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INFINITY CARE OF EAST LOS ANGELES	101 S FICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one complaint and one facility reported incident during an Annual Recertification Survey conducted on 6/7/2024. Complaint Number: CA00903013 Facility Reported Incident Number: CA00901395 Representing the California Department of Public Health: Surveyor 48395, Health Facilities Evaluator Nurse (HFEN) Surveyor 46919, HFEN Surveyor 45456, HFEN Surveyor 45523, HFEN Surveyor 48143, HFEN Total Resident Population: 87 Total Resident Sample Size: 24 Highest scope and severity: E Complaint Number CA00903013: Refer to F tag F609 and F610 Facility Reported Incident Number: CA00901395: Unsubstantiated	F 000	Infinity Care of East Los Angeles makes every effort to comply with State and Federal regulations. Nothing in this plan of correction is an admission otherwise. Infinity Care of East Los Angeles has submitted this plan of correction to comply with the regulatory obligation and does not waive any objections obtained therein. This plan of correction is Infinity Care of East Los Angeles' credible allegation of compliance.	
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.	F 550	**Corrective Action: F 550** On 6/04/24, CNA for Resident 30 placed dignity bag cover over Foley catheter collection bag for Resident 30.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samir Amin	Administrator	7/08/24

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 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal 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 provide care in a manner that maintained the resident's dignity and respect in full recognition of their individuality for	F 550	**Other Residents Potentially Effected:** On 6/04/24, DON checked and verified that no other residents with Foley Catheter were observed to have missing dignity bag cover over their urine collection bag. **Measures and Systemic Changes:** Beginning 6/04/24, CNAs and licensed nurses will visually inspect for placement of dignity bag covers over Foley catheter urine collection bags daily on each shift and will request for Central Supply Director to provide a new bag if existing bag is soiled, torn, or missing entirely. Additional urine collection bags will be made available at nursing stations to ensure adequate supply is readily available at all times. On 6/10/24, DSD in-serviced licensed nurses and CNAs on Resident's Rights - Dignity, with emphasis on urine collection bags being covered at all times by dignity bags.	

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F 550	Continued From page 2 one of one sampled resident (Resident 30) by failing to ensure Resident 30's indwelling catheter (a tube inserted into the bladder to help drain urine) collection bag (designed to collect urine drained from the bladder via a catheter or sheath) as covered with a "dignity bag (a bag used to cover and hold the catheter drainage/collection bag so it is not visible)." This deficient practice violated Resident 30's right for privacy and had the potential to affect Resident 30's self-worth, self-esteem, and psychosocial well-being (the state of mental, emotional, and social health of an individual). Findings: A review of Resident 30's Admission Record indicated Resident 30 was admitted to the facility on 3/8/2024 with diagnoses that included hemiplegia (paralysis on one side of the body) following cerebral infarct affecting left non dominant side (when the blood supply to part of the brain is blocked or reduced causing muscle weakness or partial paralysis on one side of the body), non-traumatic chronic subdural hemorrhage (a condition in which blood slowly leaks beneath the outermost layer of the tissue that covers and protects the brain), and mechanical complication of other urinary catheter (indwelling catheter). A review of Resident 30's History and Physical Examination (H&P), dated 3/10/2024, indicated Resident 30 had the capacity to understand and make decisions. A review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care	F 550	**Performance Monitoring:** Beginning 6/25/24, The DON in cooperation with Central Supply Director and licensed nurses will visually inspect daily dignity bag supply and placement over urine collection bag and discuss during the monthly QA meeting any discrepancies that are identified related to dignity bags. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/10/24

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F 550	Continued From page 3	F 550		

planning tool), dated 3/15/2024, indicated Resident 30 had intact memory and cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision making and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and toilet transfer.

A review of Resident 30's Physician Orders, dated 6/2024, indicated a physician order, with a start date of 3/8/2024, for foley catheter (indwelling catheter) for urinary retention/benign prostatic hyperplasia (BPH- enlargement of the prostate gland causing urination difficulty).

During a concurrent observation of Resident 30 and interview with Certified Nursing Assistant 1 (CNA 1), on 6/4/2024, at 8:43 AM, Resident 30 was observed awake in bed. Resident 30's indwelling catheter collection bag was placed on the right side of the bed. Resident 30's in the indwelling catheter collection bag was not covered by a dignity bag and his urine was exposed. CNA 1 stated Resident 30's indwelling catheter collection bag should always be covered with a dignity bag. CNA 1 stated Resident 30's dignity bag was hanging on Resident 30's wheelchair.

During an interview with the Director of Nursing (DON), on 6/7/2024, at 9:33 AM, the DON stated indwelling catheter collection bags should always be covered by a dignity bag to prevent staff and visitors from seeing the urine inside the collection bag. The DON stated residents can feel embarrassed if staff or visitors see the urine in the collection bag. The DON stated the dignity bag is used to protect the resident's dignity. The

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F 550	Continued From page 4 DON stated the treatment nurse and certified nursing assistants are responsible for making sure the indwelling catheter collection bags are covered with a dignity bag. A review of the facility's policy and procedure (P&P), titled, "Dignity," revised on 3/2024, indicated, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings or self-worth and self-esteem." A review of the facility's P&P, titled, "Resident's Rights," revised on 3/2024, indicated, "Employees shall treat all residents with kindness, respect, and dignity." The P&P also indicated, "Federal and state laws guarantee certain basic rights to all residents in the facility. These rights include the resident's right to a dignified existence and be treated with respect, kindness, and dignity."	F 550		
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	F 578	**Corrective Action: F 578** On 7/03/24, SSD met with Resident 47, on that date Resident 47 declined to sign an advance directive form. On 7/05/24, SSD met with responsible party of Resident 2 to complete the incomplete sections identified on Resident 2's advance directive form. On 7/05/24, Responsible party for Resident 2 completed the incomplete sections of Resident 2's advance directive form and the completed form was placed in Resident 2's chart.	

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F 578	Continued From page 5 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 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 follow their policy and procedure titled "Advance Directive (a written statement of a resident's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the resident be unable to communicate them)" by not providing a written information to three (3) of seven (7) sampled residents (Residents 47, 2, and 10) concerning the option to formulate an advance directive. This deficient practice violated Resident 47, 2,	F 578	On 7/05/24, SSD assisted Resident 10 with completion of the advance directive form. On 7/05/24, Resident 10's advance directive form was completed and placed into the resident's chart. **Other Residents Potentially Effected:** On 7/05/24, Medical Records department audited resident charts for incomplete or missing advance directive forms and no additional deficient practice was identified. **Measures and Systemic Changes:** Beginning 7/01/24, Medical Records Director in cooperation with Social Services Director will verify all new admissions and readmissions have completed advance directive forms avaialable in the resident charts. SSD and/or IDT team will verify completeness of advance directive forms for all residents quarterly. IDT and SSD will conduct annual review of advance directives for all residents and document any changes on the advance directive forms, any identified changes to advance directives during annual review will be forwarded to DON and Administrator for QA purposes.	

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F 578	Continued From page 6 and 10 the right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding health care. Findings: 1. During a review of Resident 47's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 7/5/2023 and readmitted 4/23/2024 with diagnoses of leukemia (a type of cancer found in your blood and bone marrow and is caused by the rapid production of abnormal white blood cells) and cellulitis (a deep infection of the skin caused by bacteria) of the left lower limb. During a review of Resident 47's History and Physical Examination (H&P), dated 4/27/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 47's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 5/3/2024, the MDS indicated the resident had an intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 47 needed substantial/maximal assistance (helper does more than half the effort) with bed-to-chair transfers, lower body dressing, and personal hygiene and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. During a review of Resident 47's medical chart dated 4/23/2024 to 6/5/2024, neither an Advance	F 578	On 7/02/24, DSD and Administrator conducted 1-on-1 in-service with Social Services Director with emphasis on ensuring advance directives are always fully complete and made available in the resident's chart at all times. **Performance Monitoring:** Beginning 7/01/24, The DON in cooperation with IDT, SSD, and Medical Records Department will conduct chart audits weekly for completed advance directive forms for all existing residents and new admissions and discuss during the monthly QA meeting any discrepancies that are identified related to incomplete or missing advance directives. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	7/05/24

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Directive nor and Advance Directive Acknowledgement Form was found in Resident 47's medical chart.

During a concurrent interview and record review on 6/6/2024 at 9:55 AM with Social Services Director (SSD), Resident 47's medical chart dated 4/23/2024 to 6/6/2024 was reviewed. No Advance Directive Acknowledgment Form or Advance Directive was found in Resident 47's medical chart. SSD stated, there was no Advance Directive Acknowledgement Form in the resident's medical chart and stated that the form indicates whether the resident has executed an advance directive or did not, and that a copy should be available and accessible in the resident's chart.

2. During a review of Resident 2's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 9/15/2023 with diagnoses of paroxysmal (an attack or sudden increase or recurrence of symptoms) atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the hart] fire rapidly at the same time) and cerebral infarction (damage to the tissues in the brain due to a loss of oxygen in the area).

During a review of Resident 2's H&P, dated 9/16/2024, the H&P indicated the resident has the capacity to understand and make decisions.

During a review of Resident 2's MDS, dated 3/22/2024, the MDS indicated the resident had intact cognitive skills for daily decision making. Resident 2 needed supervision or touching assistance (helper set up or cleans up; resident

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completes activity) with walking 50 feet and making 2 turns and dressing (how a resident puts on, fastens and takes off all items of clothing), needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) transferring from bed-to-chair, going from a sit to stand position, personal hygiene and eating.

During a review of Resident 2's medical chart, dated 9/15/2023 to 6/5/2024, neither an Advance Directive nor and Advance Directive Acknowledgement Form was found in Resident 2's medical chart.

During a concurrent interview and record review on 6/6/2024 at 9:58 AM with SSD, Resident 2's medical chart dated 9/15/2024 to 6/6/2024 was reviewed. The Advance Directive Acknowledgement Form was not filled out in its entirety and was not initialed (signed) by the resident indicating that they were informed and provided information of their right to formulate an advance directive. SSD stated the Advance Directive Acknowledgement Form was not filled out and signed by the resident or the resident representative. SSD stated it should have been fully filled out and initialed to show that SSD did go over the information of the resident's right to formulate an advance directive if the resident chooses to do so.

3. During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was originally admitted on 8/2/2017 and re admitted on 1/15/2024 with diagnoses that included other Schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions)

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unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), and unspecified severity with other behavioral disturbances, delusional disorders, chronic obstructive pulmonary disease with acute exacerbation (sudden worsening in airway function and respiratory symptoms).

During a review of Resident 10's H&P, dated 1/16/2024, the H&P indicated Resident 10 does not have the capacity to understand and make decisions.

During a review of the MDS, dated 4/2/2024, the MDS indicated Resident 10 was able to make self-understood and does have the ability to understand others and required substantial/maximal assistance (helper does more than half the effort) from staff members for oral and personal hygiene, upper and lower dressing and is dependent (helper does all of the effort) for transfer, toilet use, and bathing.

During a review of Resident 10's Physician Orders for Life-Sustaining Treatment (POLST) dated 5/21/2020, the POLST did not indicate if Advance Directive information was discussed with Resident 10 and there was no advance directive date available or advance directive follow up information documented as given.

During an interview with Director of Staff Development (DSD) on 6/04/2024 at 11:41 AM, DSD stated all charts should have the advance directive acknowledgement form to indicate if there was an advanced directive or not.

During an interview and record review with Licensed Vocational Nurse 2 (LVN 2) on 6/5/2024

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F 578	Continued From page 10 at 2:16 PM, LVN2 stated there was no hard copy of advance directive in Resident 10's chart. LVN2 stated, "It is important to have the advance directive in the resident's chart in case there is an emergency and the code staff (a team that provides immediate resuscitative [action of reviving someone from unconsciousness or apparent death] efforts to a patient who is on cardiac arrest [sudden or unexcepted loss of heart functions, breathing and consciousness]) need to know what steps to take next and to respect their wishes." During a review of the facility's policy and procedure (P&P) titled "Advance Directives" dated March 2024, the P&P indicated: 1. "If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. 2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff."	F 578		
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	F 609		

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F 609	Continued From page 11 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 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: Cross reference F610 Based on interview and record review, the facility failed to report an allegation of verbal abuse (a range of words of behaviors used to manipulate, intimidate and maintain power and control over someone) within two hours for two (2) of 24 sampled residents (Residents 28 and 77) to the State Survey Agency (SA, where state law provides for jurisdiction in long-term care facilities), the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement, in accordance with the facility's	F 609	**Corrective Action: F 609** On 6/07/24, Resident 28's care plan was updated to reflect the recent incident of alleged resident to resident verbal abuse. Beginning June 11th 2024, Resident 28 began to recieve bi-monthly sessions with facility contracted psychologist. On 5/29/24, Resident 77 was discharged home with their responsible party. **Other Residents Potentially Effected:** From 6/07/2024 to 7/07/2024, Administrator verified that no other residents reported incidents of resident to resident verbal abuse	

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F 609	Continued From page 12 abuse policy. This deficient practice has the potential to result in unreported abuse in the facility and failure to protect Resident 28 and other residents from abuse. Findings: 1. During a review of Resident 28's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 12/24/2014 and readmitted 6/29/2017 with diagnoses of bilateral (both) primary osteoarthritis (degenerative joint disease in which the tissues in the joint break down over time) of the knee and hemiplegia (one sided muscle paralysis or weakness) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the right dominant side. During a review of Resident 28's History and Physical Examination (H&P), dated 4/1/2023, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 3/4/2024, the MDS indicated the resident had intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 28 was dependent (helper dopes all of the effort) for bed-to-chair transfers and needed substantial/maximal assistance (helper does more than half the effort) with dressing (how a resident puts on, fastens, and takes off all items of clothing). Resident 28 needed supervision or touching assistance (helper provides verbal cues/or	F 609	**Measures and Systemic Changes:** On 6/27/24, Administrator instructed Activities Director to encourage residents in the activities program and residents participating in the monthly resident council meeting to always report to a trusted member of staff any instances or feelings of abuse they may experience during their stay at the facility. Additionally, residents will be encouraged to report directly to the administrator any feelings or experiences related to abuse, should the residents feel comfortable doing so. On 6/27/24, Administrator and Director of Staff Development in-serviced all staff on abuse reporting, types of abuse, and mandated reporter functions and responsibilites. **Performance Monitoring:** Beginning 6/27/24, The Administrator in cooperation with IDT team, DON, and SSD will monitor weekly for cases of alleged abuse of any kind and discuss during the monthly QA meeting any discrepancies that are identified related to abuse investigation and reporting. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/27/24

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F 609	Continued From page 13	F 609		

touching/steadying and/or contact guard assistance as resident completes activity) with personal hygiene & needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating.

2. During a review of Resident 77's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 4/5/2024 with diagnoses of atherosclerotic heart disease (involves plaque buildup in artery walls) and cerebral infarction.

During a review of Resident 77's H&P, dated 4/25/2024, the H&P indicated the resident has the capacity to understand and make decisions.

During a review of Resident 77's, dated 4/12/2024, the MDS indicated the resident had intact cognitive skills for daily decision making. Resident 77 was dependent with transfers (how resident moves to and from bed, chair, wheelchair, standing position), lower body dressing and personal hygiene, and needed setup or clean-up assistance (helper set up or cleans up; resident completes activity) with eating.

During a review of Resident 77's Interdisciplinary Team (IDT; team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) Note dated 5/6/2024, the IDT Meeting Note indicated that when Certified Nursing Assistant 2 (CNA 2) was assisting Resident 28 to the shower, Resident 77 yelled at Resident 28 and used socially inappropriate verbal language towards her.

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During a concurrent interview and record review on 6/6/2024 at 3:49 PM with Social Services Director (SSD), Resident 77's IDT Meeting Note, dated 5/6/2024, was reviewed. Resident 77's IDT Meeting Note addressed an incident that occurred when Resident 77 yelled at Resident 28 using socially inappropriate verbal language. SSD stated that the language Resident 77 used toward Resident 28 was considered verbal abuse.

During an interview on 6/6/2024 at 4:00 PM with Resident 28, Resident 28 stated that on the morning of 5/8/24 Resident 77 used socially inappropriate verbal language towards her as CNA 2 was helping her to the shower. Resident 28 stated that the next day, she spoke with SSD and MDS Nurse (MDSN) about the incident and told them that no one is allowed to or has the right to speak to her like that and that. Resident 28 further stated that Resident 77 using inappropriate language towards her made her feel very angry.

During an interview on 6/7/2024 at 2:40 PM with SSD, SSD stated that verbal abuse is when someone says something to someone that is offensive and unacceptable and stated that what Resident 77 said to Resident 28 offended her and was unacceptable. SSD stated that the timeline for reporting is within two hours and that CNA 2 should have reported the incident to the supervisor and charge nurse since she was the one who witnessed the incident. SSD further stated that it was important that allegations of abuse be reported to SA so it will not happen again for the safety and wellbeing of the residents and staff involved.

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During an interview on 6/7/2024 at 3:18 PM with CNA 3, CNA 3 stated, "Verbal abuse is when bad words are used, yelling, saying something degrading or negative." CNA3 also stated the incident that happened between Resident 77 using inappropriate language toward Resident 28 was considered verbal abuse. CNA 3 also stated that the incident should have been reported within two hours to CDPH, the ombudsman, and the police.

During an interview on 6/7/2024 at 3:26 PM with the Director of Nursing (DON), the DON stated that verbal abuse is when a person directly screams at another person by swearing and using foul language. The DON also stated that if a resident was offended by this type of behavior, then it was not acceptable and should be considered an allegation of abuse. The DON stated the allegation of abuse should have been reported by CNA 2 within two hours or earlier to the authorities and the facility's abuse coordinator. The DON further stated that if an allegation of abuse was not investigated, it could psychologically (affects the mind or relates to the emotional state of a person) harm the resident, could be detrimental (formal way of saying "harmful") to the resident's mental health and the incident could possibly happen again.

During a review of the facility's Policy and Procedure (P&P) titled, "Identifying Types of Abuse," revised March 2024, the P&P indicated, "Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance,

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regardless of age, ability to comprehend, or disability and Examples of mental and verbal abuse include, but are not limited to:
a. Harassing a resident;
b. Mocking, insulting, ridiculing;
c. Yelling or hovering over a resident, with the intent to intimidate."

During a review of the facility's P&P titled, "Abuse Investigation and Reporting," revised March 2024, the P&P indicated:
1. "All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:
a. The State licensing/certification agency responsible for surveying/licensing the facility;
b. The local/State Ombudsman;
c. The Resident's Representative (Sponsor) of Record;
d. Adult Protective Services (where state law provides jurisdiction in long-term care);
e. Law enforcement officials;
f. The resident's Attending Physician; and
2. An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:
- Two (2) hours if the alleged violation involves abuse of any kind."

During a review of the facility's policy and procedure (P&P) titled "Abuse Reporting" revised 4/2023, the P&P indicated that, "If you suspect an incident of abuse has occurred, you must report the event to the first three agencies listed below

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F 609	Continued From page 17 via telephone within two (2) hours of the suspected abuse incident. Follow the steps below to report: " Step 1 - Call California Department of Public Health (CDPH), Long term Care (LTC) Ombudsman, and Police Department (PD) within two hours of the alleged event."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Cross reference: F609 Based on interview and record review, the facility failed to investigate an allegation of verbal abuse (a range of words of behaviors used to manipulate, intimidate and maintain power and control over someone) for two (2) of 24 sampled residents (Residents 28 & 77) as indicated in the	F 610	**Corrective Action: F 610** On 6/07/24, Resident 28's care plan was updated to reflect the recent incident of alleged resident to resident verbal abuse. Beginning June 11th 2024, Resident 28 began to recieve bi-monthly sessions with facility contracted psychologist. On 5/29/24, Resident 77 was discharged home with their responsible party.	

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F 610	Continued From page 18 facility's abuse policy when Resident 77 used inappropriate verbal language with Resident 28. This failure had the potential to result in failing to protect Resident 28 and other residents from abuse. Findings: 1. During a review of Resident 28's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 12/24/2014 and readmitted 6/29/2017 with diagnoses of bilateral (both) primary osteoarthritis (degenerative joint disease in which the tissues in the joint break down over time) of the knee and hemiplegia (one sided muscle paralysis or weakness) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the right dominant side. During a review of Resident 28's History and Physical Examination (H&P), dated 4/1/2023, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 3/4/2024, the MDS indicated the resident had intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 28 was dependent (helper dopes all of the effort) for bed-to-chair transfers and needed substantial/maximal assistance (helper does more than half the effort) with dressing (how a resident puts on, fastens, and takes off all items of clothing). Resident 28 needed supervision or touching assistance (helper provides verbal cues/or touching/steadying and/or contact guard	F 610	**Other Residents Potentially Effected:** Between 6/07/24 - 7/07/24, Administrator verified that no other cases of alleged abuse of any kind went unreported or un-investigated. **Measures and Systemic Changes:** Administrator will attend resident council quarterly, to discuss importance of reporting abuse to facility staff immediately. Administrator will encourage residents to report any feelings or experiences of abuse to the administrator directly for swift reporting and investigation. On 6/27/2024, Administrator and DSD in-serviced all staff regarding abuse. Emphasis was placed on the different types of abuse, the investigation process for abuse, mandated reporter status, the consequences of abuse towards residents, the consequences of witholding information about abuse, and the consequences of not reporting cases of alleged abuse to the relevent agencies.	

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F 610	Continued From page 19 assistance as resident completes activity) with personal hygiene & needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. 2. During a review of Resident 77's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 4/5/2024 with diagnoses of atherosclerotic heart disease (involves plaque buildup in artery walls) and cerebral infarction. During a review of Resident 77's H&P, dated 4/25/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 77's, dated 4/12/2024, the MDS indicated the resident had intact cognitive skills for daily decision making. Resident 77 was dependent with transfers (how resident moves to and from bed, chair, wheelchair, standing position), lower body dressing and personal hygiene, and needed setup or clean-up assistance (helper set up or cleans up; resident completes activity) with eating. During a review of Resident 77's Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) Note dated 5/6/2024, the IDT Meeting Note indicated that when Certified Nursing Assistant 2 (CNA 2) was assisting Resident 28 to the shower, Resident 77 yelled at Resident 28 and used socially inappropriate verbal language towards her.	F 610	On 6/27/2024, Administrator attended CAHF webinar regarding "New Mandated Reporting Requirements in Long-Term Care Under AB-1417". On 6/27/2024, Administrator discussed with department heads that any findings of alleged abuse observed by department heads or their subordinates must be immediately reported to the administrator so that the reporting and investigation of abuse can begin immediately.	

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F 610	Continued From page 20 During a concurrent interview and record review on 6/6/2024 at 3:49 PM with Social Services Director (SSD), Resident 77's IDT Meeting Note, dated 5/6/2024, was reviewed. Resident 77's IDT Meeting Note addressed an incident that occurred when Resident 77 yelled at Resident 28 using socially inappropriate verbal language. SSD stated that the language Resident 77 used toward Resident 28 was considered verbal abuse. During an interview on 6/6/2024 at 4:00 PM with Resident 28, Resident 28 stated that on the morning of 5/8/24 Resident 77 used socially inappropriate verbal language towards her as CNA 2 was helping her to the shower. Resident 28 stated that the next day, she spoke with SSD and MDS Nurse (MDSN) about the incident and told them that no one is allowed to or has the right to speak to her like that and that. Resident 28 further stated that Resident 77 using inappropriate language towards her made her feel very angry. During an interview on 6/7/2024 at 2:40 PM with SSD, SSD stated that verbal abuse is when someone says something to someone that is offensive and unacceptable. SSD stated that what Resident 77 said to Resident 28 offended her and was unacceptable. SSD also stated that the Administrator (ADM) is the facility's abuse coordinator and that there was no documentation of the allegation being investigated. During an interview on 6/7/2024 at 3:18 PM with CNA 3, CNA 3 stated, "Verbal abuse is when bad words are used, yelling, saying something degrading or negative." CNA3 also stated the incident that happened between Resident 77 using inappropriate language toward Resident 28	F 610	**Performance Monitoring:** Beginning 6/27/24, The Administrator in cooperation with IDT team, DON, Activities Director and SSD will monitor weekly for cases of alleged abuse of any kind and discuss during the monthly QA meeting any discrepancies that are identified related to abuse investigation and reporting. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/27/24

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was considered verbal abuse.

During an interview on 6/7/2024 at 3:26 PM with the Director of Nursing (DON), the DON stated that verbal abuse is when a person directly screams at another person by swearing and using foul language. The DON also stated that if a resident was offended by this type of behavior, then it was not acceptable and should be considered an allegation of abuse. The DON further stated that if an allegation of abuse was not investigated, it could psychologically (affects the mind or relates to the emotional state of a person) harm the resident, could be detrimental (formal way of saying "harmful") to the resident's mental health and the incident could possibly happen again.

During a review of the facility's Policy and Procedure (P&P) titled, "Identifying Types of Abuse," revised March 2024, the P&P indicated, "Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability and Examples of mental and verbal abuse include, but are not limited to:
a. Harassing a resident;
b. Mocking, insulting, ridiculing;
c. Yelling or hovering over a resident, with the intent to intimidate."

During a review of the facility's P&P titled, "Abuse Investigation and Reporting," revised March 2024, the P&P indicated:
" All reports of resident abuse, neglect,

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F 610	Continued From page 22 exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source ("abuse") shall be thoroughly investigated by facility management. " If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657	**Corrective Action: F 657** From 6/07/24 to 6/21/24, Resident agreed to have showers with supervision as traditionally required in the SNF setting. On 6/21/24, MDS nurse conducted quarterly review with Resident 2 and during the meeting Resident 2 requested to shower alone but to have facility staff set-up shower equipment and cleaning products. On 6/21/24, after explaining the risks and benefits of showering alone to Resident 2, MDS nurse updated the resident's person-centered care plan to reflect Resident 2's preference for showering by themselves.	

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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 657	Continued From page 23 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise and update the care plan as indicated on the facility policy and procedure to address Resident 2's preference for activities of daily living (ADL) while in the shower. This deficient practice placed Resident 2 at risk of not having appropriate care and interventions during showering and potential to violate resident's rights to choose preferred care. Findings: A review of Resident 2's Admission Record indicated the resident was initially admitted to the facility on 9/15/2023 with diagnoses of paroxysmal (an attack or sudden increase or recurrence of symptoms) atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), and cerebral infarction (damage to the tissues in the brain due to a loss of oxygen in the area). A review of Resident 2's History and Physical Examination (H&P), dated 9/16/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 2's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 3/22/2024, indicated Resident 2 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 2 required supervision or touching	F 657	**Other Residents Potentially Effected:** Medical Records director verified that between 6/07/24 to 7/04/24 no other resident was affected by this deficient practice. **Measures and Systemic Changes:** On 6/11/2024, DSD in-serviced licensed nurses on importance of revising person-centered care plans within 48 hours of observed COC, behavioral change, or change of resident preference. IDT team will review person centered care plans during quarterly meetings with the residents to ensure any changes in resident preferences are documented and updated in the person-centered plan of care within 48 hours of observed change.	

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F 657	Continued From page 24 assistance with shower/bathe self, tub/shower transfer, lower body dressing, putting on/taking off footwear, walking 10 feet, and walking 50 feet with two turns. During an interview, on 6/4/2024, at 1:09 PM, Resident 2 stated she showers by herself without the assistance or supervision from the facility staff. During a concurrent interview and observation of Resident 6 on 6/6/2024, at 8:11 AM, Resident 2 was observed sitting on a chair in the hallway with a basin on her lap that contained several washcloths. Resident 2 stated she was going to take a shower. During an interview with Certified Nursing Assistant 4 (CNA 4) on 6/6/2024, at 8:25 AM, CNA 4 stated Resident 2 was inside the shower room. CNA 4 stated CNA 3 was assigned to Resident 2 but was not inside the shower to supervise and assist Resident 2. During a concurrent observation of Shower 1 and interview with CNA 3 on 6/6/2024, at 8:26 AM, CNA 3 was observed standing next to the Shower 1. CNA 3 stated Resident 2 likes to shower by herself. CNA 3 stated she waits outside to make sure Resident 2 was alright. During a follow up interview with CNA 3 on 6/6/2024, at 9:06 AM, CNA 3 stated she sets up the shower for Resident 2 on her shower days. CNA 3 stated Resident 3 refuses to have facility staff in the shower with her. CNA 3 stated she monitors Resident 2's needs by standing outside the door. CNA 3 stated she can hear Resident 2 call out her needs through the door. CNA 3 stated	F 657	**Performance Monitoring:** Beginning 6/25/24, The DON in cooperation with IDT team will monitor, as changes of condition occur, for timely updates to person-centered plans of care and discuss during the monthly QA meeting any discrepancies that are identified related to plans of care not being updated within at least 48 hours of a reported or observed change of condition, behavior, or preference. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/21/24

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Resident 2 informs her when she is done in the shower and CNA 3 helps dry up Resident 2.

During a concurrent record review of Resident 2's MDS, dated 3/22/2024, and interview MDS Nurse (MDSN) on 6/6/2024, at 9:51 AM, MDSN stated Resident 2 was assessed to require supervision/touching assistance in the shower/bathe and with tub/shower transfer. MDSN stated supervision means the CNA will be in the shower with Resident 2 to supervise and assist Resident 2 with her needs. MDSN stated facility staff should inform the charge nurse, document, and inform the physician if Resident 2 refused to be supervised in the bathroom. MDSN stated Resident 2's care plan should also be updated to inform facility staff of Resident 2's preference regarding her activities of daily living. MDSN stated licensed nurses and MDSN are responsible for updating and revising the resident's care plan. MDSN stated Resident 2's care plan did not indicate Resident 2's refusal to be supervised in the shower.

During an interview with the Director of Nursing (DON), on 6/7/2024, at 6:03 PM, the DON stated Resident 2's care plan for showering should have been revised to reflect Resident 2's refusal to be supervised in the shower. The DON stated it was important for Resident 2's care plan to be up to date for facility staff to know how to properly implement interventions regarding Resident's 2 refusal to be supervised in the shower.

A review of the facility's policy and procedure (P&P), titled, "Care Plans-Revising," revised on 6/7/2024, indicated the following:
" Person Centered Care Plans are revised

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F 657	Continued From page 26 based on clinical or behavioral changes observed by the facility staff. " Any member of staff is capable of reporting noticeable changes in a resident' behavior and is therefore able to document those findings and report these changes to the licensed nurse. " Not all the items listed in a resident's individualized plan of care need to be clinical in nature to be included into the individualized plan of care; resident preferences can be added to plan of care. " Individualized Plans of Care should be updated within 48 hours, or as needed, by the licensed nursing staff OR relevant member of the interdisciplinary team (IDT- a coordinated group of experts from different departments)	F 657		
F 686 SS=D	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 interview and record review, the facility failed to provide care services to prevent worsening and promote healing of pressure	F 686	**Corrective Action: F 686** On 6/07/24, Treatment Nurse ensured weight setting of Low Air Loss Mattress for Resident 26 was correct.	

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F 686	Continued From page 27 ulcer/injury (damaged skin caused by staying in one position for too long) for one of three sample residents (Resident 26) who was admitted in the facility with a UTD (unable to determine or unstageable pressure ulcer). The facility did not accurately monitor and set the correct settings of the low air loss mattress (LALM, is designed to prevent and to treat pressure sores, or pressure ulcers) according to Resident 26's weight. These deficient practices placed Resident 26 at risk of poor wound healing and deterioration of current pressure ulcers. Findings: A review of the admission record indicated Resident 26 was admitted to the facility on 4/3/2024, with diagnoses that included but not limited to encounter for palliative care (specialized medical care for people living with a serious illness), retention of urine (the inability to empty the urine from your bladder), and pressure ulcer of sacral region (an area of the skin that has been damaged as a result of constant pressure). During record review of Resident 26's Physicians Telephone Orders dated 4/3/24 at 5:39 PM, indicated, "LALM skin maintenance." A review of the Physician History and Physical dated 4/5/2024 indicated Resident 26 does not have the capacity to understand and make decisions. A review of the Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 4/10/2024, indicated Resident 26 was severely impaired in cognitive skills for daily	F 686	**Other Residents Potentially Effected:** From 6/07/24 to 7/07/24, DSD and Central Supply Director reviewed other residents utilizing Low Air Loss Mattresses to ensure proper weight setting is used as indicated by manufacturer's recommendations and found no other resident was effected by this deficient practice. **Measures and Systemic Changes:** Beginning 6/07/24, Licensed nurses will verify weight setting of low air loss mattresses on each shift and will consult with DON or treatment nurse regarding any discrepancies in the weight setting of a Low Air Loss Mattress. On 6/11/24, DSD in-serviced licensed nurses on how to properly set up Low Air Loss Mattresses. Emphasis was placed on following manufacturer's recommendations for use including setting the dial control to the weight in pounds of the resident. DSD emphasized that the weight setting must only be set to its maximum setting when facility staff clean and disinfect the Low Air Loss Mattresses and that cleaning of the mattress should only occur when a resident is not in their bed.	

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F 686	Continued From page 28 decision making, and needed total assistance from the staff for the activities of daily living such as eating, oral and toilet hygiene, shower, and dressing. During record review of Resident 26's Integumentary/Skin assessment dated 4/11/2024, indicated, "altered skin integrity related to disease progression, Stage IV pressure ulcer (full thickness skin loss with extensive destruction. Damage to muscle, bone or supporting structures such as tendons) to sacral (at the bottom of the spine and tail bone) area, multiple unstageable (UTD) sites to left 5th metatarsal (five long bones found in each foot), left lateral malleolus (bony part on the side of the ankle), right heel, left lateral mid foot. Multiple Deep Tissue Pressure Injury (DTPI, a serious form pf pressure injuries/ ulcer. Purple or maroon discoloration under the skin but with underlying soft tissue damage and can progress rapidly to extensive tissue damage) to 1st metatarsal (toe), right medial malleolus." During an observation on 6/4/2024 at 8:26 AM, Resident 26 was resting on LALM set to maximum of 400 pounds (lbs., unit of measurement for weight). During a concurrent observation in Resident 26' room and interview with Certified Nurse Assistant 2 (CNA2) on 6/5/2024 at 8:43 AM, CNA2 stated Resident 26's LALM was set to 400 lbs. the maximum in the settings. CNA2 stated, "the company that brings the bed is the one that programs the settings, we only report if the mattress deflates then we call the charge nurse." During an interview and record review with LVN2 on 6/5/2024 at 9:38 AM, LVN2 stated "I was not	F 686	**Performance Monitoring:** Beginning 6/25/24, The DON in cooperation with Treatment Nurse and Central Supply director will visually inspect daily for proper weight setting of Low Air Loss Mattresses and discuss during the monthly QA meeting any discrepancies that are identified related to weight set-up of Low Air Loss Mattresses. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/11/24

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here when they brought the mattress, she (Resident 26) came in with a wound. There is an order for a LALM, but the settings would not be on the order."

During a concurrent interview and record review of Resident 26 admission orders with Licensed Vocational Nurse (LVN2) on 6/5/2024 at 9:41 AM, LVN2 stated, "the order for LALM should be upon admission. She is a wound patient so she should have an order for the LALM." LVN2 stated the LALM is important for Resident 26's for prevention of further ulcers and because Resident 26 is bedbound and requires full assistance. LVN2 stated, "we do not touch the settings on the bed at all, we just make sure it's turned on to the green light and inflated."

During an interview with Medical Director on 6/7/2024 at 12:30 PM, Medical Director stated, there was an order for Resident 26's LALM but it did not include the indication and it was needed either for weight or comfort. Medical Director stated, "I just give the order, but the wound care nurse is the one that follows with the settings (LALM settings)."

During an interview with the Director of Nursing (DON) on 6/7/2024, the DON stated, the setting for a low air loss mattress should be according to the resident's weight.

During an interview and record review with Treatment Nurse on 6/7/2024 Treatment Nurse stated, "I do not check the settings for the LALM, during the initial assessment if there is an order for settings then it will be in the treatment book. Treatment Nurse could not find an order for LALM settings in the treatment book.

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During an interview with the DME Vendor Trainer Tech on 6/7/2024 at 1:33 PM, Trainer Tech stated, "when the bed gets delivered, we test it out before setting it up as firm as possible to make sure there are no holes on the mattress. We set it as firm as possible which is 400 lbs. making it very firm, but the bed is supposed to be set determined to patient's (resident's) weight. Technically it is the patient's weight. The tech checks the form for the patient's weight or grabs the nurse and asks them for the resident's weight that way he can set it accordingly."

During record review of Resident 26's weight chart on 6/7/2024 at 1:40 PM, it indicated, as of 6/6/2024 Resident 26' weight was 121 lbs.

During a concurrent observation of Resident 26' LALM setting and interview with the DON on 6/7/2024 at 1:42 PM, the DON confirmed the settings for the LALM were set at 400 lbs. The DON also stated it was set to alternating and normal pressure, but the settings should be according to Resident 26's weight which is 121 lbs.

A review of the Brand 1 Alternating Pressure Low Air Loss Mattress Replacement System Operators Manual revised 3/22/2021 indicated, "Determine the patient's weight and set the control knob to that weight setting on the control unit."

A review of the facility's Policy titled "Prevention of Pressure Injuries", revised 3/2024 indicated, "The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific

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F 686	Continued From page 31 risk factors." The policy also indicated to select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate services to prevent complications for one of three sampled residents (Resident 46) who has G-tube (GT, is a tube inserted through the belly that brings nutrition directly to the stomach).observe infection control measures for Resident 46:	F 693	**Corrective Action: F 693** On 6/04/24, LVN labeled Resident 46's G-tube feeding bag with the name of resident and staff initials as well as the date and time the formula was hung. On 6/07/24, licensed nurse changed Resident 46's Lopez valve to a new clean Lopez valve. Upon changing, licensed nurse capped Lopez valve to ensure no infectious materials or agents can enter the valve.	

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F 693	Continued From page 32 1. Failed to ensure Resident 46's Lopez valve (a device allowing movement in one direction only to use for the administration of medication without having to disconnect a suction or feeding line and reduces exposure to potentially infectious bodily fluids or gastric secretions) was covered at GT site. 2. Failed to ensure Resident 46's enteral tube feeding (delivery of liquid nutrients through a tube directly into the gastrointestinal tract) equipment were cleaned and did not have an accumulation of dried brown stains. 3. Ensure Resident 46's enteral tube feeding was labeled, with date and time formula was prepared as per Facility's Policies and Procedures (P&Ps). These deficient practices had the potential to transmit infectious microorganisms (bacteria, viruses, parasites, or fungi) and increase the risk of infection and contamination of the resident's care equipment and placed Resident 46 at risk for infection. Findings: A review of Resident 46's Face Sheet indicated Resident 46 was originally admitted on 5/17/2021 and readmitted on 5/4/2024, with diagnoses that included but not limited to unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), encounter for attention to gastrostomy (artificial opening to stomach), contracture, left hand (one or more fingers to bend toward the palm of the hand. The affected fingers can't straighten completely), and primary generalized osteoarthritis (a degenerative joint disease-causing pain, stiffness, swelling, and decreased	F 693	**Other Residents Potentially Effected:** From 6/07/24 to 7/07/24 DSD verified no other residents recieving g-tube feeding were found to have unlabelled feeding bags or soiled or uncapped Lopez valves. **Measures and Systemic Changes:** Beginning 6/11/24, Licensed nurses on each shift will verify that G-tube feeding bags are labelled and that soiled or uncapped Lopez valves are immediately replaced to ensure health and safety of the residents is maintained. On 6/11/24, DSD in-serviced licensed nurses regarding facility P&P "Enteral Tube Feeding via Continuous Pump" with emphasis on proper labeling of forumula before hanging and subsequent feeding.	

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F 693	Continued From page 33 mobility). A review of Resident 46's Care Plan dated 5/5/2024 indicated Resident 46 needs GT feeding due to impaired swallowing. Resident 46's goals were Resident 46 will have no infection at GT site daily for 3 months. A review of the Physician History and Physical dated 5/7/2024 indicated Resident 46 does not have the capacity to understand and make decisions. A review of the Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 5/29/2024, indicated Resident 46 was severely impaired in cognitive skills for daily decision making, and needed total assistance from the staff for the activities of daily living such as eating, oral and toilet hygiene, shower, and dressing. During an observation on 6/4/2024 at 9:16 AM, Resident 46 was resting in bed with GT feed running. There was no name, date, or time labeled on the GT feeding bag of when the formula was prepared or hung. During an observation and interview with Licensed Vocational Nurse (LVN) 3 on 6/6/2024 at 7:57 AM, LVN3 confirmed Resident 46's Lopez valve was not capped, was not clean and had accumulation of dried brown stains. LVN3 stated, "the Lopez valve should be covered, and it should not be dirty. If it is not covered and it is dirty, it has the potential to cause the resident infection and bacteria can go in there causing the resident harm."	F 693	On 6/11/24, DSD in-serviced licensed nurses on the importance of Lopez valve being capped at all times. DSD emphasized that the Lopez valve must be replaced when visibly soled or when a missing valve cap is observed. On 6/11/24, DSD emphasized to the licensed nurses that Central Supply Director will provide new Lopez valve if required. DSD additionally emphasized that clean unused Lopez valves are available in the nursing supply rooms on both floors for quick access by facility nursing staff. **Performance Monitoring:** Beginning 6/25/24, The DON in cooperation with Treatment Nurse, DSD, and Central Supply Director will visually inspect daily for proper labelling of G-tube feeding bags and cleanliness of Lopez valves and discuss during the monthly QA meeting any discrepancies that are identified related to unlabelled G-tube feeding bags or uncapped Lopez valves. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/11/24

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During an observation and interview with the Director of Nursing (DON) on 06/07/2024 at 9:00 AM, the DON confirmed the Lopez valve was not covered and was dirty. The DON stated, "the Lopez Valve for the GT feed should have a cap for infection control, it is important to have a cap to prevent any type of possible infection to the resident and it should also be clean. The DON also stated, for the Lopez valve, the nurse should either use a cap or change the whole part. The nurses know they can go to the supply room and grab a new one."

A review of the Facility's P&Ps titled "Enteral Tube Feeding via continuous Pump" revised 3/2024 indicated, "The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings." The P&P also indicated, on the formula label document initials, date, and time the formula was hung/administered and initial that the label was checked against the order.

A review of the Facility's P&Ps titled "Infection Prevention and Control Program" revised 3/2024 indicated, "An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." The P&P also indicated:
a. Important facets of infection prevention include:
(1) Identifying possible infections or potential complication of existing infections
(2) Instituting measures to avoid complications or dissemination
(3) educating staff and ensuring that they adhere to proper techniques and procedures

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F 695 F 695 SS=E	Continued From page 35 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: Based on observation, interview, and record review, the facility failed to provide oxygen therapy (treatment that provides supplemental, or extra oxygen) and necessary respiratory care services for two (2) of three (3) sampled residents (Resident 92 and 22) in accordance with the facility's policy and care plan by failing to: 1. Administer oxygen at 2 liters per minute (lpm, unit of measurement) via nasal cannula (device used to deliver supplemental oxygen placed directly on a resident's nostrils) to Resident 92 as indicated on the physician's order. This deficient practice had the potential to result in respiratory distress and/or other complications to Resident 92. 2. Keep Residents 22's oxygen nasal cannula (NC, a device that delivers extra oxygen through a tube into your nose) tubing sprawled out on and touching the floor. This deficient practice had the potential to result in infection to Resident 22. Findings: 1. A review of Resident 92 's Admission Record	F 695 F 695	**Corrective Action: F 695** On 6/04/24, LVN replaced nasal cannula of Resident 22 so that it was no longer touching the floor of the resident room. On 6/05/24, licensed nurse adjusted oxygen setting to the appropriate 2 lpm for Resident 92, in accordance with the physician's order. **Other Residents Potentially Effected:** From 6/07/24 to 7/07/24, DSD verified that no other residents recieving supplemental oxygen were observed to have incorrect setting or cannula tubing touching the floor.	

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F 695	Continued From page 36 indicated the resident was admitted to the facility on 5/10/2024 with diagnoses which included pulmonary hypertension (a serious condition where there is abnormally high pressure in the blood vessels between the lungs and the heart), chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with hypoxia (lack of oxygen in the body tissues) A review of Resident 92's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 11/20/23, indicated Resident 92 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 92 needed supervision or touching assistance (helper provides verbal cues/touching/steady/contact guard assistance as resident completes activity) with eating, oral hygiene, lower and upper body dressing. Resident 92 needed partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides lee than half the effort) toileting hygiene, sit to lying, and putting on/taking off footwear. A review of Resident 92's Care Plan (CP) for Ineffective airway clearance, dated 5/18/2024, indicated Resident 92 has a potential for shortness of breath associated with COPD exacerbation. The staff intervention included was to administer oxygen as needed. A review of Resident 92's Physician's Order, dated 5/10/2024, indicated oxygen at 2 lpm per nasal cannula continuously for shortness of breath.	F 695	**Measures and Systemic Changes:** Beginning 6/11/24, Licensed personnel will verify oxygen setting on each shift in accordance with physician's order. Licensed personnel and/or treatment nurse will monitor for correct placement of oxygen tubing daily. On 6/11/24, DSD in-serviced licensed nurses on importance of oxygen setting following the physician's exactly as written. Additionally, emphasis was placed on nasal cannula tubing being clean at all times and not in contact with potentially unclean surfaces such as the floor of the resident room. **Performance Monitoring:** Beginning 6/25/24, The DON in cooperation with RN Supervisor, DSD, and licensed nurses will visually inspect daily for proper oxygen setting for residents recieving supplemental oxygen and cleanliness of cannula tubing and discuss during the monthly QA meeting any discrepancies that are identified related to unclean oxygen tubing or improper oxygen flow rate. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/11/24

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During a concurrent observation in Resident 92's room on 6/4/2024 at 9:18 AM, Resident 92 was observed on oxygen at 2.5 lpm via nasal cannula.

During an observation in Resident 92's room on 6/5/2024 at 7:04 AM, Resident 92 was sleeping and observed with oxygen at 2.5 lpm via nasal cannula.

During a concurrent record review of Resident 92's physician's order and interview with the Licensed Vocational Nurse 1 (LVN 1) on 6/5/2024 at 2:54 PM, LVN 1 stated Resident 92's Physician's order indicated oxygen at 2 lpm via nasal cannula continuously for shortness of breath.

During a concurrent observation in Resident 92's room and interview with the LVN 1 on 6/5/2024 at 2:56 PM, Resident 92 was laying on his bed with his oxygen between 2.5-3 lpm via NC. LVN 1 verified Resident 92's oxygen machine was set between 2.5-3 lpm. LVN 1 stated "The oxygen level was set incorrectly. The licensed staff should always check the oxygen every time we come inside the resident's room. If the oxygen setting is lower than the physician's order, the resident will not get enough oxygen. if the oxygen setting is higher, the resident will retain carbon dioxide and will not get enough oxygen in his body."

During a concurrent record review of CP for Ineffective airway clearance, dated 5/18/2024, and interview with the Director of Nursing (DON) on 6/7/2024 at 4:34 PM, the DON stated, "The care plan indicated oxygen as needed, it should have been added continuously. We have to revise the care plan, or we are not able to

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implement the correct intervention that we have to give to the Resident."

During a concurrent observation and interview with the DON on 6/7/2024 at 5:59 PM, the DON stated, "Oxygen was set incorrectly." The DON stated Resident 92 has COPD and if the oxygen setting was wrong, the resident might be receiving lesser or more oxygen that was ordered. The DON stated, "It could have a negative effect on the Resident."

A review of facility's policy and procedure (P&P) titled, "Oxygen Administration," dated 3/2024, indicated the purpose of the procedure was to provide guidelines for safe oxygen administration. P&P indicated "To verify that there is a physician's order for this procedure, adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered."

2. A review of Resident 22's Admission Record indicated the resident was initially admitted to the facility on 3/23/2019 and readmitted 8/9/2023 with diagnoses of Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements such as shaking, stiffness and difficulty with balance and coordination) and epilepsy (a disorder of the brain characterized by repeated seizures [a sudden alteration of behavior due to a temporary change in the electrical functioning of the brain]).

A review of Resident 22's History and Physical Examination (H&P), dated 8/10/2023, indicated

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the resident does not have the capacity to understand and make decisions.

A review of Resident 22's MDS, dated 4/22/2024, MDS indicated the resident was severely impaired (never/rarely made decision) with cognitive skills for daily decision making. Resident 22 had minimal difficulty (difficulty in some environments [for example when person speaks softly or setting is noisy]) with hearing and had no speech (absence of spoken words). Resident 22 was also dependent (helper does all the effort) with tub/shower transfers, bed-to-chair transfers, rolling left and right (ability to roll from lying on back to the left and right side and return to lying on back on the bed), dressing (how resident puts on, fastens and takes off all items of clothing), personal hygiene and eating.

During a review of Resident 22's Physician's Order, dated 8/9/2023, the Physician's Order indicated oxygen at 2 lpm via (by) nasal cannula as needed (PRN) for shortness of breath (SOB).

During an observation on 6/4/2024 at 8:57 AM in Resident 22's room, Resident 22's oxygen tubing was observed on the floor.

During a concurrent observation and interview on 6/4/2024 at 9:01 AM with Certified Nursing Assistant 3 (CNA 3) in Resident 22's room, Resident 22's oxygen NC tubing was observed on the floor. CNA 3 stated that the resident's oxygen NC tubing should not be on the floor.

During an interview on 6/6/2024 at 2:57 PM with Infection Preventionist (IP), IP stated the residents' oxygen tubing is changed weekly by central supply and that the NC tubing should not

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F 695	Continued From page 40 be touching the floor because residents could get an infection and could potentially get something from the floor onto the tubing and into their nose which could result in a respiratory infection. A review of the facility's P&P titled, "Oxygen Administration," revised June 2024, indicated, "If tubing is visibly soiled or touching the floor or any other potentially unclean surface, tubing shall be changed by a licensed nurse."	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a one (1) of 1 sampled resident (Resident 33) who was receiving dialysis (process of removing waste products and excess fluid from the body) received care and treatment in accordance with the resident's care plan by failing to ensure a dialysis emergency kit was placed at bedside. This deficient practice had the potential for Residents 33 to be at risk for complications such as bleeding and potential for delay in provision of dialysis care and treatment in case of emergencies. Findings:	F 698	**Corrective Action: F 698** On 6/05/24, LVN placed emergency dialysis kit at bedside for Resident 33. **Other Residents Potentially Effected:** From 6/05/24 to 7/07/24, RN Supervisor verified no other residents recieving dialysis services experienced missing their associated emergency dialysis kit at their bedside.	

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F 698	Continued From page 41 A review of Resident 33's Admission Record indicated the resident was initially admitted to the facility on 12/24/2015 and readmitted on 4/24/2024 with diagnosis that included end stage renal disease (ESRD, stage when the kidneys can no longer support the body's needs of removing waste and excess water from the body), dependence on renal dialysis, and hypertension (high blood pressure). A review of Resident 33's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 5/17/2024, indicated Resident 33 has intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 33 needed supervision or touching assistance (helper provides verbal cues/touching/steady/contact guard assistance as resident completes activity) with toileting hygiene, shower/bathe self, lower and upper body dressing and putting on/taking off footwear and personal hygiene. A review of Resident 33's care plan for hemodialysis (a machine filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately), revised on 4/25/2024, indicated staff interventions included to have a dialysis kit readily available at bedside when unusual bleeding occurs at access site. During an observation inside Resident 33's room on 6/4/2024 at 8:28 AM, there was no emergency dialysis kit on Resident 33's bedside.	F 698	**Measures and Systemic Changes:** Beginning 6/12/24, Licensed nurses on each shift will ensure that those residents recieving dialysis services have an emergency dialysis kit made available at the bedside before they return from their dialysis treatment appointments. Treatment Nurse will ensure that if an emergency dialysis kit is used or unable to be found, it will be immediately be replaced with a new emergency dialysis kit. On 6/12/24, DSD in-serviced licensed nurses on importance of emergency dialysis kit being available at the resident's bedside to ensure materials are available if the resident experiences unusual bleeding at their dialysis access site.	

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F 698	Continued From page 42 During a concurrent observation in Resident 33's room and interview with Licensed Vocational Nurse 1 (LVN 1) on 6/4/2024 at 12:55 PM, LVN 1 stated Resident 33 did not have an emergency dialysis kit at bedside earlier. During a concurrent review of the "Dialysis Care" Policy and interview with the Director of Nursing (DON) on 6/6/2024 at 2:35 PM, the DON stated, "Emergency dialysis kit should be on Resident 33's bedside so we can use it in case of emergency to stop the bleeding on the dialysis access. The emergency dialysis kit should always be on the Resident's bedside, and it should be included in the dialysis policy because it is part of the nursing measures just in case the resident had an emergency incident like bleeding on the dialysis site." A review of the facility's Policy and Procedure titled, "Dialysis Care," dated 8/4/2007, indicated facility shall ensure provision of standards if care for residents on Renal Dialysis, including but not limited to monitoring and assessment of resident every shift for the following potential for bleeding, infection, edema and/or dehydration.	F 698	**Performance Monitoring:** Beginning 6/25/24, The DON in cooperation with RN Supervisor, DSD, and treatment nurse will visually inspect daily for proper placement of emergency dialysis kits at the bedside for residents recieving dialysis services and discuss during the monthly QA meeting any discrepancies that are identified related to misplaced emergency dialysis kits. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/12/24
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756	**Corrective Action: F 756** On 6/10/24, DSD and RN Supervisor reviewed MRR for May 2024 and no recommendations were listed for Resident 15 on the pharmacy vendor's MRR report.	

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F 756	Continued From page 43 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy on Medication Regimen Review (MRR, a monthly thorough evaluation by the consulting pharmacist of a resident's medication regimen, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with	F 756	On 6/10/24, RN supervisor reviewed MRR for Resident 40 and implemented changes identified by pharmacy vendor for May 2024. **Other Residents Potentially Effected:** Upon review of MRR May 2024 on 6/10/24, RN Supervisor, DON, and DSD verified that no other residents were found to be affected by this deficient practice. **Measures and Systemic Changes:** Beginning 6/10/24, DON or designee will ensure MRR is recieved in a timely manner each month by pharmacy vendor. Beginning 6/10/24, DON or designee will ensure that monthly MRR recommendations are implemented immediately after receipt of MRR report for a given month. On 6/10/24, DSD in-serviced licensed nurses on importance of implementing MRR recommendations immediately after receipt of the monthly MRR report.	

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F 756	Continued From page 44 medication) for two of five sampled residents (Residents 15 and 40) by failing to: 1. Conduct an MRR for Resident 15 for May 2024 2. Act upon the pharmacy recommendations for Resident 40's MRR for May 2024 This deficient practice had the potential to result in adverse medication outcome for potential unnecessary medications to Residents 15 and 40. Findings: 1. A review of Resident 15's Admission Record indicated the resident was admitted to the facility on 2/16/2024, with diagnoses that included chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and pleural effusion (abnormal fluid accumulation within the thin cavity between the pleural layers surrounding the lungs). A review of the Minimum Data Set (MDS- a comprehensive assessment and screening tool), dated 5/24/2024, indicated Resident 15 had moderately impaired cognitive (the process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. Resident 15 required extensive assistance with two or more persons physical assist for toilet use and personal hygiene. The MDS also indicated Resident 15 was receiving antipsychotic medications. During a concurrent interview and record review on 6/7/24 at 9:21 A.M., with Director of Nursing (DON), the DON confirmed there was no Medication Regiment Review (MRR) for the month of May 2024 for Resident 15. The DON	F 756	**Performance Monitoring:** Beginning 6/25/24, The DON in cooperation with RN Supervisor and Medical Records department will monitor monthly via audits for proper implementation of MRR recommendations for identified residents upon receipt of the monthly report and discuss during the monthly QA meeting any discrepancies that are identified related to recommendations in the MRR monthly report not being implemented. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/10/24

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F 756	Continued From page 45 stated this was important to prevent the use of unnecessary medications. 2. A review of Resident 40's Admission Record indicated the resident was admitted to the facility 4/11/2018 and readmitted on 4/26/24 with diagnosis that included cardiomegaly (various conditions leading to enlargement of the heart). A review of Resident 40's MDS, dated 5/3/2024, indicated the resident was moderately impaired with cognitive skills for daily decision making. The MDS indicated Resident 40 was independent with walking, eating, and oral hygiene. During an interview on 6/7/24 at 9:21 AM. with the DON, the DON stated she had just printed out the May 2024 MRR and will work on the MRR for Resident 40. The DON stated each resident in the facility should have their medications reviewed monthly by the consultant pharmacist to prevent the use of unnecessary medications. A review of the facility's Policy and Procedure titled, "Medication Regimen Reviews," updated in October 2015, indicated the consultant pharmacist reviews the medication regimen of each resident at least monthly.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761	**Corrective Action: F 761** On 6/06/24, DSD clarified order for Resident 19's medication route of administration against the physician's order.	

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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 761	Continued From page 46 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services by failing to properly label the medications of one (1) of 24 sampled residents (Resident 19) as indicated on the facility policy. This deficient practice had the potential for adverse reaction if these improperly labeled medications were administered to Resident 19 in the wrong route. Findings: A review of Resident 19's Admission Record indicated the resident was admitted to the facility on 8/2/2022 and re-admitted on 4/17/2023. Resident 57's diagnoses included diabetes mellitus (DM, is a metabolic disease, involving	F 761	On 6/06/24, DSD confirmed that Resident 19's medication was to be administered orally and D/C'd the previous order for the medication to be given via G-tube. On 6/06/24, DSD faxed current order for oral route medication to pharmacy vendor for delivery of appropriately labeled medication bubble pack. **Other Residents Potentially Effected:** On 7/07/24, Nursing Consultant verified upon review of recaps for June 2024, that no other residents were found to be affected by the deficient practice.	

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F 761	Continued From page 47 inappropriately elevated blood glucose levels), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). A review of Resident 19's history and physical dated 5/11/2024, indicated Resident 19 has the capacity to understand and make decisions. A review of Resident 19's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 5/7/2024, indicated Resident 19 has intact cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 19 needs supervision or touching assistance (helper provides verbal cues/touching/steady/contact guard assistance as resident completes activity) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. A review of Resident 19's Nurses' Progress notes dated 4/17/2023 at 3:15 PM, Resident 19 was re-admitted from the hospital with diagnosis of status post gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) removal. During a concurrent interview with Licensed Vocational Nurse 4 (LVN 4) and record review of Resident 19's lisinopril (medication to treat high blood pressure) bubble pack (medication packaging in which each tablet is sealed between a cardboard backing and a clear plastic over) on 6/6/2024, at 9:36 AM, stated, LVN 4 stated, "The label on the bubble pack was wrong. The doctor's order has changed, and we have the round sticker (sig change refer to chart date) for the medication administration." LVN 4 stated, it was	F 761	**Measures and Systemic Changes:** Beginninig 6/12/24, Licensed nurses while conducting med-pass, will review each medication for accurate labeling against the current physician's orders for all their assigned residents before giving a medication to their assigned residents. Beginning 6/12/24, Licensed nurses will report immediately any identified discrepancies related to medication labeling to the pharmacy vendor for timely correction by the pharmacy vendor. On 6/12/24, DSD in-serviced licensed nurses on the importance of accurate drug labeling and explained that facility nurses must report to the pharmacy any changes to medication orders immediately after any change is identified.	

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F 761	Continued From page 48 wrong because the bubble pack indicated to be given via G- Tube but Resident 19 did not have G- Tube anymore. During an interview with the Pharmacist (PHR) on 6/6/2024 at 10:40 AM, PHR stated, "The label on the bubble pack for lisinopril is via G-tube route and it is not the correct route because the direction has changed and now, the staff in the facility needs to send the new order for this request. But a request did not come with any modification or adjustment. We are not aware of any modification." During a concurrent observation and interview with the Registered Nurse Supervisor 1 (RNS 1) on 6/6/2024 at 10:44 PM, RNS 1 stated, "The bubble pack label was incorrect because Resident 19 was receiving oral medications. The staff who received the new order from the doctor should have faxed the updated order (to give oral and not via G- Tube) to the pharmacy." During a concurrent interview with the Director of Staff Development (DSD) and record review on 6/6/2024 at 2:45 PM, DSD stated, the label on the lisinopril bubble pack was wrong because it did not indicate to give the medication by mouth. The DSD also stated the staff who received the physician's order to give the lisinopril by mouth should have clarified with the doctor or pharmacist and should have faxed the new order to the pharmacy to correct and update Resident 19's order. DSD stated, it is important to send the updated order to the pharmacy, to clarify the order, and to provide correct label and direction for Resident 19's medication to avoid medication error (any preventable event that may cause or lead to inappropriate medication use and resident	F 761	**Performance Monitoring:** Beginning 7/01/24, The DON in cooperation with RN Supervisor and pharmacy consultant will conduct monthly audits for proper labeling and storage of medications and discuss during the monthly QA meeting any discrepancies that are identified related to improper medication storage or labeling. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/12/24

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F 761	Continued From page 49 harm). During a concurrent observation and interview with the Director of Nursing (DON) on 6/7/2024 at 4:45 PM, the DON stated, the medication label for Resident 19's lisinopril in the bubble pack was incorrect. The DON also stated, the pharmacy did not receive the new order and the staff did not communicate to the pharmacy. The DON also stated, the label on Resident 19's lisinopril bubble pack was wrong because it indicated to give the medication via G-tube, the physician order was by mouth (PO). The DON further stated, if medication has the wrong label, the facility must call pharmacy because they (pharmacy) need to change the label then send the medication with the correct label. A review of the facility's policy and procedure titled, "Storage of Medication," dated 03/2024, indicated drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before being stored.	F 761		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of two outside garbage dumpsters' lids were fully closed per facility policy and procedure (P&P). This failure had the potential to attract pests and insects to the facility and can place its resident's	F 814	**Corrective Action: F 814** On 6/07/24, Maintenance Supervisor closed lids of both facility dumpsters. On 6/10/24, Administrator placed signage on both dumpsters stating that the dumpster lids must be closed at all times. Signage is written in both English and Spanish to accomodate bilingual staff.	

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F 814	Continued From page 50 health at risk for potential infections. Findings: During an observation on 6/4/2024 at 2:39 PM in the facility's parking lot, one of the dumpster's lids was wide open and not closed properly. During an observation on 6/5/2024 at 7:12 AM, in the facility's parking lot, both dumpster's lids was open and not closed properly because of they are overflowing with trash bags. During an observation on 6/6/2024 at 7:15 AM, in the facility's parking lot, one of the dumpster's lids was wide open and not closed. During a concurrent observation in the facility's parking lot and interview on 6/6/2024 at 12:05 PM with the Dietary Supervisor (DS), DS stated the dumpsters lids are supposed to be closed. DS stated that it is the infection control issue, flies will be everywhere if the lids of the dumpster were left open, and all the departments will be responsible for the trashes. During a review of the facility's P&P titled, "Waste Disposal" revised in March 2024, the policy and procedure indicated: - All infectious and regulated waste shall be handled and disposed of in a safe and appropriate manner. - All infectious and regulated waste destined for disposal shall be placed in closable leak-proof containers.	F 814	**Other Residents Potentially Effected:** From 6/07/24 to 7/07/24, Maintenance Supervisor verified that no residents were effected by the deficient practice. **Measures and Systemic Changes:** Beginning 6/10/24, Maintenance Supervisor, Dietary Supervisor and subordinate staff, Housekeeping Supervisor and subordinate staff will verify daily that both dumpster lids are closed immediately after deposit of refuse into the containers. On 6/10/24, Administrator in-serviced housekeeping staff, maintenance staff, and kitchen staff on importance of closing the dumpster lids immediately after disposal of refuse. Emphasis was placed on reduction of access to dumpster waste by flying insects or crawling pests such as ants, roaches, and rats. **Performance Monitoring:** Beginning 6/25/24, The Administrator in cooperation with Maintenance Supervisor will visually inspect daily for proper closure of dumpster lids and discuss during the monthly QA meeting any discrepancies that are identified related to the facility's dumpsters. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/10/24
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 51 §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: §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 §483.70(e) 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,	F 880	**Corrective Action: F 880** On 6/06/24, Administrator revised facility's Water Management Program to Reduce Growth and Spread of Legionella. Documents for the Legionella Water Management Program are maintained in a binder located in the Administrator's office. Program team includes the following individuals: Administrator, Infection Preventionist, Director of Maintenance, Director of Dietary Services, and Director of Housekeeping and Laundry. Water Management program binder includes a Legionella Risk Assessment based on facility's water distribution system, a building description incluiding lot size and square footage of grounds, diagram of areas where Legionella could potentially grow and spread, and a diagram for how to monitor control measures in the facility water distribution system. On 7/02/24, Administrator contacted local lab capable of performing water sample analysis for Legionella. On 7/02/24, water sampling kits were ordered by Administrator.	

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F 880	Continued From page 52 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 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 observe infection control measures as indicated on the facility policy when facility failed to establish and maintain an effective water management program to prevent the development and transmission of Legionnaire's disease (LD, a serious and often deadly form of lung infection [pneumonia], acquired by breathing in water droplets caused by the bacteria, legionella [the bacteria that causes LD]).	F 880	Based on water testing results, facility will implement changes such as increased disinfectant at relevant control points or increasing water temperature at the facility's water heater system. **Other Residents Potentially Effected:** From 6/07/24 to 7/07/24, DON verified that no residents were effected by the deficient practice.	

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F 880	Continued From page 53 This deficient practice placed the residents in the facility at risk for developing severe respiratory infection (pneumonia). Findings: During an interview with the Maintenance Supervisor (MS) on 6/6/2024, at 9:59 AM, MS stated, "We do not have a particular treatment for Legionella (a genus of pathogenic gram-negative bacteria that includes the species L. pneumophila, causing legionellosis [all illnesses caused by Legionella] including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) or water pathogens. We do not treat the water coming from outside the facility. We do not have binder for water management treatment." During an interview with MS on 6/6/2024, at 10:29 AM, MS stated, "We have a company doing the treatment for the water management. I have not seen them come in the facility to do the testing or monitoring. Nobody came in yet since 2018." During an interview with the MS on 6/6/2024, at 11:04 AM, MS stated, "We do not have any water treatment this year (2024). Water management is important to make sure we're protecting the residents' health and prevention of any infection." During a concurrent interview with the Administrator (ADM) and record review on 6/6/2024, at 12:38 PM, Hot Water Monitoring Log dated May 2024 from the Kitchen and Laundry were reviewed. ADM stated, "On 3/12/2019 the facility only had Legionella program review that year and nothing after that year. We only have	F 880	**Measures and Systemic Changes:** Beginning 7/02/24, Maintenance Supervisor will sample water at various control points and send water samples to local lab for testing each quarter. Beginning 7/02/24, Maintenance Supervisor will adjust control measures based on lab testing of water samples or lab confirmed diagnosis of legionella in a resident or member of staff. **Performance Monitoring:** Beginning 7/02/24, The Administrator in cooperation with Maintenance Supervisor and Water Management Program Team will monitor monthly for proper implementation of Water Management Program for Reduction in Growth and Spread of Legionella and discuss during the monthly QA meeting any discrepancies that are identified related to the facility's water management program. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	7/02/24

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F 880	Continued From page 54	F 880		

hot water temperature log from the kitchen and laundry where hot water temperatures were recorded daily. We do not have any monitoring, testing, or analyzing of water samples done in the facility."

During an interview with the Director of Nursing (DON) on 6/7/2024, at 4:43 PM, the DON stated, "Water management is important because they also have bacteria, and it can be delivered to the residents in the facility, and we can all get sick."

A review of the facility's Policy and Procedure titled, "Legionella Water Management Program," revised 6/7/2024, indicated the water management program used by the facility is based on the Centers for Disease Control and Prevention (CDC) and American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) recommendations for developing a Legionella water management program. The water management program included the following elements:
5.d. The identification of situations that can lead to Legionella growth such as construction; water main breaks; changes in municipal water quality; the presence of biofilm, scale, or sediment; water temperature fluctuations; water pressure changes; water stagnation; and inadequate disinfection.
e. Specific measures used to control the introduction and/or spread of legionella (e.g. temperature, disinfectants);
f. The control limits or parameters that are acceptable and that are monitored;
g. A diagram of where control measures are applied;
h. A system to monitor control limits and the effectiveness of control measures;

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i. A plan for when control limits are not met and/or control measures are not effective; and
j. Documentation of the program.
6. The water management program will be reviewed at least once a year, or sooner if the control limits are consistently not met.

A review of the CDC's toolkit titled, "Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings," dated 6/24/2021, indicated control measures and limits should be established for each control point. You will need to monitor to ensure your control measures are performing as designed. Control limits, in which a chemical or physical parameter must be maintained, should include a minimum and a maximum value. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: Water quality should be measured throughout the system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring. Water heaters should be maintained at appropriate temperatures. Decorative fountains should be kept free of debris and visible biofilm. Disinfectant and other chemical levels in cooling towers and hot tubs should be continuously maintained and regularly monitored. Surfaces with any visible biofilm (i.e., slime) should be cleaned.

A review of ASHRAE Addendum to ASHRAE Standard 188-2015 (defines types of buildings and devices that need a water management program) titled, "Legionellosis: Risk Management for Building Water Systems," dated 6/23/2018, indicated the Program Team shall establish procedures to confirm, both initially and on an ongoing basis, that the Program is being

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F 880	Continued From page 56 implemented as designed. The resulting process is verification. The Program Team shall establish procedures to confirm, both initially and on an ongoing basis, that the Program, when implemented as designed, controls the hazardous conditions throughout the building water systems. The resulting process is validation. The Program Team shall determine whether testing for Legionella shall be performed and if so, how test results will be used to validate the Program. If the Program Team determines that testing is to be performed, the testing approach, including sampling frequency, number of samples, locations, sampling methods, and test methods, shall be specified and documented. The Program Team shall consider include the following as part of the determination of whether to test for Legionella: a. Program control limits are not maintained in the building water systems, including in water systems with supplemental disinfection.	F 880		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately equip and allow resident to call for staff assistance for five	F 919	**Corrective Action: F 919** On 6/07/24, call lights for Resident 74, 26, and 46 were adjusted so that they are within reach of the residents at all times and not placed in a manner which would not allow for the residents to access their call lights easily. On 6/07/24, facility call light vendor arrived to inspect call light board on second floor to repair communication issues between the first and second floor call light boards.	

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F 919	Continued From page 57 (5) of 24 sampled residents (Residents 74, 55, 79, 26 and 46) by: 1., 2, and 3. Failing to ensure the call light (used in healthcare facilities as an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach of Residents 74, 26 and 46 as indicated in the facility's policy and procedure. 4. and 5. Failing to ensure the call light was working for Resident 79 and 55. This deficient practice had the potential not to meet Resident 74, 55, 79, 26 and 46's needs and preference. Findings: 1. A review of Resident 74's Admission Record indicated the resident was admitted to the facility on 2/18/2023 with diagnoses which included chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), ataxia (poor muscle control that causes clumsy or awkward movements, having trouble walking or balancing), hypoxia (low levels of oxygen in the body tissues) and history of falling. A review of Resident 74's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/12/2024, indicated Resident 74 has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 74 required setup or clean-up assistance (helper sets up or cleans up, Resident completes the activity) in eating, oral hygiene, personal hygiene, upper body dressing	F 919	On 6/07/24, Call light technicians then repaired any communication issues between the first and second floor call light boards. On 6/07/24, maintenance supervisor replaced button based call light hand control with a switch based hand control which allows for Residents 79 and 55 to press the switch once in order to keep the call light alarm in the "on" setting so only the responding nurse can deactivate the call light once they arrive at the resident room.	

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F 919	Continued From page 58	F 919	**Other Residents Potentially Effected:**	

and walk 10-50 feet. The MDS also indicated Resident 74 needs supervision or touching assistance (helper provides verbal cues/ touching/ steady/ contact guard assistance as resident completes activity) with toileting hygiene, shower/ bathe self, lower body dressing and putting on/ taking off footwear.

A review of Resident 74's care plan dated on 5/17/2024, indicated Resident 74 potential for self-care deficit and requires assistance in activities of daily living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). The care plan intervention indicated maintain call light within easy reach and frequently used items.

During an observation in Resident 74's room on, 6/4/2024 at 8:30 AM, Resident 74 was sleeping, and the call light was hanging on her overhead lights, and it was not within Resident 74's reach.

During an observation in Resident 74's room on, 6/5/2024 at 7:08 AM, Resident 74 was sleeping, and the call light was hanging on her overhead lights, and it was not within Resident 74's reach.

During concurrent observation in Resident 74's room and interview with the Registered Nurse Supervisor 1 (RNS 1) on, 6/5/2024 at 2:58 PM, Resident 74 was sleeping on her bed. RN supervisor observed the Resident 74's call light was hanging on the overhead light and not within resident's reach. RNS 1 stated the call light should be placed next to Resident 74 so that the resident can easily reach or access the call light and use it right away to call for assistance. The DON stated, it is important to have the call light

On 6/10/24, maintenance supervisor and maintenace assistant inspected call lights on both resident floors to ensure that communication between the resident rooms and nursing station panels are functioning properly.

On 6/10/24, maintenance supervisor checked each resident room to ensure that call light hand controls were not placed in a manner that would make them difficult to access by the residents.

No other residents were found to be affected by malfunctioning or out of reach call light hand controls after maintenace supervisor's inspection.

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F 919	Continued From page 59 within the residents' reach so the residents can call for help if they need assistance. During concurrent observation in Resident 74's room and interview with the Director of Nursing (DON) on, 6/5/2024 at 3:06 PM. Resident 74's call light is not within Resident 74's reach. DON stated, "The call light should be within Resident 74's reach all the time. It is important to have the call light within the resident's reach because it is their way of communicating their needs with the staff." A review of facility's policy and procedure (P&P) titled, "Answering the Call Light," dated 3/2024, indicated, ensure that call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the door. 2. A review of the admission record indicated Resident 26 was admitted to the facility on 4/3/2024, with diagnoses that included but not limited to encounter for palliative care (specialized medical care for people living with a serious illness), retention of urine (the inability to empty the urine from your bladder), pressure ulcer of sacral region (an area of the skin that has been damaged as a result of constant pressure), unstageable and hepatic (a large organ of in the human body that helps with important changes in many of the substances contained in the blood) fibrosis (excessive connective tissue accumulates in the liver). A review of the Physician History and Physical dated 4/5/2024 indicated Resident 26 does not have the capacity to understand and make decisions.	F 919	**Measures and Systemic Changes:** On 6/13/24, DSD in-serviced CNAs and licensed nurses on importance of verifying that their assigned residents can reach their call lights easily and the importance of immediately reporting to the maintenance supervisor or designee that any observed malfunction with call light hand controls and/or the call light board at either nursing station. Facility will have call light vendor inspect call lights for both resident floors quarterly or more frequently if problems arise. **Performance Monitoring:** Beginning 6/25/24, The Administrator in cooperation with Maintenance Supervisor, DON, and DSD will monitor weekly via equipment testing for proper functioning of facility's call light system and discuss during the monthly QA meeting any discrepancies that are identified related to malfunctioning call light panels at the nursing stations or out of reach call light hand controls. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/10/24

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A review of the Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 4/10/2024, indicated Resident 26 was severely impaired in cognitive skills for daily decision making, and needed total assistance from the staff for the activities of daily living such as eating, oral and toilet hygiene, shower, and dressing.

A record review of Resident 26's Baseline Care plan (undated) indicated Resident 26's Nursing Interventions were to have the call light within reach.

During an observation on 6/4/2024 at 8:26 AM, Resident 26's call light was not within reach and was hanging from the top of the side rail (barrier attached to the side of bed) at the head of the bed.

During an interview with Licensed Vocational Nurse (LVN) 2 on 6/4/2024 at 9:50 AM, LVN2 stated the call light should be nearest where the resident can easily reach it.

3. A review of the admission record indicated Resident 46 was admitted to the facility on 5/17/2021 and re admitted on 5/4/2024, with diagnoses that included but not limited to primary generalized osteoarthritis (a degenerative joint disease causing pain, stiffness, swelling, and decreased mobility), other unspecified hypothyroidism (the thyroid is a small, butterfly-shaped gland in the front of your neck, when the thyroid gland doesn't make enough thyroid hormones [help control how cells and organs do their work] to meet the body's needs), contracture of the left hand (one or more fingers

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to bend toward the palm of the hand. The affected fingers can't straighten completely), and unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities).

A review of the Physician History and Physical dated 5/7/2024 indicated Resident 46 does not have the capacity to understand and make decisions.

A review of the MDS dated 5/29/2024, indicated Resident 46 was severely impaired in cognitive skills for daily decision making, and needed total assistance from the staff for the activities of daily living such as eating, oral and toilet hygiene, shower, and dressing.

During an observation on 6/4/2024 at 9:06 AM, Resident 46 was laying in bed, and the resident's call light was on right side of bed wrapped around top part of the side rail and not within the resident's reach.

During a concurrent observation in Resident 46's room and interview with Restorative Nurse Assistant (RNA) 1 on 6/6/2024 at 9:54 AM, RNA1 stated, "he (Resident 46) has a touch call light, he (Resident 46) can use it if you put within his reach but right now, I am not sure if he (Resident 46) can reach it I am not sure if he can use it since it was wrapped on the top side of rail. He (Resident 46) would not be able to use if it is on the side rail since he (Resident 46) cannot reach. The call light is important for the residents for any needs, any emergency the call light should be within the resident's reach at all times."

A review of the facility's Policy titled "Answering

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the Call Light" Revised 3/2024, indicated, "The purpose of this procedure is to ensure timely responses to the residents requests and needs."

4. A review of Resident 79's Admission Record indicated Resident 79 was admitted to the facility on 8/24/2023 with diagnoses that included ataxic gait (awkward, uncoordinated walking), thrombocytopenia (a condition that occurs when the platelet count in your blood is too low), and rickettsiosis (a group of diseases caused by closely related bacteria and spread to people through the bite of infected ticks and mites).

A review of Resident 79's History and Physical Examination (H&P), dated 8/24/2023, indicated Resident 79 have the capacity to understand and make decisions.

A review of Resident 79's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/29/2024, indicated Resident 79 was able to understand others and made herself understood. The MDS also indicated, Resident 79 required moderate physical assistance with bed mobility and transfer, and moderate physical assistance with toilet use (helper does less than half the effort) and moderate physical assistance with oral hygiene, toileting hygiene, lower body dressing, and personal hygiene.

During a concurrent observation in resident 79's room and interview with Maintenance Supervisor (MS) on 6/6/2024 at 5:26 PM, observed Resident 79 pressed on the call light, and the call light turned on but was turned off when the call light button was not pressed. MS stated the call light in

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Resident 79's room was not working properly since the call light should have turned on after Resident 79 pressed on the call light one time.

During interview with the DON on 6/7/2024 at 4:37 PM, the DON stated, the residents' call light should be working properly so staff will know when the resident called for help and/ or for assistance.

5. A review of Resident 55's Admission Record indicated Resident 55 was initially admitted to the facility on 3/24/2020 and was readmitted on 3/31/2023 with diagnoses that included pleural effusion (a condition in which this occurs when fluid builds up in the space between the lung and the chest wall), stroke (a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off) , and COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).

A review of Resident 55's H&P, dated 4/30/2024, indicated Resident 55 can make needs known but cannot make medical decisions.

A review of Resident 55's MDS, dated 4/3/2024, indicated Resident 55 was assessed having moderately impaired cognition for daily decision making and required substantial/maximal assistance with toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and sit to stand.

During an observation on 6/4/2024 at 09:52 AM in front of Resident 55's room, Certified Nurse Assistant (CNA) 6 pressed on Resident 55's call light to check if it was working, after pressing on the call light, the call light by the Resident 55's

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F 919	Continued From page 64 door lit up and turned off immediately. During a concurrent observation at the second-floor nursing station and interview on 6/6/2024 at 3:50 PM with Registered Nurse (RN) 1, observe RN1 called first floor nursing station to check on which room was calling for service on the second floor. RN1 stated the whole call light panel on second floor is not working, it makes beeping noise, but there was only one room that has the light on for the whole call light panel and they were unable to tell who is the resident that needs help or pressed the call light button. During an interview with MS on 6/6/2024 at 5:26 PM, MS stated, the wall outlets are old and that could be the reason why the call light on the second floor in Resident 79 and 55's room were not working properly, and the facility need to fix it. During a review of the facility's policy and procedure titled, "Maintenance Service", revised on March 2024, indicated, functions of maintenance personnel include, but are not limited to maintain the paging system in good working order.	F 919		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were provided a homelike environment for three of 13	F 921	**Corrective Action: F 921** On 6/06/24, CNA for Resident 55 removed white towels and linen from the floor and placed into the appropriate dirty linen cart for pickup by Housekeeping and Laundry personnel.	

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F 921	Continued From page 65 sampled residents (Residents 79,76, and 55) for the environment care area by: 1. and 2. Failed to provide Resident's 79 and 76 with a clean and comfortable environment. The resident's room have unfinished patching, water marks and peeling paint on the ceilings and walls. 3. Failed to provide Resident's 55 a clean room by having white towels on the floor. 4. Failed to ensure ceiling in the resident's hallways in the first and second floor did not have water leak marks and brownish discoloration. These deficient practices had the potential for an unsafe and unclean resident's environment and had the potential to negatively affect the resident's quality of life. Findings: 1. A review of Resident 79's Admission Record indicated Resident 79 was admitted to the facility on 8/24/2023 with diagnoses that included ataxic gait (awkward and/ or uncoordinated walking), thrombocytopenia (a condition that occurs when the platelet count in your blood is too low), and rickettsiosis (a group of diseases caused by closely related bacteria and spread to people through the bite of infected ticks and mites). A review of Resident 79's History and Physical Examination (H&P), dated 8/24/2023, indicated Resident 79 have the capacity to understand and make decisions. A review of Resident 79's Minimum Data Set (MDS, a standardized assessment and care	F 921	On 6/12/24, Maintenance Supervisor completed patching and repainted ceilings and walls for the rooms of resident's 79 and 76. On 6/13/24, Maintenance Supervisor replaced soiled ceiling tiles with new ceiling tiles for the first and second floor hallways. **Other Residents Potentially Effected:** From 6/13/24 to 7/07/24 Maintenance Supervisor and DSD verified that no other resident rooms or resident hallways were found to be affected by unfinished paintwork or patchwork or linen not being placed in the appropriate recepticles.	

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F 921	Continued From page 66 planning tool), dated 2/29/2024, indicated Resident 79 was able to understand others and made herself understood. The MDS also indicated, Resident 79 required moderate physical assistance with bed mobility and transfer, and moderate physical assistance with toilet use (helper does less than half the effort) and moderate physical assistance with oral hygiene, toileting hygiene, lower body dressing, and personal hygiene. During an observation of Resident 79's room, on 6/4/2024, at 10:34 AM, Resident 79's room was observed to have multiple unfinished patching, watermarks, and holes in between the wall and the ceiling. Watermarks are mostly on the left side of the wall to Resident 79's bed. During an interview on 6/4/2024, at 10:35 AM in Resident 79's room, Resident 79 stated the watermarks from the wall were from the leak from the last rain around March of 2024. Resident 79 stated her room has been like that for a while. 2. A review of Resident 76's Admission Record indicated Resident 76 was initially admitted to the facility on 2/7/2024 with diagnoses that included ataxic gait, thrombocytopenia, unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and other lack of coordination. A review of Resident 76's H&P, dated 2/7/2024, indicated Resident 76 have the capacity to understand and make decisions. A review of Resident 76's MDS, dated 5/15/2024,	F 921	**Measures and Systemic Changes:** Beginning 6/13/24, Maintenance supervisor will report immediately to the Administrator any signs of wall damage such as unfinished patchwork or peeling paint as well as signs of water leaks. Beginning 6/13/24, Administrator will direct Maintenance Supervisor to repair any damages discovered in a timely fashion with great consideration to resident safety and maintenance of a homelike environment. Beginning 6/13/24, Administrator and Maintenance Supervisor will discuss any major projects or repairs which cannot feasibly be completed by facility staff alone. So that the appropriate licensed building/ maintenance/plumbing/HVAC vendor can be identified and commissioned. On 6/10/24, DSD in-serviced CNAs on importance of placing linen in the appropriate designated areas, with emphasis on always placing used linens in the soiled linen cart and not on the floor of a resident's room.	

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F 921	Continued From page 67 indicated Resident 76 was independent and need very minimum assistance (resident completes the activity by themself with no assistance from a helper) with shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS also indicated Resident 76 required no assistance with toilet transfer, sit to stand, eating, oral hygiene, and toileting hygiene. During an observation of Resident 76's room, on 6/4/2024, at 10:36 AM, Resident 76's room was observed to have unfinished patching on the ceiling located above the resident's bed. During an interview with Maintenance Supervisor (MS), on 6/5/2024, at 3:33 PM, MS stated he was the one who supposed to fix Resident 79's room but there was nothing done so far. MS stated he did not know how long it has been like that and what cause it. MS stated the residents like it when everything in their room is fixed and being homelike. During an interview with the Director of Nursing (DON), on 6/7/2024, at 9:21 AM, the DON stated the resident's rooms should be presentable and personalized to what the resident need and like. The DON stated it is important for the resident feel like they are at home. The DON stated when the residents have a nice room, they feel dignified and respected. The DON stated unfinished patching, peeling paint, and white patches on the walls is not considered a homelike environment. The DON stated the Maintenance Department is responsible for checking which rooms need to be repaired. 3. A review of Resident 55's Admission Record	F 921	**Performance Monitoring:** Beginning 6/25/24, The Administrator in cooperation with Maintenance Supervisor and DON will visually inspect daily for proper maintenance of resident rooms and hallways and discuss during the monthly QA meeting any discrepancies that are identified related to maintenance projects and preservation of a homelike environment for the residents. Monthly QA discussion will occur for three months to ensure total compliance is achieved.	6/13/24

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indicated Resident 55 was initially admitted to the facility on 3/24/2020 and was readmitted on 3/31/2023 with diagnoses that included pleural effusion (a condition in which this occurs when fluid builds up in the space between the lung and the chest wall), stroke (a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off) , and COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).

A review of Resident 55's H&P, dated 4/30/2024, indicated Resident 55 can make needs known but cannot make medical decisions.

A review of Resident 55's MDS, dated 4/3/2024, indicated Resident 55 was assessed having moderately impaired cognition for daily decision making and required substantial/maximal assistance with toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and sit to stand.

During a concurrent observation in Resident 55's room and interview with Certified Nurse Assistant (CNA6), on 6/6/2024 at 8:28 AM, there were three white towels on the floor in between the wall and the headboard of Resident 55's bed. In addition, there was a white linen/ sheet on the floor of Resident 55's shared restroom. CNA6 stated the towels, and the white sheet are not supposed to be left on the floor. CNA 6 also stated, it is housekeeper's responsibility to clean up and remove those white towels and white linen/ sheet.

During an interview with the DON, on 6/7/2024, at 9:21 AM, the DON stated CNA is supposed to remove the towels and housekeeping are

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F 921	Continued From page 69	F 921		

supposed to keep the area clean. The DON also stated the towels and white sheet are not supposed to be on the floor. The DON stated towels and linen, or sheets are not supposed to be on the floor, and it may cause infection to the resident, and this is not homelike environment if facility staff did not clean up the room.

A review of the facility's P&P titled, "Maintenance Service," revised on March 2024, indicated, "The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times." The P&P further indicated, "Functions of the Maintenance Department may include, but are not limited to maintaining the building in good repair and free from hazards."

4. During an observation in the first-floor resident hallways on 6/6/2024 at 10:50 AM, the ceilings have water leak marks and has a brownish discoloration.

During a concurrent observation in the first - floor resident hallway and interview with the Maintenance Supervisor (MS) on 6/6/2024, at 11:10 AM, MS stated, "the ceiling has leaks from the rain and air conditioning vents. When the ceilings get soaked, it leaves stain, and it does not look good. It can also form molds that can get the residents' sick."

During an observation in the second-floor resident hallways on 6/6/2024 at 5:50 PM, the ceilings have water leak marks and brownish discoloration in the resident hallways.

During an interview with the Director of Nursing (DON) on 6/7/2024, 9:24 AM, the DON stated, "the environment it is what it is and there is

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F 921	Continued From page 70 nothing I can do in this old environment. Itis the maintenance job. It does not feel good to look at the old environment, it does not feel homelike." A review of the facility's policy titled, "Homelike Environment" dated on 3/2024, indicated the facility provides residents with a safe and clean, comfortable, and homelike environment ... The facility staff and management maximize, to the extent as possible, the characteristics of the facility that reflect a personalized, homelike setting.	F 921		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have an effective pest control program for gnats' (small, winged insect) infestation, which affected three (3) of 24 sampled residents (Residents 2, 70, and 89). This deficient practice had the potential to cause itchy, painful bites to Residents 2, 70, and 89, which could result to open sores (an ulcer) that are susceptible to bacterial infection. This also had the potential for transmission of infectious diseases to other residents. Findings: 1. During a review of Resident 2's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on	F 925	**Corrective Action: F 925** On 6/04/24, facility pest control vendor came to the facility for inspection and treatment of rooms affected by flying insects. On 6/05/24, Resident 2 and Resident 70 had their shared room deep cleaned by Housekeeping staff which included washing and buffing of floors, cleaning of bedside tables and overbed tables, as well as laundering of resident privacy curtains. On 6/05/24, Resident 89's room was also deep cleaned by housekeeping staff. On 6/05/24, Resident 2 was provided storage containers for personal food and snacks so that they remain covered and unaccessible to flying insects.	

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F 925	Continued From page 71 9/15/2023 with diagnoses of paroxysmal (an attack or sudden increase or recurrence of symptoms) atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the hart] fire rapidly at the same time), and cerebral infarction (damage to the tissues in the brain due to a loss of oxygen in the area). During a review of Resident 2's H&P, dated 9/16/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 2's MDS , dated 3/22/2024, the MDS indicated the resident had intact cognitive skills of daily decision making. Resident 2 needed supervision or touching assistance (helper set up or cleans up; resident completes activity) with walking 50 feet and making 2 turns and dressing (how a resident puts on, fastens and takes off all items of clothing), needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) transferring from bed-to-chair, going from a sit to stand position, personal hygiene and eating. During a concurrent observation and interview on 6/4/2024 at 1:09 PM with Resident 2 in her room, multiple little black flies were observed on the privacy curtain, crawling around on the floor, and flying around the resident's bedside. Resident 2 stated that she tries to not keep fruit or food out but stated that the little flies were always there. During an observation on 6/5/2024 at 7:50 AM in Resident 2's room, a small black fly was observed on the resident's privacy curtain.	F 925	**Other Residents Potentially Effected:** From 6/07/24 to 7/07/24, Maintenance Supervisor and Housekeeping Supervisor verified that no other resident rooms were observed to be affected by the presence of flying insects. **Measures and Systemic Changes:** Beginning 6/10/24, Facility will have licensed pest control vendor inspect and treat the facility for flying insects and crawling pests once per month or more frequently if necessary. **Performance Monitoring:** Beginning 6/25/24, The Administrator, Maintenance Supervisor, and DSD in cooperation with nursing staff and housekeeping staff will visually inspect daily for the prescence of flying insects in resident rooms and hallways and discuss during the monthly QA meeting any discrepancies that are identified related to pest control. Monthly QA discussion will occur for three months to ensure total compliance is achieved. **---- END of PLAN of CORRECTION ----**	6/10/24

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2. During a review of Resident 70's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on 4/22/2024 with diagnoses of malignant (a term for diseases in which abnormal cells divide without control and can invade nearby tissues) neoplasm (an abnormal mass of tissue that forms when cells grow and divide more than they should or do not die when they should) of endometrium (the layer of tissue that lines the uterus [the hollow, pear-shaped organ in the female pelvis]), and spinal stenosis (narrowing of the spinal column that causes pressure on the spinal cord).

During a review of Resident 70's H&P, dated 4/24/2024, the H&P indicated the resident has the capacity to understand and make decisions.

During a review of Resident 70's MDS dated 4/29/2024, the MDS indicated the resident had intact cognitive skills for daily decision making. Resident 70 needed supervision or touching assistance with bed-to-chair transfers, going from a sitting to a standing position, upper body dressing and personal hygiene and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating.

During a concurrent observation and interview on 6/4/2024 at 12:54 PM with Resident 70 in her room, multiple small little black flies were observed flying around her bedside. Resident 70 stated that the little flies are everywhere and that they bother her. Resident 70 stated she had to buy her own bug spray to prevent her from getting bitten.

3. During a review of Resident 89's Admission Record, the Admission Record indicated the

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resident was initially admitted to the facility on 3/18/2024 and readmitted 4/9/2024 with diagnoses of weakness and low back pain.

During a review of Resident 89's H&P, dated 4/13/2024, the H&P indicated the resident has the capacity to understand and make decisions.

During a review of Resident 89's MDS, dated 3/26/2024, the MDS indicated the resident had intact cognitive skills of daily decision making. Resident 89 needed substantial/maximal assistance (helper does more than half the effort) with rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed) and with lower body dressing, needed partial/moderate assistance (helper does less than half the effort) with upper body dressing and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating.

During a concurrent observation and interview on 6/4/2024 at 8:40 AM with Certified Nursing Assistant 1 (CNA 1), multiple small little black flies were observed flying around Resident 89's bedside. CNA 1 stated that there were a lot of little black flies flying around the resident.

During an interview on 6/4/2024 at 11:25 AM with Maintenance Supervisor (MS), MS stated that it was important that the building be free of insects to prevent contamination, infection, and disease.

A review of the facility's Policy and Procedure (P&P), "Pest Control," dated 3/2024, the P&P indicated, the facility shall maintain an effective pest control program. The facility maintains an on-going pest control program to ensure that the

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F 925	Continued From page 74 building is kept free of insects, and rodents.	F 925		