Unneccessary Psychotropic Meds/ PRN Use** **CORRECTIVE ACTIONS** Resident 197's Ativan was discontinued on 3/18/25 as ordered by MD. No reports of new onset of acute distress noted related to previously not having a 14-day stop date. On 3/21/25, the SSD validated that the informed consent for Resident's 5 the use of Olanzapine and Lorazepam has been obtained. The informed consent verification was done on 3/21/25. OTHER RESIDENTS AFFECTED IDENTIFICATION The DON/Designee audited all residents on 3/21/25 to 3/28/25 receiving Psychotropic medications if a valid informed consent has been verified. There are 72 residents receiving Psychotropic medications - all informed consents for residents on Psychotropics have been verified from 3/21/25 to 3/28/25. All Other residents with PRN psychotropics are noted with 14-day stop date.	

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F 758	Continued From page 107 §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. §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 interview and record review, the facility failed to implement its policy titled, "Psychotropic (medication that affects behavior, mood, thoughts, or perception) Medication Use" for two of two sampled residents (Resident 5 and 197) by failing to: a. Ensure Resident 197's order for Ativan (medication used to treat anxiety) 0.5 milligrams (mg, unit of measurement) tablets every six hours as needed (PRN) for anxiety had an end date of 14 days. b. Obtain a signed informed consent for the use of Olanzapine (mediation used to treat schizophrenia [serious mental disorder in which people interpret reality abnormally] and bipolar disorder [mental illness that causes extreme mood swings]) and Lorazepam (medication used to treat anxiety) for Resident 5. These failures had the potential to result in unnecessary psychotropic medication use for Resident 5 and 197.	F 758	**MEASURE AND SYSTEMIC CHANGES** The DON/Designee initiated education to licensed staff on 3/21/25 to ensure that any residents receiving psychotropic medications shall have an informed consent verified prior to initial administration and all PRN Psychotropics must have a 14- day stop date initially upon ordering. DON/DSD to monitor to monitor all PRN medication prescribed to ensure order is limited to 14 days. Bimonthly X 2 months, then monthly X 3 months then quarterly thereafter. **MONITORING PERFORMANCE** The DON/ SSD will present the result to the QA Committee for monthly review for the next 3 months and quarterly thereafter or until substantial compliance is achieved.	3/28/2025

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Findings:

a. During a review of Resident 197's Admission Record, the Admission Record indicated Resident 197 was admitted to the facility on 3/2/2025 with diagnoses that included anxiety.

During a review of Resident 197's History and Physical (H&P) dated 3/3/2025, the H&P indicated Resident 197 can make needs known but cannot make medical decisions.

During a concurrent interview and record review on 3/5/2025 at 10:54 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 197's OSR dated 3/3/2025 was reviewed. The OSR indicated an active physician's order for Ativan 0.5 mg by mouth every six hours PRN for anxiety manifested by verbalization of anxiety. LVN 1 stated there was no end date for Ativan and stated there should be an end date of 14 days. LVN 1 stated by not putting an end date to a psychotropic medication can place the resident at risk for unnecessary medication use.

During an interview on 3/7/2025 at 1:54 PM with the Director of Nursing (DON), the DON stated PRN psychotropic medications are required to have an end date of 14 days. The DON stated if there was no end date it would put the resident at risk for unnecessary medication usage.

During a review of the facility's P&P titled, "Psychotropic Medication Use" dated 7/2022, the P&P indicated PRN orders for psychotropic medications are limited to 14 days.

b. During a review of Resident 5's Admission

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Record (AR), the AR indicated Resident 5 was admitted to the facility on 12/18/24 and readmitted on 2/25/25 with diagnoses that included end stage renal disease (kidneys lose the ability to remove waste and balance fluids), Type 1 diabetes mellitus (pancreas makes little or no insulin\ leading to high sugar levels), and non-ST elevation myocardial infarction (partial blockage of coronary [heart] artery).

During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 12/24/24, the MDS indicated Resident 5 was cognitively intact (ability to understand and process thoughts), and required partial/moderate assistance with personal hygiene and upper body dressing and substantial/maximal assistance with lower body dressing.

During a review of Resident 5's History & Physical (H&P), dated 2/28/25, the H&P indicated Resident 5 had the capacity to make medical decisions.

During a record review of Resident 5's Physician Orders (PO), the PO indicated Resident 5 was given Olanzapine (Zyprexa- antipsychotic medication that used to treat mental disorders) oral tablet 2.5 milligrams (mg), one tablet, by mouth, two times a day (BID) for schizoaffective disorder (schizophrenia- [a disorder affecting a person's ability to think, feel, and behave] and mood disorder [psychiatric conditions causing intense and persistent changes in mood, energy, and behavior]) manifested by (m/b) verbal aggression toward others.

During an interview on 3/7/25, at 10:00 a.m., Resident 5 stated facility staff "tried to give her a

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pill this morning," and Resident 5 refused to take the pill. Resident 5 stated Resident 5 "has not signed nothing about medication." Resident 5 stated Resident 5 does not have schizophrenia and does not need the medication.

During a concurrent interview and record review, on 3/7/25, at 2:11 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 5's Preadmission Screening and Resident Review (PASRR, federal regulation requiring nursing facilities to screen potential residents for serious mental illness), dated 4/5/22 was reviewed, the PASRR indicated Resident 5's result was negative and a PASARR II (federal regulation required when PASRR I is positive) was not required. LVN 3 stated Resident 5 stated Resident 5 does not have schizophrenia (a disorder affecting a person's ability to think, feel, and behave clearly). LVN 3 stated Resident 5 refused to take Olanzapine on 3/7/25. LVN 3 stated it is important for Resident 5 to be informed because the resident has a right to be aware of what medication the resident is taking. LVN 3 stated Resident 5 needed to know why the resident is taking the medication for and the dosages of the medication. LVN 3 stated Resident 5 is self-responsible. LVN 3 stated Medication Rights are name, dosage, time, route, right to refuse, and frequency. LVN 3 stated Resident's 5 Informed Consent (healthcare professional educates a patient about risks, benefits, and alternatives of a given procedure or intervention), dated 1/13/25, was not signed by Resident 5 for Olanzapine and Lorazepam (Ativan- medication to treat anxiety).

During a concurrent interview and record review of Resident 5's Informed Consent, on 3/7/25, at 4:01 p.m., with LVN 3. Resident 5's Informed

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Consent dated 1/13/25 and 2/25/25, for Olanzapine 2.5 mg, every 12 hours, as needed were reviewed. The inform consent indicated when Resident 5 was admitted to the facility from General Acute Care Hospital 1 (GACH 1), facility staff should has contacted Resident 5 Primary Care Physician (PCP) and the Psychiatric physician (PP) to evaluate Resident 5 for a medical diagnosis of psychosis based on the facility's policy. LVN 3 stated, "It is important to get an Informed Consent due to the side effects and for the safety of the resident." LVN 3 stated, "It is important to give a medication to treat a specific diagnosis."

During an interview on 3/7/25, at 5:18 p.m., with the Director of Nursing (DON), the DON stated anti-psychotropic medications are given to treat a specific diagnosis. During a concurrent record review of Resident 5's AR, Resident 5's R did not indicated Resident 5 had a diagnosis for the use of Olanzapine. The DON stated the DON does not see a diagnosis indicated for the use of Olanzapine for Resident 5 on Resident 5's AR. The DON stated Resident 5's Informed Consent was incomplete and did not have Resident 5's signature. The DON stated, it is important to obtain an Informed Consent to know if the resident or the resident Responsable Party agrees with the doctor's plan of care. The DON stated inform consent is a part of the resident rights.

During a record review of the facility's Policy & Procedure (P&P) titled, "Psychoactive Medication Informed Consent," dated, March 2024, indicated before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the

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F 758	Continued From page 112 resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. The P&P indicated before initiating treatment with psychotherapeutic drugs, facility staff shall verify that he resident's health record contains written informed consent with the required signatures.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure they had a medication error rate of five (5) percent (%) or lower for two of two sampled residents (Resident 13 and 26) during the medication administration on 3/6/2025. This failure resulted in three (3) medication errors out of 25 opportunities for errors, which resulted in a Medication Administration Error Rate of 12%. Findings: a. During a review of Resident 13's Admission Record (AR), the AR indicated Resident 13 was admitted to the facility on 10/9/2024 and readmitted on 10/28/2024 with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks) and schizophrenia (serious	F 759	**F759: Free of Mediation Error Rates 5 Perceent or More** **CORRECTIVE ACTION** On 3/7/25 LVN 4 was provided 1:1 in-service regarding checking of heart rate and blood pressure prior to administration of metoprolol and amlodipine, DON/ Designee conducted in-service following 5 rights of medications administration which are the standard of safe practice. **OTHERS RESIDENTS AFFECTED IDENTIFICATION** On 3/25/2025, the DON randomly followed nurses during med pass randomly to check if residents were given Metoprolol or Amlodipine after heart rate was checked. No other residents were affected by the deficient practice.	

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F 759	Continued From page 113 mental disorder in which people interpret reality abnormally). During a review of Resident 13's History and Physical (H&P) dated 10/11/2024, the H&P indicated Resident 13 lacked capacity to make medical decisions. During a review of Resident 13's Order Summary Report (OSR) dated 11/2/2024, the OSR indicated Resident 13 had a physician's order for Acetaminophen (Tylenol, medication used to treat mild to moderate pain) 325 milligrams (mg, unit of measurement) two (2) tablets every six (6) hours as needed (PRN) for mild pain. During a review of Resident 13's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 2/4/2025 indicated Resident 13's cognitive abilities (ability to think, learn, and process information) were severely impaired and indicated Resident 13 required setup assistance with eating. b. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was admitted to the facility on 3/30/2018 with diagnoses that included hypertension (HTN, high blood pressure) and heart failure (HF, condition when the heart cannot pump enough blood to the body). During a review of Resident 24's H&P dated 11/24/2024, the H&P indicated Resident 24 can make needs known but cannot make medical decisions.	F 759	On 3/25/25, DON conducted an in-service for 5 rights in medication of Safe practices: >right patient >right dose >right route >right time >right drug And to follow up on the parameter for medications metoprolol and amlodipine and monitor heart rate and blood pressure. **MEASURING AND SYSTEMIC CHANGES** DON/Designee will perform random skill check on licensed staff weekly to ensure that blood pressure and heart rate will check prior to administrating medications. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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During a review of Resident 24's MDS dated 12/13/2024, the MDS indicated Resident 24's cognitive abilities were intact and required set up assistance with eating.

During a review of Resident 24's OSR dated 12/9/2023 the OSR indicated an MD order for Amlodipine five (5) mg by mouth once a day and to hold if the systolic blood pressure (SBP, pressure in arteries when heart beats and pumps blood) was less than 110 or if the heart rate (HR) was less than 60. On 10/19/2024, the OSR indicated an MD order for Metoprolol Succinate Extended Release (ER) 24 hours 100 mg by mouth once a day and to hold if SBP was less than 110 or HR less than 60.

During a concurrent observation and interview on 3/6/2025 at 8:16 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 was observed to pull out a bottle of 500 mg of Tylenol and placed two tablets of 500 mg into the medication cup for Resident 13. LVN 4 stated LVN 4 prepared the wrong dose of Tylenol because Resident 13 had an order for two tablets of 325 mg of Tylenol and not 500 mg of Tylenol. LVN 4 stated it was not the right dose and stated it was a medication error. LVN 4 stated the wrong dose could have caused potential harm to the resident because it was not the right dosage per MD order.

During a concurrent observation and interview on 3/6/2025 at 8:45 AM with LVN 4 in Resident 26's room, LVN 4 was observed to place the medicine cup with Metoprolol and Amlodipine in front of Resident 26. LVN 4 stated to Resident 26, "Okay, take your medications." LVN 4 stated the HR was not checked prior to administering Metoprolol and Amlodipine. LVN 4 stated by not

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F 759	Continued From page 115 checking the HR LVN 4 could've administered both medications when the heart rate was not within the parameters of the MD order. During an interview on 3/7/2025 at 2:04 PM with the Director of Nursing (DON), the DON stated staff must check the dose prior to administering a medication. The DON stated it would be a medication error because the wrong dose was almost administered to Resident 13. The DON stated the HR needs to be checked prior to administering Amlodipine and Metoprolol. The DON stated staff need to follow the parameters of the medication and if it was not followed it could cause harm to the resident. During a review of the facility's policy and procedure (P&P) titled, "Administering Medication" revised 4/2019, the P&P indicated medications are to be administered in a safe, timely manner, and as prescribed. The P&P indicated the individual administering the medication must check the label three times to verify the right resident, medication, dosage, time, and method of administration before giving the medication.	F 759		
F 760 SS=E	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 ensure significant medication error were prevented for two of two sampled resident (Resident 24 and 27) by failing	F 760	**F760: Residents are Free of Significant Med Errors** **CORRECTIVE ACTION** On 3/7/25 LVN 4 was provided 1:1 in-service regarding checking of heart rate and blood pressure prior to administration of metoprolol and amlodipine, Don/Designee conducted in-service following 5 rights of medications administration which are the standard of safe practice.	

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F 760	Continued From page 116 to: a. Check the heart rate (HR) prior to administration of Metoprolol (medication used to lower blood pressure) and Amlodipine (medication used to lower blood pressure) to Resident 24. b. Administer Zosyn (type of antibiotic) intravenous (IV, route of administration that was directly inserted into the vein) and Daptomycin (type of antibiotic) IV as ordered by the Medical Doctor (MD) for Resident 27. These failures had the potential to result in discomfort or jeopardize the residents' health and safety. Findings: a. During a review of Resident 27's Admission Record (AR), the AR indicated Resident 27 was admitted to the facility on 3/12/2023 and readmitted on 1/13/2025 with diagnoses that included acute osteomyelitis (bone infection caused by bacteria) of the left foot and ankle and cellulitis (serious bacterial skin infection). During a review of Resident 27's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 1/10/2025, the MDS indicated Resident 27's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 27's Order Summary Report dated 2/19/2025 indicated Resident 27 had an MD order for Zosyn 3.375 gram IV every eight hours for osteomyelitis to the left third toe	F 760	**OTHER RESIDENTS AFFECTED IDENTIFICATION** On 3/25/2025, the DON randomly followed nurses during med pass randomly to check if residents were given Metoprolol or Amlodipine after heart rate was checked. No other residents were affected by the deficient practice. On 3/25/25, DON conducted an in-service for 5 rights in medication of Safe practices: >right patient >right dose >right route >right time >right drug And to follow up on the parameter for medications metoprolol and amlodipine and monitor heart rate and blood pressure. **MEASURING AND SYSTEMIC CHANGES** DON/Designee will perform random skill check on licensed staff weekly to ensure that blood pressure and heart rate will check prior to administrating medications. **MONITORING PERFORMANCE** DON/Designee will report findings and trends to the monthly QAA meeting for further recommendations for 3 months or until substantial compliance is met.	3/28/2025

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F 760	Continued From page 117	F 760		

and status post Incision and Drainage (I&D, medical procedure used to relieve pressure and treat infections to drain out pus or fluids in an infected area) until 3/26/2025. On 2/20/2025 the OSR indicated an active MD order for Daptomycin 700 milligrams (mg, unit of measurement) IV once a day for osteomyelitis of the left third toe until 3/26/2025.

During a review of Resident 27's History and Physical (H&P) dated 2/20/2025, the H&P indicated Resident 27 had the capacity to understand and make decisions.

b. During a review of Resident 24's AR, the AR indicated Resident 24 was admitted to the facility on 3/30/2018 with diagnoses that included hypertension (HTN, high blood pressure) and heart failure (HF, condition when the heart cannot pump enough blood to the body).

During a review of Resident 24's H&P dated 11/24/2024, the H&P indicated Resident 24 can make needs known but can not make medical decisions.

During a review of Resident 24's OSR dated 12/9/2023 the OSR indicated an MD order for Amlodipine five (5) mg by mouth once a day and to hold if the systolic blood pressure (SBP, pressure in arteries when heart beats and pumps blood) was less than 110 or if the HR was less than 60. On 10/19/2024, the OSR indicated an MD order for Metoprolol Succinate Extended Release (ER) 24 hours 100 mg by mouth once a day and to hold if SBP was less than 110 or HR less than 60.

During a review of Resident 24's MDS dated

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12/13/2024, the MDS indicated Resident 24's cognitive abilities were intact and required set up assistance with eating.

During a concurrent observation and interview on 3/6/2025 at 8:45 AM with Licensed Vocational Nurse (LVN 4) in Resident 26's room, LVN 4 was observed to place the medicine cup with metoprolol and amlodipine in front of Resident 26 without taking the HR and stated to Resident 26, "Okay, take your medications." LVN 4 stated the heart rate was not checked prior to administering Metoprolol and Amlodipine. LVN 4 stated by not checking the heart rate LVN 4 could've administered both medications when the heart rate could've been too low per MD parameters.

During a concurrent interview and record review on 3/6/2025 at 11:34 AM with Registered Nurse Supervisor 4 (RN 4), Resident 27's Intravenous Medication Administration Record (IMAR) dated 2/2025 to 3/2025 was reviewed. RN 4 stated Zosyn was not administered on 2/21/2025, 2/25/2025, and 3/1/2025. RN 4 stated Daptomycin was not administered on 2/23/2025, 2/26/2025, and 3/1/2025. RN 4 stated if the IMAR was blank then the medication was not given as ordered. RN 4 stated if antibiotics were not given as ordered it could worsen the current infection or put the resident at risk of developing a new infection.

During an interview on 3/7/2025 at 1:38 PM with the Director of Nursing (DON), the DON stated if the IMAR was blank then the antibiotics were not given. The DON stated if the resident did not receive the antibiotics as prescribed it could worsen the current infection or the infection can become resistant to the antibiotic. At 2:04 PM,

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F 760	Continued From page 119 the DON stated the HR needs to be checked prior to administering Amlodipine and Metoprolol. The DON stated staff need to follow the parameters of the medication and if it was not followed it could cause harm to the resident. During a review of the facility's policy and procedure (P&P) titled, "Medication Administration-General Guidelines" dated 3/2024, the P&P indicated medications are to be administered in accordance with written orders of the attending physician.	F 760		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.	F 801	**F801: Qualified Dietary Staff** **CORRECTIVE ACTION** On 03/11/25 Dietary Supervisor conducted a 1:1 staff in-service to dishwasher 1 regarding the facility policy and procedure of sanitizing, dishwashing practice and handling equipment. On 03/11/25 Dietary Supervisor performed skills check regarding sanitizing, dishwashing practice and handling equipment. **OTHER RESIDENTS AFFECTED IDENTIFICATION** On 03/11/25 Dietary supervisor conducted in service to dietary staff regarding the facility policy and procedure of sanitizing, dishwashing practice and handling equipment. On 03/11/25 Dietary supervisor performed skills check to dietary staff regarding sanitizing, dishwashing practice and handling equipment.	

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F 801	Continued From page 120 (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the	F 801	Dietary staff will conduct daily dishwasher chlorine check and temperature using the form titled “Daily Dishwasher Chlorine and Temperature Log. **MEASURES AND SYSTEMIC CHANGES** Dietary supervisor/designee will conduct in service upon hire and monthly every 1st of the month x 3 months and annually thereafter regarding dietary staff duties and responsibilities. Dietary supervisor/designee will conduct competency skills training upon hire and monthly every 1st of the month x 3 months and annually thereafter regarding dietary staff duties and responsibilities. Dietary supervisor will review the daily dishwasher chlorine check and temperature log, any significant findings will discuss with the administrator. **MONITORING PERFORMANCE** The Administrator/Designee will review the daily dishwashing chlorine and temperature log weekly and any significant findings or trends will be reported to QAA committee during monthly meeting for any deficient practice for review and any recommendations x 3 months.	3/28/2025

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F 801	Continued From page 121	F 801		

position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure one of one sampled nutrition services staff member (Dishwasher 1 [DW 1]) was in-serviced monthly.

These failures had the potential to result in resident injuries related to dietary needs.

Findings:

During a concurrent observation and interview on 3/4/2025 at 9:49 AM with the Dietary Supervisor (DS) while in the kitchen, the chlorine parts per millions (ppm, unit of a concentration of chlorine in water that is used for sanitation) was checked. The DS stated the strip indicated the ppm was at zero and it should be at 100 ppm.

During an interview on 3/4/2025 at 10:05 AM with DW 1, DW 1 stated DW 1 did not check the chlorine ppm in the morning prior to washing the dishes. DW 1 stated DW 1 does not check the

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F 801	Continued From page 122 chlorine ppm and does not know what the chlorine is used for in the dishwashing machine. DW 1 stated DW 1 never checks the chlorine ppm in the morning and has been working mornings in the kitchen for the last three months. During an interview on 3/7/2025 at 9:30 AM with the DS, the DS stated there were no in-services provided to dietary staff for sanitizing and dishwashing practices. The DS stated there were no in-services provided in 2024 and only a couple in 2023. The DS stated there should have been in-services provided and stated if in-services were not provided to staff, then staff would not know the proper and current practices for sanitizing and handling equipment. During a review of the facility's policy and procedure (P&P) titled, "Staff Development" dated 2023, the P&P indicated the food and nutrition services staff will be in-service at least monthly by the food and nutrition services director or the registered dietician.	F 801		
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	F 812	**F812: Food Pocurement, Store/ Prepare/Serve-Sanitary** **CORRECTIVE ACTION** Dietary supervisor/staff discarded apple sauces, mandarin oranges, fruit cocktail, and boxes of milk that were not dated, Remove the vanilla extract from the dry storage when it was opened on 11/22/2024 and remove the chicken pozole from refrigerator 1 (Ref 1) when the use by date of 2/27/2025 had passed, opened muffin mix, powdered sugar, baking soda, peanut butter, cottage cheese, cream cheese, pepperoni, salad dressing, and liter of milk, peanut butter, bag of grilled cheese sandwiches in Ref 1.	

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F 812	Continued From page 123 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 ensure food was stored in a sanitary manner by failing to: a. Date apple sauces, mandarin oranges, fruit cocktail, and boxes of milk with the received date. b. Remove the vanilla extract from the dry storage when it was opened on 11/22/2024 and remove the chicken pozole from refrigerator 1 (Ref 1) when the use by date of 2/27/2025 had past. c. Ensure an opened date was listed on an opened muffin mix, powdered sugar, baking soda, peanut butter, cottage cheese, cream cheese, pepperoni, salad dressing, and liter of milk. d. Ensure the peanut butter was stored in a sanitary manner when the peanut butter canister was observed with crusted peanut butter and jelly on the outside of the canister and stored in the dry storage. e. Date a bag of grilled cheese sandwiches in Ref 1. f. Report out of range chlorine PPM results to the Dietary Supervisor for 3/2025. g. Ensure the dishwater's chlorine parts per million (ppm, unit of a concentration of chlorine in water that is used for sanitation) was tested when the chlorine ppm had a reading of zero during the initial kitchen tour on 3/4/2025.	F 812	On 03/11/25 Dietary Supervisor conducted a 1:1 staff in-service to dishwasher 1 regarding the facility policy and procedure of sanitizing, dishwashing practice and handling equipment. On 03/11/25 Dietary Supervisor performed skills check to dishwasher 1 regarding sanitizing, dishwashing practice and handling equipment. On 03/11/25 Dietary supervisor conducted in service to dietary staff regarding the facility policy and procedure of sanitizing, dishwashing practice and handling equipment. On 03/11/25 Dietary supervisor performed skills check to dietary staff regarding sanitizing, dishwashing practice and handling equipment. Dietary supervisor/designee conducted in service and skill check on 03/17/25 regarding food safety: labeling and dating of food. On 03/25/25 Dietary supervisor conducted in service to dietary staff regarding the policy and procedure regarding Kitchen logs: food temperature, dishwasher log, refrigerator logs and thawing. **OTHER RESIDENTS AFFECTED IDENTIFICATION** Dietary supervisor removed all other food and were not labeled and dated.	

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F 812	Continued From page 124 These failures had the potential to result in foodborne illnesses (illness caused by consuming contaminated food or beverages). Cross reference F801 Findings: During a concurrent observation of the initial kitchen tour and interview on 3/4/2025 at 9:20 AM with the Dietary Supervisor (DS) while in the kitchen, apple sauces, mandarin oranges, fruit cocktails and boxes of milk were observed with no received date. No opened dates were observed on opened muffin mixes, powdered sugar, baking soda, peanut butter, cottage cheese, cream cheese, pepperoni, salad dressing, and a liter of milk. The peanut butter canister was observed to be crusted with peanut butter and jelly around the canister. A bag of undated grilled cheese and chicken pozole with a use by date of 2/27/2025 was observed in the refrigerator 1 (Ref 1).The DS stated items received should be listed on all items to ensure foods are fresh. The DS stated there were no dates on the opened items and stated there should be an open date so staff can track when the item was opened. The DS stated there was peanut butter and jelly around the peanut butter canister and it should've been wiped down prior to storing in the dry storage. The DS stated it was unsanitary and stated it could attract roaches and ants. The DS stated the grilled cheese and chicken pozole should've been removed from Ref 1 because there was no indication of when it was opened or used and stated the chicken pozole was past the use by date.	F 812	Dietary supervisor/designee conducted in service and skill check on 03/17/25 regarding food safety: labeling and dating of food. Dietary staff will check refrigerator temperature using the form titled “Refrigerator/Freezer Temperature Log” and check chlorine level during dishwashing using the form titled “Daily Dishwasher Chlorine and Temperature Log. **MEASURES AND SYSTEMIC CHANGES** Dietary supervisor/designee will review Refrigerator/Freezer Temperature Log and Daily Dishwasher Chlorine and Temperature Log, any significant findings will discuss with Administrator. Dietary supervisor/designee will conduct in service upon hire and monthly every 1st of the month x 3 months and annually thereafter regarding food safety: labeling and dating of food Dietary supervisor/designee will conduct competency skills training upon hire and monthly every 1st of the month x 3 months and annually thereafter regarding food safety: labeling and dating of food.	

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F 812	Continued From page 125 During an interview on 3/4/2025 at 10:05 AM with dishwasher 1 (DW 1), DW 1 stated DW 1 did not check the chlorine ppm in the morning before washing the dishes. DW 1 stated DW 1 does not check the chlorine ppm levels and does not know what the chlorine was used for in the dishwashing machine. During a concurrent observation and interview on 3/4/2025 at 10:34 AM with the DS and the Registered Dietician (RD), the dishwasher's chlorine ppm was checked. The chlorine ppm strip indicated a result of zero (0) ppm. The DS stated the chlorine ppm should be between 50 to 100 ppm and stated the staff should be checking the chlorine ppm to ensure the dishwasher was sanitizing the dishes. The DS stated by not checking the chlorine ppm the dishes would not be sanitized. During an interview on 3/4/2025 at 2:46 PM with the DS, the DS stated the chloring tubing for the dishwasher was placed into the tub correctly. The DS stated the if the tubing is not placed correctly for the chlorine solution, then the dishwasher would not be able to properly sanitize the dishes. During a concurrent interview and record review on 3/7/2025 at 8:45 AM with the DS, the facility's Daily Dishwasher Chlorine and Temperature Log (DDCTL) dated 3/2025 was reviewed. The DDCTL indicated the chlorine ppm to be 200 on 3/1/2025, 3/4/2025, and 3/5/2025. The DDCTL indicated blank spaces on 3/2/2025 and 3/3/2025. The DS stated the chlorine level was not in the correct range on 3/1/2025, 3/4/2025, and 3/5/2025. The DS stated there were blank spaces on 3/2/2025 and 3/3/2025 and this would indicate the dishwasher's wash temperature and	F 812	**MONITORING PERFORMANCE** The Administrator/Designee will review the daily dishwashing chlorine and temperature log & Refrigerator/Freezer Temperature Log weekly and any significant findings or trends will be reported to QAA committee during monthly meeting for any deficient practice for review and any recommendations x 3 months.	3/28/2025

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F 812	Continued From page 126 chlorine ppm was not checked. The DS stated the out-of-range levels for chlorine ppm was not reported to the DS. The DS stated if it was not reading the right chlorine ppm level it should've been reported to the DS for further investigation. The DS stated staff would need an in-service on how to properly manage the kitchen's dishwasher. During a review of the facility's undated, policy and procedure (P&P) titled, "Labeling and Dating of Foods Policy," the P&P indicated all food items must be labeled with the date received. The P&P indicated any food without a label or past its discard date must be thrown away immediately. During a review of the facility's undated, P&P titled, "Dishwashing" the P&P indicated the chlorine should read 50 to 100 ppm and indicated if unable to reach the chlorine level to resort to manual method of dishwashing.	F 812		
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 diseases and infections. §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:	F 880	**F880: Infection Prevention and Control** **CORRECTIVE ACTION** On 3/6/2025, IP nurse started the line listing and isolation for residents who were exposed to CNA 12. On 3/7/2025, the residents who were exposed to CNA 12 were put on isolation precautions. On 3/7/2025, LVN 3 was provided an in-service regarding the importance of following isolation protocol. Sign for EBP was posted and isolation cart was put outside of resident 68's room on 3/6/2025 by the IP nurse.	

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F 880	Continued From page 127 §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	**CORRECTIVE ACTION (CONTINUED)** On 3/5/2025, the oxygen tubing was immediately replaced by the charge nurse. On 3/3/2025, resident 27 was already off isolation. OTHER RESIDENTS AFFECTED IDENTIFICATION On 3/13/2025, residents who were not in CNA 12's run but had rashes were put on isolation precautions. On 3/14/2025, residents who were exposed to CNA 12 who had rashes and residents who were not in CNA 12's run but had rashes had skin scrapings done to test for scabies. On 3/17/2025, the results for the skin scraping were negative for all the tested residents. Isolation precautions were removed. On 3/10/2025, CNA 12 was cleared back to work by the IP nurse. On 3/7/2025, the IP nurse reviewed all residents that needed to be on EBP and checked if there were any other rooms that needed signage, and appropriate PPE was provided outside of the room. No other resident was affected by the deficient practice.	

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F 880	Continued From page 128 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 infection prevention and control program for 58 out of 91 sampled residents (Resident 1, 5, 7, 9, 11, 12, 13, 15, 16, 17, 18, 21, 24, 25, 26, 27, 28, 30, 31, 32, 33, 34, 36, 37, 39, 40, 42, 44, 46, 47, 49, 50, 52, 53, 54, 55, 56, 57, 59, 62, 63, 64, 65, 67, 68, 69, 71, 72, 74, 77, 78, 80, 88, 89, 294, 295, 296, 298) by failing to: a. Initiate a line listing, contact tracing, monitoring, and isolation measures after Certified Nursing Assistant (CNA) 12 notified the facility that CNA 12 was diagnosed with scabies (a contagious skin infestation caused by the microscopic mite, Sarcoptes scabie) on 2/28/2025. b. Ensure that proper personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) was worn while providing direct care to Resident 5. c. Ensure that signage was posted, and appropriate PPE was provided for enhanced	F 880	On 3/5/2025, the IP nurse went in the other residents' rooms to check if there are any other oxygen tubing that needed to be replaced. No other resident was affected by the deficient practice. On 3/5/2025, the IP nurse reviewed all isolation orders and verified that they were carried out. No other resident was affected by the deficient practice. On 3/7/2025, resident 62 was assessed to check if there are any infections that were received during cohorting. No negative findings were found. **MEASURES AND SYSTEMIC CHANGES** On 3/12/2025, the IP nurse/ designee started to provide in-services to staff regarding the importance of following isolation protocol and proper PPE for EBP. IP nurse/designee provided an in service regarding the importance of clear communication between departments, especially regarding infectious conditions like scabies. the to staff starting on 3/7/2025.	

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F 880	Continued From page 129 based precautions (EBP-extra measures, like wearing gowns and gloves, used during high-contact care activities with residents who are at a higher risk of having or spreading germs that are hard to treat, like multidrug-resistant organisms [MDROs]) following the readmission of Resident 68 to the facility. d. Ensure that Resident 36's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was kept off the floor while in use. e. Properly cohort Resident 27, who had orders for contact isolation from 2/17/2025 to 3/3/2025, with a roommate (Resident 62) who did not have orders for contact isolation. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for the residents, staff, and visitors. Findings: a. During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/19/2018, with a diagnosis of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on 2/1/2025, with a diagnosis of transient cerebral ischemic attack (interruption of blood flow to the brain, causing stroke-like symptoms that resolve quickly, usually within minutes or hours, without causing long-term damage).	F 880	ON 3/21/2025, the clinical consultant provided additional in-service to the DSD and IP regarding the importance of clear communication between departments, especially regarding infectious conditions like scabies. On 3/10/2025, IP nurse provided an in-service to department heads regarding the daily (Monday to Friday) room rounds to check for oxygen tubing on the floor and replace them as needed.	

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F 880	Continued From page 130 During a review of Resident 9's AR, the AR indicated the facility admitted Resident 9 on 3/30/2018, with a diagnosis of end stage renal disease (ESRD-irreversible kidney failure). During a review of Resident 11's AR, the AR indicated the facility admitted Resident 11 on 8/16/2024, with a diagnosis of diabetes mellitus (DM-a brain disorder caused by problems with the body's chemical processes or metabolism, leading to brain dysfunction). During a review of Resident 12's AR, the AR indicated the facility admitted Resident 12 on 8/12/2024, with a diagnosis of acute respiratory failure (ARF- a serious condition that makes it difficult to breathe on your own) with hypercapnia (is when you have too much carbon dioxide [CO2- a colorless, odorless, non-flammable gas] in your blood). During a review of Resident 13's AR, the AR indicated the facility admitted Resident 13 on 10/9/2024, with a diagnosis of hypertensive heart disease (a long-term condition that develops over many years in people who have high blood pressure). During a review of Resident 15's AR, the AR indicated the facility admitted Resident 15 on 1/8/2025, with a diagnosis of schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia [such as hallucinations and delusions] with symptoms of a mood disorder [such as mania and depression]). During a review of Resident 16's AR, the AR indicated the facility admitted Resident 16 on	F 880	During the daily (Monday to Friday) standup meeting the department heads will discuss any infection control concerns, including staff and resident being exposed to infectious diseases. Starting 3/10/2025, the IP nurse/ designee will do daily rounds to check if staff are following infection control protocols including wearing proper PPE during care for residents on EBP. During the daily (Monday to Friday) standup meeting the department heads will discuss and correct any found oxygen tubing on the floor. During the daily (Monday to Friday) standup meeting the DON/designee will review new admissions and verify if isolation/EBP is needed and was carried out. PERFORMANCE MONITORING DON/designee will report any findings/trends during monthly QAA meeting for review x90 days or until substantial compliance has been met.	3/28/2025

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10/22/2024, with a diagnosis of metabolic encephalopathy (a brain disorder caused by problems with the body's chemical processes or metabolism, leading to brain dysfunction).

During a review of Resident 17's AR, the AR indicated the facility admitted Resident 17 on 10/15/2016, with a diagnosis of hypertensive heart disease (a long-term condition that develops over many years in people who have high blood pressure).

During a review of Resident 18's AR, the AR indicated the facility admitted Resident 18 on 9/8/2024, with a diagnosis of diabetes mellitus (DM-a brain disorder caused by problems with the body's chemical processes or metabolism, leading to brain dysfunction).

During a review of Resident 21's AR, the AR indicated the facility admitted Resident 21 on 3/3/2022, with a diagnosis of peripheral vascular disease (PVD-a slow progressive narrowing of the blood flow to the arms and legs).

During a review of Resident 24's AR, the AR indicated the facility admitted Resident 24 on 7/4/2018, with a diagnosis of peripheral vascular disease.

During a review of Resident 25's AR, the AR indicated the facility admitted Resident 25 on 2/1/2022, with a diagnosis of hypertensive heart disease.

During a review of Resident 26's AR, the AR indicated the facility admitted Resident 26 on 3/30/2018, with a diagnosis of cerebral infarction (a type of stroke that occurs when blood flow to

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the brain is blocked).

During a review of Resident 27's AR, the AR indicated Resident 27 was admitted to the facility on 3/12/2023, with diagnosis of acute osteomyelitis (bone infection caused by bacteria) of the left foot and ankle and cellulitis (serious bacterial skin infection).

During a review of Resident 28's AR, the AR indicated the facility admitted Resident 28 on 4/22/2019, with a diagnosis of hypertensive heart disease.

During a review of Resident 30's AR, the AR indicated the facility admitted Resident 30 on 7/16/2024, with a diagnosis of metabolic encephalopathy.

During a review of Resident 31's AR, the AR indicated the facility admitted Resident 31 on 2/2/2022, with a diagnosis of peripheral vascular.

During a review of Resident 32's AR, the AR indicated the facility admitted Resident 32 on 1/8/2020, with a diagnosis of diabetes mellitus.

During a review of Resident 33's AR, the AR indicated the facility admitted Resident 33 on 9/26/2023, with a diagnosis of hereditary and idiopathic neuropathy (nerve damage that occurs without a known or identifiable cause, even after a thorough medical evaluation).

During a review of Resident 34's AR, the AR indicated the facility admitted Resident 34 on 3/29/2022, with a diagnosis of diabetes mellitus.

During a review of Resident 37's AR, the AR

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indicated the facility admitted Resident 37 on 10/11/2024, with a diagnosis of metabolic.

During a review of Resident 39's AR, the AR indicated the facility admitted Resident 39 on 5/6/2020, with a diagnosis of hypertensive heart disease.

During a review of Resident 40's Admission Record (AR), the AR indicated the facility admitted Resident 40 on 7/12/2023, with a diagnosis of end stage renal.

During a review of Resident 42's AR, the AR indicated the facility admitted Resident 44 on 5/24/2025, with a diagnosis of hypertensive heart disease.

During a review of Resident 44's AR, the AR indicated the facility admitted Resident 44 on 6/13/2024, with a diagnosis of diabetes mellitus.

During a review of Resident 46's AR, the AR indicated the facility admitted Resident 46 on 4/18/2024, with a diagnosis of chronic obstructive pulmonary.

During a review of Resident 47's AR, the AR indicated the facility admitted Resident 47 on 12/31/2024, with a diagnosis of sickle cell disease (an inherited blood disorder that affects hemoglobin [the protein that carries oxygen through the body]).

During a review of Resident 49's AR, the AR indicated the facility admitted Resident 49 on 8/26/2022, with a diagnosis of diabetes mellitus.

During a review of Resident 50's AR, the AR

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indicated the facility admitted Resident 50 on 9/9/2024, with a diagnosis of encephalopathy (a change in how the brain functions).

During a review of Resident 52's AR, the AR indicated the facility admitted Resident 52 on 9/15/2022, with a diagnosis of hypertensive heart disease.

During a review of Resident 53's AR, the AR indicated the facility admitted Resident 53 on 12/19/2024, with a diagnosis of hereditary and idiopathic neuropathy.

During a review of Resident 54's AR, the AR indicated the facility admitted Resident 54 on 11/28/2022, with a diagnosis of diabetes mellitus.

During a review of Resident 55's AR, the AR indicated the facility admitted Resident 77 on 12/23/2024, with a diagnosis of lack of coordination.

During a review of Resident 56's AR, the AR indicated the facility admitted Resident 56 on 10/4/2022, with a diagnosis of peripheral vascular disease.

During a review of Resident 57's AR, the AR indicated the facility admitted Resident 57 on 11/9/2023, with a diagnosis of hereditary and idiopathic neuropathy.

During a review of Resident 59's AR, the AR indicated the facility admitted Resident 59 on 11/4/2025, with a diagnosis of metabolic encephalopathy.

During a review of Resident 62's AR, the AR

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indicated the facility admitted Resident 62 on 11/13/2023, with a diagnosis of end stage renal disease.

During a review of Resident 63's AR, the AR indicated the facility admitted Resident 63 on 7/15/2024, with a diagnosis of lack of coordination.

During a review of Resident 64's AR, the AR indicated the facility admitted Resident 64 on 7/24/2024, with a diagnosis of encephalopathy.

During a review of Resident 65's AR, the AR indicated the facility admitted Resident 65 on 2/1/2024, with a diagnosis of diabetes mellitus.

During a review of Resident 67's AR, the AR indicated the facility admitted Resident 67 on 12/21/2023, with a diagnosis of lack of coordination.

During a review of Resident 69's AR, the AR indicated the facility admitted Resident 69 on 6/20/2024, with a diagnosis of metabolic epileptic seizures (abnormal, excessive, sudden discharges of the neurons [nerve cells] in the brain).

During a review of Resident 71's AR, the AR indicated the facility admitted Resident 71 on 7/31/2024, with a diagnosis of adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability).

During a review of Resident 72's AR, the AR indicated the facility admitted Resident 72 on 10/9/2024, with a diagnosis of metabolic encephalopathy.

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During a review of Resident 74's AR, the AR indicated the facility admitted Resident 21 on 1/2/2025, with a diagnosis of diabetes mellitus.

During a review of Resident 77's AR, the AR indicated the facility admitted Resident 77 on 12/23/2024, with a diagnosis of encephalopathy.

During a review of Resident 78's AR, the AR indicated the facility admitted Resident 78 on 12/13/2024, with a diagnosis of acute on chronic systolic (congestive) heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen).

During a review of Resident 80's AR, the AR indicated the facility admitted Resident 80 on 12/19/2024, with a diagnosis of traumatic subdural hemorrhage (caused by a traumatic head injury, such as a blow to the head or a fall).

During a review of Resident 88's AR, the AR indicated the facility admitted Resident 88 on 1/29/2025, with a diagnosis of hypertensive heart disease.

During a review of Resident 89's AR, the AR indicated the facility admitted Resident 89 on 2/13/2025, with a diagnosis of hereditary and idiopathic neuropathy.

During a review of Resident 294's AR, the AR indicated the facility admitted Resident 294 on 2/24/2025, with a diagnosis of toxic encephalopathy (brain dysfunction caused by exposure to toxic substances, either through external sources or internal metabolic

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imbalances, leading to a range of symptoms including altered mental state and cognitive deficits).

During a review of Resident 295's AR, the AR indicated the facility admitted Resident 295 on 1/28/2025, with a diagnosis of chronic obstructive pulmonary disease.

During a review of Resident 296's AR, the AR indicated the facility admitted Resident 296 on 7/6/2018, with a diagnosis of hypertensive heart disease.

During a review of Resident 298's AR, the AR indicated the facility admitted Resident 298 on 2/19/2025, with a diagnosis of lack of coordination.

During a review of Certified Nursing Assistant (CNA) 12's Work Activity Status Report (WASR) from CNA 12's Occupational Health Services Provider (OHSP- a medical provider that aims to protect and promote the health and well-being of worker) 1, dated 2/28/2025, indicated that CNA 12 had been diagnosed with a scabies infestation. The WASR indicated that the employee was to return for a follow-up in 4 days.

During a concurrent interview and record review on 3/5/2025 at 1:30 PM, the list of employees sent to the employee health clinic for January 2025 and February 2025 was reviewed with the Administrator (ADM). The ADM stated that CNA 12 was seen at the employee health clinic on 2/28/2025 for a skin rash and had not been cleared to return to work.

During an interview on 3/5/2025 at 2:13 PM, with

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the Director of Staff Development (DSD), the DSD stated CNA 12 was currently out due to a medical illness.

During a telephone interview on 3/5/2025 at 4:15 PM, with CNA 12, CNA 12 stated that CAN 12 had developed a rash that started around her wrist and began spreading to her forearms, elbows, shoulders, chest, and back. CNA 12 stated that the rash in the wrist area had appeared around a week before CNA 12 visited the employee health clinic. CNA 12 stated that CNA 12 had notified the DSD when she noticed the rash spreading beyond her wrist. CNA 12 stated that CNA 12 expressed her concerns about a possible scabies outbreak to the DSD, as CNA 12 had observed several residents with rashes. CNA 12 stated that nothing had been done about her concern. CNA 12 stated that CNA 12 suggested doing a skin check particularly for residents in rooms 27 and 36.

During the same telephone interview on 3/5/2025 at 4:15 PM, with CNA 12, CNA 12 stated that the health clinic had diagnosed her with scabies; however, the clinic had not obtained a skin scraping sample to confirm the diagnosis. CNA 12 stated that she notified the DSD on 2/28/2025 around 12 PM about her diagnosis, but the DSD did not seem concerned when CNA 12 asked if a skin scraping had been taken. CNA 12 stated that CNA 12 was given Permethrin (a topical medication that kills the mites and eggs that cause scabies and lice) cream during her initial visit on 2/28/2025 and was told to return for a follow-up in 4 days. CNA 12 stated that although CNA 12 was unable to attend her appointment on 3/4/2025, she was able to follow-up with the clinic on 3/5/2025. CNA 12 stated that during this visit,

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CNA 12 was told that she still had patches of scabies, would require another treatment, and would need to return to the clinic for another follow-up in 4 days.

During a concurrent interview and record review on 3/7/2025 at 10:08 AM, with the Director of Staff Development (DSD), CNA 12's WASR from OHSP 1, dated 2/28/2025, was reviewed. The DSD stated that she provided CNA 12 with the authorization form for the employee health clinic on 2/28/2025, as CNA 12 was complaining of a rash. The DSD stated that CNA 12 had mentioned concerns about a possible scabies infestation, but the facility had not experienced any outbreaks or received concerns from the dermatologist regarding scabies among residents. The DSD stated that CNA 12 was sent to the employee health clinic for evaluation and check-up. The DSD stated CNA 12 had notified her the same day, around noon, about CNA 12's diagnosis of scabies. The DSD asked CNA 12 if a skin scraping had been obtained, to which CNA 12 replied that no scraping was done. The DSD stated that the DSD did not immediately notify the Infection Preventionist (IP) until later that evening. The DSD stated that it was important to notify the IP nurse promptly when an employee was diagnosed with scabies, even without a skin scraping, because scabies was highly contagious. The DSD noted that once the employee was diagnosed with scabies, the facility should have ensured that proper precautions were taken to prevent potential outbreaks. The DSD stated that notifying the IP nurse immediately was crucial, as the IP nurse played a central role in assessing the situation and taking appropriate actions. The DSD stated the importance of clear communication between

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departments, especially regarding infectious conditions like scabies. The DSD stated by failing to notify the IP nurse right away, she acknowledged the potential risk of scabies spreading to other employees or residents, which could lead to an outbreak.

During a review of the facility's Nursing Staffing Assignment and Sign-In Sheet, from 2/14/2025 to 2/27/2025, CNA 12's work schedule indicated the following:
CNA 12 was off on 2/14/2025 to 2/15/2025.
CNA 12 worked the night shift (11 PM to 7 AM) from 2/16/2025 to 2/20/2025.
CNA 12 was off on 2/21/2025 to 2/22/2025.
CNA 12 worked from 2/23/2025 to 2/27/2025.
The Nursing Staff Assignment and Sign-In Sheet indicated CNA 12 had direct patient care and contact with Residents 1, 7, 9, 11, 12, 13, 15, 16, 17, 18, 21, 24, 25, 26, 27, 28, 30, 31, 32, 33, 34, 37, 39, 40, 42, 44, 46, 47, 49, 50, 52, 53, 54, 55, 56, 57, 59, 62, 63, 64, 65, 67, 69, 71, 72, 74, 77, 78, 80, 88, 89, 294, 295, 296, and 298 during this time period.

During a concurrent interview and record review on 3/7/2025 at 9 AM, with the Infection Preventionist (IPN), the facility's "Rashes" list was reviewed). The IPN stated that 4 residents (Resident 25, 49, 72, 82) were identified with rashes after 2/28/2025, and had been seen by the dermatologist, with treatment orders initiated. The IPN stated that the dermatologist had no concerns regarding scabies and will continue to monitor the residents.

During an interview on 3/7/2025 at 10:47 AM, with the IPN, the IPN stated that the DSD notified her about CNA 12's scabies diagnosis late in the

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evening on 2/28/2025. The IPN stated the DSD reported that no skin scrapping had been obtained. The IPN stated that once she was notified, she did not initiate the proper measures to mitigate the potential risk of a scabies outbreak. The IPN stated that scabies was highly contagious, and when an employee was diagnosed, it was essential to act promptly to prevent potential transmission to both other employees and residents in the facility. The IPN stated that scabies mites could spread through direct skin-to-skin contact, and in a healthcare setting like the facility's, this made rapid response even more important. The IPN stated if left unchecked, scabies could spread quickly, leading to outbreaks among staff and residents, which were much harder to contain once they started to spread. The IPN stated that she did not initiate a line listing in a timely manner. The IPN stated that a line listing was essentially a log of all individuals who may have been exposed, allowing the facility to take appropriate precautions for each person. The IPN stated that the goal was to identify anyone who might have been at risk for contacting scabies from the diagnosed individual. The IPN stated that a line listing was important because it helped the facility quickly identify who needed to be monitored or treated.

During the same interview on 3/7/2025 at 10:47 AM, with the IPN, the IPN stated contact tracing was another key factor of the response. The IPN stated that once the facility identified those who had been in contact with the affected employee, the facility needed to trace their interactions and possible exposures within the facility. The IPN stated that early identification and intervention were critical. The IPN stated that monitoring would be the next step, which included checking

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for symptoms like itching, redness, or skin lesions, that might have indicated scabies. The IPN stated that in the case of employees, this may have required staying home from work until they had completed treatment and were no longer contagious. The IPN stated, for residents, the facility may have needed to isolate residents in a private room or ensure that they had limited interaction with other residents until treatment was completed. The IPN stated that clear communication among team members ensured that the facility responded quickly, monitored affected individuals, and prevented the spread. The IPN stated that without coordination, the facility risked delays that could have made a bad situation worse.

During a review of the facility's policy and procedure (P&P) titled, "Surveillance for Infections," revised 9/2017, the P&P indicated, "The Infection Preventionist will conduct ongoing surveillance for healthcare-associated infections (HAI) and other epidemiological significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions." The P&P indicated ...
"1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections.
2. The criteria for such infections are based on the current standard definitions of infections.
3. Infections that will be included in routine surveillance include those with:
a. Evidence of transmissibility in a healthcare environment.

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b. Available processes and procedures that prevent or reduce the spread of infection.
c. Clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C. difficile); and
d. Pathogens associated with serious outbreaks (e.g., invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza).
4. Infections that may be considered surveillance include those with limited transmissibility in a healthcare environment; and/or limited prevention strategies.
5. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the Charge Nurse as soon as possible.
6. If a communicable disease outbreak is suspected, this information will be communicated to the Charge Nurse and Infection Preventionist immediately.
7. When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures.
8. The Charge nurse will notify the Attending Physician and the Infection Preventionist of suspected infections.
a. The Infection Preventionist and the Attending Physician will determine if laboratory testes are indicated, and whether special precautions are warranted.
b. The Infection Preventionist will determine if the infection is reportable.
c. The Attending Physician and interdisciplinary

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team will determine the treatment plan for the resident.
9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect data to determine the effectiveness of such measures."

During a review of the facility's manual titled, "Addendum for Infection Prevention and Control Manual," dated 2013, the manual indicated that infection prevention and control should be an interdisciplinary effort. All members of the healthcare team in a skilled facility must participate in providing a safe and sanitary environment for the residents, staff and visitors.

b. During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted to the facility on 12/18/2024 and readmitted on 2/25/25 with diagnoses that included end stage renal disease (kidneys lose the ability to remove waste and balance fluids), Type 1 diabetes mellitus (pancreas makes little or no insulin\ leading to high sugar levels), and non-ST elevation myocardial infarction (partial blockage of coronary [heart] artery).

During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 12/24/24, the MDS indicated Resident 5 was cognitively intact (ability to understand and process thoughts), and required partial/moderate assistance with personal hygiene and upper body dressing and substantial/maximal assistance with lower body dressing.

During a review of Resident 5's History & Physical (H&P), dated 2/28/25, the H&P indicated

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Resident 5 had the capacity to make medical decisions.

During an observation, on 3/7/25, at 10:05 a.m., Licensed Vocational Nurse (LVN) 3 picked up, replaced and applied Resident 5's oxygen nasal cannula as Resident 5 requested. LVN 3 also checked Resident 5's blood glucose (BG- measures the amount of glucose in the blood) level. LVN 3 was not wearing PPE when providing high-contact care to Resident 5.

During an interview on 3/7/25, at 11:56 a.m., with LVN 3, LVN 3 stated Resident 5 was on Enhanced Barrier Precautions (EBP- use of gowns and gloves during high-contact resident care activities) due to (d/t) Resident 5's dialysis port (medical device that provides a pathway for blood to be removed from the body). LVN 3 stated LVN 3 did not don (put on) personal protective equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) prior to providing high-contact care to Resident 5. LVN 3 stated LVN 3 should have donned PPE when LVN 3 changed Resident 5's nasal cannula and checked Resident 5's blood glucose. LVN 3 stated LVIN 3 needed to don a new set of PPEs when LVN 3 returned to Resident 5's room to obtain Resident 5's blood pressure (BP), doffed (removed) the PPE after obtaining Resident 5's BP, and performed hand hygiene after. LVN 3 stated the appropriate PPEs for EBP are gloves, gown, and mask. LVN 3 stated donning proper PPE is important because safety of the resident and staff from infection and fluids.

During an interview on 3/7/25, at 12:15 p.m., with Infection Prevention Nurse (IPN), the IPN stated

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EBP is implemented for high-risk residents with indwelling devices, chronic wounds that are not expected to heal, and any history of (h/o) multidrug-resistant organism (MDRO). The IPN stated Resident 5's port for dialysis is an indwelling medical device and requires EBP. The IPN stated the staff are supposed to perform hand hygiene, wear gown and gloves when direct patient care/direct high-risk activities. The IPN stated, "It is important to wear appropriate PPE" to prevent spread of infection from and to those residents are at high risk for transferring and receiving infections.

During a review of the facility's Policy & Procedure (P&P) titled, "Enhanced Barrier Precautions," dated, August 2022, the P&P indicated enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms to the residents. The P&P indicated Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs included: g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.).
c. During a review of Resident 68's AR, the AR indicated Resident 68 was admitted to the facility on 9/28/2024 with diagnoses that included respiratory failure (a condition caused by inadequate supply of oxygen and/or the inability to remove carbon dioxide from the lungs), a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dementia (a progressive state of decline in mental abilities) with an onset date of 9/28/2024.

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During a review of Resident 68's History and Physical (H&P), dated 1/21/2025, the H&P indicated Resident 68 did not have the capacity to understand and make decisions and was dependent (a helper does all of the effort, resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required) for basic activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).

During a review of Resident 68's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 2/19/2025, the MDS indicated Resident 68 had severe cognitive (ability to understand) impairment.

During a review of Resident' 68's Order Summary Report (OSR), dated active as of 3/6/2025, the OSR included a physician order, start date 1/3/2025, the order indicated Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs- a germ that is resistant to many antibiotics) that employs targeted gown and glove use during high contact resident care activities and are indicated for residents with infections, wounds, and indwelling medical devices) related to gastrostomy tube (G-tube).

During an observation on 3/5/2025 at 10:38 am outside of Resident 68's room, there were no personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) supplies outside the room and no EBP signage posted outside or inside Resident

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68's room to indicate EBP precautions for Resident 68.

During a concurrent observation and interview on 3/5/2025 at 10:41 am with Licensed Vocational Nurse 4 (LVN 4) outside of Resident 68's room, there was no EBP signage or PPE outside or inside the room. LVN 4 stated, Resident 68 had a G-tube and needed EBP. LVN 4 further stated, the Infection Preventionist Nurse (IPN) was responsible for putting up EBP signage and providing PPE carts, which would be done as soon as they arrived.

During an interview on 3/5/2025 at 1:57 pm with the IPN, the IPN stated Resident 68 was under EBP due to Resident 68 having a G-tube. The IPN stated EBP could be initiated by any nurse by setting up a PPE cart & posting an EBP sign. The IPN further stated, EBP was used to prevent the spread of infections to everyone [staff and residents], especially residents who were at high-risk.

During an interview on 3/7/2025 at 9:39 am with the Director of Nursing (DON), the DON stated when a resident was admitted or readmitted with an EBP physician order, EBP should be started immediately. The DON further stated, the risk of not using EBP for the resident allowed the spread of infection to staff, family members, and the residents.

During a review of the facility's policy and procedure (P&P), titled, "Enhanced Barrier Precautions," last reviewed 8/2022, the P&P indicated, EBP were utilized to prevent the spread of multi-drug resistant organisms to residents. The P&P indicated EBP were indicated (when

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contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. The P&P indicated, signs were posted on the door or wall outside the resident's room indicating the type of precautions and PPE required and PPE was available outside of the resident rooms.

d. During a review of Resident 36's AR, the AR indicated Resident 36 was readmitted to the facility on 1/28/2024 with diagnoses that included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).

During a review of Resident 36's H&P, dated 2/4/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions.

During a review of Resident 36's Physician Orders (PO), with order date 6/13/2024, the PO indicated Resident 36 had an order for oxygen at 2 liters per minute via nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) for chronic obstructive pulmonary disease (COPD-a chronic [long standing] lung disease causing difficulty in breathing).

During a review of Resident 36's MDS, dated 11/27/2024, the MDS indicated Resident 36 had intact cognition, was at risk of developing pressure ulcers (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin), and a pressure reducing device was in use for Resident 36's bed.

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During a concurrent observation and interview on 3/4/2025 at 11:04 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 36's room, Resident 36 was asleep in bed and the NC was on the floor. LVN 2 stated, the NC should not be touching the ground and should be free floating off the ground for infection control [purposes]. LVN 2 further stated, the floor was probably as dirty as the building.

During a review of Resident 36's Medication Administration Record (MAR), dated 3/1/2025-3/31/2025, the MAR indicated the resident was receiving oxygen via NC on 3/4/2025 continuously.

During an interview on 3/7/2025 at 9:19 am with the Director of Nursing (DON), the DON stated if a resident was using a NC, and the NC touched the floor, the NC should be changed because it put the resident at risk for acquiring an infection. The DON further stated it was the facility's standard procedure to prevent infections to residents.

e.During a review of Resident 27's Admission record, the Admission Record indicated Resident 27 was admitted to the facility on 3/12/2023 and readmitted on 1/13/2025 with diagnoses that included acute osteomyelitis (bone infection caused by bacteria) of the left foot and ankle and cellulitis (serious bacterial skin infection).

During a review of Resident 27's MDS dated 1/10/2025 indicated Resident 27's cognitive abilities (ability to think, learn, and process information) were intact.

During a review of Resident 27's Surveillance Data Collection form (SDC) dated 2/17/2024, the

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	555854	A. BUILDING _____ B. WING _____	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MESA GLEN CARE CENTER	638 E COLORADO AVENUE GLENDORA, CA 91740

(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 880	Continued From page 151	F 880		

SDC form indicated the wound on Resident 27's left foot was positive culture for klebsiella pneumoniae (type of bacteria) (ESBL) and Enterococcus Faecalis (type of bacteria) (VRE) and indicated orders for contact precautions.

During a review of Resident 27's History and Physical (H&P) dated 2/20/2025 indicated Resident 27 had the capacity to understand and make decisions.

During a review of Resident 27's untitled orders (UO) dated 2/18/2025, the UO indicated to place Resident 27 on contact isolation for ESBL and VRE in the left foot wound, and on 3/3/2025 the UO indicated to discontinue contact isolation.

During a concurrent interview and record review on 3/4/2025 at 3:11 PM with the Infection Preventionist Nurse (IPN), the facility's census dated 2/18/2025 to 3/3/2025 were reviewed. The IPN stated Resident 27 was cohorted with Resident 62 from 2/18/2025 and through 3/3/2025. The IPN stated Resident 62 had a dialysis catheter and should not have been cohorted with Resident 27 who had an active infection. The IPN stated by cohorting Resident 27 and Resident 62 together put Resident 62 at a higher risk of acquiring ESBL or VRE because Resident 62 had an invasive catheter.

During an interview on 3/7/2025 at 2:02 PM with the Director of Nursing (DON), the DON stated Resident 27 and Resident 62 should not have been cohorted together when Resident 27 had orders for contact isolation. The DON stated Resident 27 should have been isolated in a separate room and stated staff put Resident 62 at risk for infection because Resident 62 had an

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(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 880	Continued From page 152 invasive catheter. During a review of the facility's undated policy and procedure (P&P) titled, "Infection Prevention and Control in LTC" the P&P indicated the roommate of the contact precaution resident (without history of same organism) should have no invasive procedure sites, should have intact skin, and should be immunocompetent (having the ability to produce a normal immune response).	F 880		