| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555429 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa Gardens Health Care Unit | 842 East Villa Street<br>Pasadena, CA 91101 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 38) received sufficient notice prior to the resident's last coverage date (LCD) for Medicare Part A (insurance which covers inpatient hospital care, skilled nursing facility [SNF], hospice [focuses on the care, comfort, and quality of life of a resident with serious illness, who is approaching the end of life], laboratory tests, surgery, home health care [wide range of health care services that can be given in the resident's home for an illness or injury]) services.This deficient practice had the potential for Resident 38 to not be aware of possible charges for services rendered that were not covered after the resident's last Medicare coverage day. Findings:During a review of Resident 38's admission Record, the admission Record indicated the resident was admitted on [DATE] with the following but not limited to diagnoses of heart failure (the heart can't pump enough blood for the body needs), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and depression ( a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with activities of daily living [ADL]). During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool), dated 11/23/2025, the MDS indicated the resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 38 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) with lower body dressing and putting on/ taking off footwear but requires partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) with upper body dressing and toileting hygiene. During a review of Resident 38's Notice of Medicare Non-Coverage (NOMNC- given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization), dated 11/26/2025, the NOMNC indicated the effective date of coverage of the current services would end on 11/27/2025.During an interview on 12/4/2025 at 4PM, the Director of Nursing (DON) stated Resident 38 was informed on 11/26/2025 regarding the resident's last covered date (LCD) which was on 11/27/2025.During an interview on 12/5/2025 at 10:15AM, the DON stated the facility uses the SNF notices - Quick Reference for guidance with the issuance of NOMNC form. During a review of the facility's undated guidance titled, SNF notices - Quick Reference, the guidance indicated generic notice to be issued two days before effective date (last paid day/LCD). |

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.

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

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe, clean, and homelike environment for one (1) of four sampled residents (Resident 5) for the environment care area in accordance with the facility's policy and procedure when facility failed to leave Resident 5's wheelchair. which was at the resident's bedside, overflowing with the resident's personal belongings. This deficient practice resulted in unsafe and unsanitary conditions placing Resident 5 at risk for infection, uncomfortable living, and harm. Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and re-admitted on [DATE], transient ischemic attack (TIA, is a temporary blockage of blood flow to the brain), functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and pneumonia (a lung infection). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 9/6/2025, the MDS indicated Resident 1 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 5 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral and toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer, and toilet transfer. During an observation on 12/3/2025 at 1:55 PM inside Resident 5's room, Resident 5's wheelchair was overflowing with resident's personal belongings (2 blankets, 2 pillows, white linens, towels, and bilateral lower leg brace). During a concurrent observation and interview on 12/3/2025 at 2:01 PM with Certified Nursing Assistant 1 (CNA 1) inside Resident 5's room, Resident 5's wheelchair was overflowing with resident's personal items. CNA 1 stated, Resident 5's bilateral leg brace when not in use, blankets, pillows and linens should be inside the resident's closet. CNA1 stated clean linens and towels should be placed inside a black bag and not left on top of the wheelchair. CNA1 stated they need to keep Resident 5's room clean, organized, and free of clutter to avoid spread infection and ensure safety. During a concurrent observation in Resident 5's room and interview on 12/3/2025 at 2:08 PM, Resident 5 stated she did not like that her room was messy because it does not feel like home. Resident 5 stated she liked her room clean and organized. During an interview on 12/3/2025 at 4:35 PM with Infection Preventionist Nurse (IPN), IPN stated Resident 5's wheelchair should be free of clutter. IPN stated Residents have their own cabinets to put their belongings. IPN stated clean linens need to be kept in a clean plastic bag. IPN stated if the staff combines dirty and clean items, it could cause cross contamination. During a concurrent observation and interview on 12/4/2025 at 8:05 AM with Licensed Vocational Nurse 2 (LVN 2) inside Resident 5's room, Resident 5's wheelchair was observed with 2 pillows. LVN 2 stated those were Resident 5's extra pillows. LVN 2 stated they should not keep the pillows on the wheelchair. During an interview on 12/5/2025 at 12:12 PM with Director of Nursing (DON), the DON stated resident's personal belongings should not be left on the wheelchair because the staff does not know if the personal items were clean or not. The DON stated the staff should not leave the extra pillows on top of Resident 5's wheelchair to ensure the pillows were kept clean. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights and Community Responsibilities, revised 11/2016, the P&P indicated, each residents has the right to have a safe, clean, comfortable and homelike environment, including but not limited to receiving treatments and supports for daily living safely. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interview and record review, the facility failed to ensure there was a Registered Nurse (RN, a healthcare professional who completed an Associate Degree in Nursing [AND] or Bachelor of Science in Nursing [BSN] from an approved program. Then, they pass a comprehensive national test [NCLEX-RN] and meet state licensure and certification requirements that develop care plans, give treatments and medications, perform diagnostic tests, work with physicians to coordinate care, and supervise Licensed Vocational Nurse [LVN] and Certified Nursing Assistant [CNA] ) for eight (8) consecutive hours, seven (7) days a week on 1/18/2025, 1/19/2025, 1/21/2025, and 1/22/2025 based on the facility assessment. This deficient practice had a potential impact on the quality of care and outcomes that the residents might experience in those days with no RN coverage, which an RN was generally responsible for more advanced care activities such as assessments and administering intravenous (IV, given directly into the blood stream) fluids or medications. Findings: During a concurrent interview and record review on 12/4/2025 at 1:16 PM with Director of Staff Development (DSD), Staff Sign in Sheet dated 1/18/2025 was reviewed. DSD stated the facility did not have an RN on the evening shift (3 PM to 11:30PM). DSD stated a registry (temporary assignment that requires you to travel to a medical facility to provide coverage when it lacks staff for the day) RN was scheduled for the evening shift but called off. DSD stated the facility did not have an RN coverage for 1/18/2025. DSD stated the facility should have an RN 8 hours daily in case of emergency that was beyond the LVN's scope of practice which could result in the residents not receiving the care they need. During a concurrent interview and record review on 12/4/2025 at 1:19 PM with DSD, Staff Sign in Sheet, dated 1/19/2025, was reviewed. DSD stated the facility did not have an RN that day. The Director of Nursing (DON) was on vacation from 1/18/2025 to 1/26/2025 and the RN from the registry that was scheduled to work that day also called off. DSD stated the facility did not have RN coverage for 1/19/2025. During a concurrent interview and record review on 12/4/2025 at 1:37 PM with DSD, Staff Sign in Sheet, dated 1/21/2025 to 1/22/2025 were reviewed. DSD stated the RN from the registry did not show up for work for both days. DSD stated the facility did not have an RN coverage for both dates. During a concurrent interview and record review on 12/5/2025 at 12:28 PM with the DON, the Facility Assessment was reviewed. The DON stated the facility assessment indicated one RN for 8 hours per day (24 hours per day). The DON stated the regulations indicated the facility needs to have an RN 8 hours a day. During a concurrent interview and record review on 12/5/2025 at 12:29 PM with the DON, the Staff Sign in Sheet dated 1/18/2025 to 1/19/2025 was reviewed. The DON stated there was no RN coverage for both dates. The DON stated she went on vacation, and the registry staff did not show up for work. The DON stated the facility was not able to get replacement for an RN coverage on 1/18/2025 to 1/19/2025. During a concurrent interview and record review on 12/5/2025 at 12:30 PM with the DON, Staff Sign in Sheet dated 1/21/2025 to 1/22/2025 was reviewed. The DON stated there was no RN coverage for both dates. The DON stated the facility should have tried to replace the RN registry staff that was scheduled who did not report to work for 1/21/2025 and 1/22/2025. During an interview on 12/5/2025 at 12:33 PM, the DON stated on 1/18/2025, 1/19/2025, 1/21/2025 and 1/22/2025, the facility did not have RN coverage. The DON stated they did not follow the regulations to have RN coverage for those days. The DON also stated they do not have a policy for nursing services or sufficient staffing. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of two (2) of three (3) sampled residents (Residents 5 and 40) in accordance with its Policy and Procedure (P&P) by failing to ensure:1.a. Resident 5's Famotidine (medication used to treat and prevent conditions caused by too much stomach acid such as heartburn [burning chest pain] and gastroesophageal reflux disease [GERD, stomach acid flows back up the esophagus (canal that connects the throat to stomach)], was not left unattended on top of the medication cart on 12/3/2025. Licensed Vocational Nurse 1 (LVN 1) also failed to administer Famotidine 30 minutes prior to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (GT) feeding on 12/3/2025 as indicated on the physician's order.1.b. LVN 1 used 2 resident identifiers prior to administering Resident 5's medication on 12/3/2025.1.c. LVN 1 flushed Resident 5's GT before and after Keppra (medication for seizures) and Metoprolol (medication that affects the heart and circulation) administration as indicated on the physician's order.2. LVN 3 used 2 resident identifiers prior to administering Resident 40's medication on 12/3/2025.This deficient practice had the potential to result in ineffectively managing Residents 5 and 40's medical condition and place the residents for medication errors and compromised resident safety. Findings:<br><br>1. During a review of Resident 5's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and aphasia (a disorder that makes it difficult to speak).<br><br>During a review of Resident 5's Minimum Data Set (MDS – a resident assessment tool), dated 9/6/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 5 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.<br><br>During a review of Resident 5's Physician Order, dated 8/27/2025, the Physician Order indicated enteral feeding (delivers liquid nutrients directly into the stomach or intestines via a soft tube when someone cannot eat enough by mouth) Osmolite 1.2 Calories at 60 milliliters (ml – unit of measure) via pump two times a day every day. Turn off at 7 AM and turn on at 3 PM.<br><br>During a review of Resident 5's Care Plan, the Care Plan indicated potential for GI distress related to GERD, revised 7/23/2025. The Care Plan interventions included were to administer medications as ordered and observe signs and symptoms of GI bleed.<br><br>During a review of Resident 5's Care Plan, the Care Plan indicated alteration in nutrition due to enteral feeding, revised 9/6/2025. The Care Plan interventions included were to administer enteral feeding and water flush per order, and flush tube at least with 30 ml of water before and after medication administration.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 5's Physician Order, dated 10/17/2025, the Physician Order indicated Famotidine oral tablet 40 milligrams (mg – unit of measure), give one time a day for GERD, and give 30 minutes prior to start GT feeding.<br><br>During a review of Resident 5's Physician Order, dated 10/30/2024, the Physician Order indicated flush GT with 10 ml of water before and after each medication.<br><br>a. During a concurrent medication administration observation and interview on 12/3/2025 at 12:25 PM, LVN 1 was observed leaving the crushed Famotidine in a cup unattended on top of the medication chart while inside Resident 5's room. LVN 1 stated he should not have left the medication on top of the cart unattended because another resident could come and take the medication.<br><br>b. During the same concurrent medication observation inside Resident 5's room and interview on 12/3/2025 at 12:25 PM, Resident 5 was in bed with her GT off. LVN 1 was observed using one resident identifier, when giving Resident 5 her Famotidine medication at 12:45PM. LVN 1 stated he did not but should have used 2 resident identifiers prior to administering medication to avoid misidentifying the resident. LVN 1 also stated the GT feeding will start at 3PM.<br><br>During an interview on 12/3/2025 at 3:45 PM, Registered Nurse 1 (RN 1) stated Resident 5's Famotidine should have been given 30 minutes prior to the feeding, which was supposed to start at 3PM according to the physician's order. RN 1 also stated Resident 5 should have been administered her famotidine at 2:30 PM as indicated on the physician's order.<br><br>c. During a concurrent medication administration observation on 12/4/2025 at 8:15 AM, LVN 1 was observed giving Resident 5's medication via GT. LVN 1 was observed flushing the tube with 10 ml of water initially, then administering Keppra and Metoprolol consecutively without flushing in between. LVN 1 stated he should but did not flush between medications. LVN 1 added Resident 5 can get adverse side effects of the medication. LVN 1 also stated that he did not follow the physician's order.<br><br>During an interview on 12/4/2025 at 11:08 AM, RN 1 and RN 3 stated physician's orders should be followed and if an order indicated to flush 10 ml before and after each medication, then the licensed nurse should be flushing 10 ml between the Keppra and Metoprolol. RN 1 and RN 3 also stated there needs to be 2 resident identifiers prior to medication administration. RN 1 and RN 3 stated medications should not be left unattended on top of the medication cart. RN 1 and RN 3 also stated medications ordered to be given 30 minutes prior to GT feeding should be 30 minutes before turning on the feeding.<br><br>During a review of the facility's P&P titled, Medication Administration General Guidelines, dated 2007, the P&P indicated medications are administered in accordance with written orders of the prescriber. P&P also indicated during administration of medications, no medications are kept on top of the cart.<br><br>During a review of the facility's P&P titled, Enteral Feeding, dated 5/2016, the P&P indicated to review the physician order for completeness such as amount and frequency of water to flush the tube and medication administration.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. During a review of the admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE]. Resident 40's diagnoses included but are not limited to left knee replacement, Parkinsons disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysarthria (a motor-speech disorder caused by damage to the brain, nerves, or muscles that control speech, resulting in difficulty with muscle strength and coordination), anarthria (the complete loss of the ability to articulate speech, resulting from damage to the brain or nervous system that impairs the motor control of the muscles used for speech) and lack of coordination.<br><br>During a review of Resident 40's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 11/20/2025, indicated Resident 40 is cognitively intact, with no or very little impairment. Resident 40 requires supervision or touching assistance for mobility such as rolling left to right, sit to lying, lying-to-sitting on the side of bed, sit to stand, transferring chair/bed-to-chair, toilet transfer, and walking 10 feet.<br><br>During an observation on 12/4/2025 at 9:19 AM in Resident 40's room during a medication pass observation with LVN 3, LVN 3 was observed identifying Resident 40 by her wrist band only, no second identifier was used.<br><br>During an observation on 12/4/2025 at 9:20 AM in Resident 40's room during medication pass with LVN 3, LVN 3 stated there is no photo identifier available in Resident 40's electronic record.<br><br>During an interview on 12/4/2025 at 9:25 AM, with LVN 3, LVN 3 stated she only used one identifier before administering medications to Resident 40 by checking the wrist band.<br><br>During an interview on 12/4/2025 at 11 AM, with LVN 3, LVN 3 stated that it is important to use a two-person identifier because it can correctly identify the resident and prevent medication errors. She also stated that the wrong medication can be given to the wrong resident.<br><br>During an interview on 12/5/2025 at 11:48 AM, with the Director of Nursing (DON), the DON stated it is important to use a two-patient identifier to identify the correct resident.<br><br>During a concurrent interview and record review on 12/4/2025 at 11:45 AM with the Registered Nurse Supervisor 3 (RNS 3), the facility's P&P titled, Medication Administration—General Guidelines, dated 1/2023, was reviewed. The P&P indicated that two-patient identifiers should be used before administering medications. RNS 3 stated, it is important to use two-patient identifiers to identify the right patient when giving medication and can help prevent protentional adverse reactions.<br><br>During a review of the facility's P&P titled, Medication Administration—General Guidelines, dated 1/2023, indicated, residents are identified before medication administration using at least two resident identifiers. And, the two methods of identification include checking a residents identification band, a photograph attached to medical record, and verifying resident identification with other nursing care center personnel. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Three medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error, to yield an overall medication error rate of 12 percent (%) for one (1) of three (3) sampled residents (Resident 5) observed during medication administration (med pass). This deficient practice resulted in Resident 5 not receiving medications as ordered which had the potential to result in harm due to unmet individual medication needs. Findings:During a review of Resident 5's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), aphasia (a disorder that makes it difficult to speak) and encounter for gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 9/6/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 5 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.During a review of Resident 5's Physician Order, dated 8/30/2023, the Physician Order indicated Metoprolol Tartrate (used to treat heart related conditions) tablet 12.5 milligrams (mg, unit of measurement) via gastrostomy tube (GT - tube to allow feedings administered to the stomach) one time a day related to essential (primary) hypertension (high blood pressure). Hold for Systolic Blood Pressure (SBP - pressure in the arteries when the heart beats [contracts]) less than 110 or heart rate less than 60.During a review of Resident 5's Physician Order, dated 10/17/2024, the Physician Order indicated Levetiracetam (Keppra - medication for seizures [sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) 100 mg/ milliliters (ml - unit of measure) solution. Give 5 ml via GT two times a day for Seizure Prophylaxis (prevention).During a review of Resident 5's Physician Order, dated 10/30/2024, the Physician Order indicated flush GT with 10 ml of water before and after each medication. During a review of Resident 5's Physician Order, dated 8/27/2025, the Physician Order indicated enteral feeding (delivers liquid nutrients directly into the stomach or intestines via a soft tube when someone cannot eat enough by mouth) Osmolite 1.2 Calories at 60 ml via pump two times a day every day. Turn off at 7 AM and turn on at 3 PM. During a review of Resident 5's Physician Order, dated 10/17/2025, the Physician Order indicated Famotidine (medication used to treat and prevent conditions caused by too much stomach acid such as heartburn [burning chest pain] and gastroesophageal reflux disease [GERD, stomach acid flows back up the esophagus (canal that connects the throat to stomach)] oral tablet 40 mg one time a day for GERD, and give 30 minutes prior to start GT feeding.During a concurrent medication observation and interview on 12/3/2025 at 12:25PM, Licensed Vocational Nurse 1 (LVN 1) was observed giving Famotidine tablet to Resident 5 at 12:45PM. LVN 1 stated the GT feeding will start at 3 PM.During an interview on 12/3/2025 at 3:45PM, Registered Nurse 1 (RN 1) stated Resident 5's Famotidine should have been given 30 minutes prior to the feeding. RN 1 also stated if the GT feeding starts at 3 PM, Famotidine should be given at 2:30 PM and not before or after that time to follow the physicians order.During a concurrent medication administration observation on 12/4/2025 at 8:15 AM, LVN 1 was observed giving Resident 5's medication via GT. LVN 1 was observed flushing the tube with 10 ml of water initially, then administering Keppra and Metoprolol consecutively without flushing in between. LVN 1 stated he should but did not flush between medications. LVN 1 added Resident 5 can get adverse side effects of the medication. LVN 1 also stated that he did not follow the physician's order. During an interview on 12/4/2025 at 11:08 AM, RN 1 and RN 3 stated physician's orders should be followed and if an order indicated to flush 10 ml before and after each medication, then the licensed nurse should be flushing 10 ml between the Keppra and Metoprolol. RN 1 and RN 3 also stated medications ordered to be given 30 minutes prior to GT feeding should be 30 minutes |

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| | 555429 | A. Building<br>B. Wing | 12/05/2025 |

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| Villa Gardens Health Care Unit | 842 East Villa Street<br>Pasadena, CA 91101 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure food was handled, prepared, and stored in accordance with the facility's policy by failing to ensure:1. Expired products were removed from the kitchen dry storage.2. Food items were dated, labeled, and kept clean after opening in the dry storage area and walk in refrigerator. These failures had the potential to result in harmful bacteria growth that could lead to food borne illnesses to 38 of 38 medically compromised residents who receive food in the kitchen. During a concurrent observation and interview on 12/2/2025 at 7:49 AM in the kitchen dry storage area and walk in refrigerator with [NAME] 1, the following were observed:1. Two (2) unopened containers of cooking wine were observed covered in dust and labeled with the dates 11/14/2022 and 11/13/2025. [NAME] 1 stated that both containers of cooking wine were expired.2. One (1) gallon opened container of vinegar had dried drippings on the exterior, and one (1) unopened container of vinegar was labeled with a handwritten date of 10/8/2023. [NAME] 1 stated that the date indicated when the products were received or delivered. [NAME] 1 also noted that the manufacturer's expiration date was not printed on the container or label. [NAME] 1 was observed wiping dust off both vinegar containers.3. 1 gallon opened container of molasses had dried drippings and dried material on the cap. [NAME] 1 stated that the container was dirty.4. 1 opened container of ketchup was observed with drippings on the exterior.5. 2 salad dressing containers/dispensers were labeled with the date 11/1/25. [NAME] 1 stated she did not know what the date referred to. One of the two containers had drippings on the holder/cover. [NAME] 1 emphasized the importance of clearly labeling and dating items so that all staff are aware of which food items can still be served or should be discarded. [NAME] 1 stated that if expired food items were served to residents, it could result in illness or hospitalization. During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, revised 1/2025, the P&P indicated: All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Cover, label, and date unused portions and open packages. Discard food past the use-by or expiration date. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>Based on observation, interview, and record review, the facility failed to ensure two (2) of three (3) dumpsters (large trash container designed to be emptied into a truck), containing garbage (mostly decomposable food waste or yard waste) and refuse (dry material such as glass, paper, cloth or wood that does not readily decompose) were covered or entirely covered as indicated on the facility's Solid Waste Disposal policy. This deficient practice had the potential to attract vermin (animals that are believed to be harmful, carry disease such as rodents, parasitic worms , or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) that could potentially infiltrate the facility, affect the resident care areas and pose a disease threat to the residents and staff of the facility. During an observation on 12/2/2025 at 7:36 AM, next to the facility kitchen loading dock and door, 2 of 3 dumpsters filled with garbage were observed without a lid and another one with a lid but was not entirely covering the dumpster. During a concurrent interview and record review on 12/3/2025 at 4:40 PM with the Infection Prevention and Control Nurse (IPN), the photo documentation of the dumpsters taken on 12/2/2025 at 7:36 AM and the policy and procedure (P&P) titled Solid Waste Disposal, were reviewed. The IPN confirmed that one (1) dumpster overflowing with trash did not have a lid/cover. The IPN stated open dumpsters can attract flies and other pests. These pests can get into the kitchen or the facility and contaminate the food and kitchen equipment that can cause illness to the residents and potentially result in hospitalization. The IPN stated that the P&P indicated to keep lids closed on all outside trash receptacles. The IPN stated the P&P of the facility was not followed. During a concurrent interview and record review on 12/4/2025 at 8:02 AM with the Director of Dining Services (DDS), the P&P titled Solid Waste Disposal was reviewed. The DDS stated the Director of Environmental Services (DES) oversees the outside dumpsters. The DDS stated the dumpster lids should be completely closed at all times according to the facility policy. The DDS stated that the P&P was not followed. During an observation of the facility dumpster area on 12/4/2025 at 7:30 AM, 1 of 3 dumpsters was observed overflowing with trash and was not entirely closed/ covered with its lid. During an observation of the facility dumpster area on 12/5/2025 at 8 AM with the IPN, 2 of 3 dumpsters were observed overflowing with trash and were not completely covered/closed. The IPN stated that both dumpsters should be completely closed because open dumpsters can attract flies and other pests which could be harmful to the residents. During a concurrent interview and record review on 12/5/2025 at 8:40 AM with the DES, the photo documentation of the dumpsters taken on 12/2/2025, 12/4/2025, and 12/5/2025 and the Solid Waste Disposal P&P were reviewed. The DES confirmed the dumpsters were not covered or completely closed as shown on the pictures. The DES stated that according to the P&P, lids should be kept closed on all outside trash receptacles. The DES stated the open dumpsters exposed trash and can potentially attract flies and rodents and can get into the open kitchen door when it is open. The DES stated the flies can contaminate the food and cooking equipment that if served to the residents, can potentially cause residents to get sick and hospitalized . During a review of the P&P titled, Solid Waste Disposal P&P, dated 1/20/25, indicated that lids should be kept closed on all outside trash receptacles. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections or diseases in the healthcare setting) were followed in accordance with the facility's policy and procedure by failing to: 1. Ensure an opened box of disposal gloves was left on top of Resident 31's dirty linen container. This failure had the potential to result in the spread and development of infection through cross contamination (when bacteria or other microorganisms are unintentionally transferred from one person or object to another). 2. Resident 36's used nasal cannula was left on the resident's wheelchair. This failure had the potential to expose Resident 36 to harmful bacteria when the resident reinserts the nasal cannula prongs. 3. a. Ensure Resident 5's tube feeding machine (enteral feeding pump, delivers liquid nutrition /formula directly into the stomach or small intestine via a feeding tube) and intravenous pole (IV pole, a medical stand used to suspend bags of IV fluids, medications, or nutritional solutions so they can be delivered to a resident) were free of dried feeding formula stains. b. Ensure soiled towels were not left on top of the trash bin and soiled Hoyer Lift (a mechanical device used to lift and/or transfer a person) sling was placed inside the soiled linen cart for Resident 5.These deficient practices have potential to contaminate clean items and can place the residents at risk for infection. 4. Ensure Licensed Vocational Nurse 1 (LVN 1) doff (take off personal protective equipment [PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments]) while in an enhanced barrier precaution (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) resident room in accordance with Centers of Disease Control (CDC, the national public health agency of the United States) guidelines. This deficient practice had the potential to result in an increased risk for the spread of bacteria, viruses and pathogens (harmful microorganisms) to residents, visitors and staff throughout the facility, while increasing the risk of [preventable] infections. 5. Ensure the medication room was maintained in a clean, clutter-free (being free from unnecessary items and mess) by allowing personal staff items to be stored in the medication room. This failure had potential to risk the resident's safety by compromising the integrity of medication storage.Findings:<br><br>1. During a review of Resident 31's admission Record, the admission Record indicated the facility admitted the resident on 10/27/2025, with diagnoses including but not limited to syncope (when the brain does not get enough oxygenated blood due to a sudden drop in blood pressure, causing you to faint), heart failure (a heart disorder which causes the heart to not pump the blood efficiently), and kidney disease (when kidneys are damaged and cannot filter blood well).<br><br>During a review of Resident 31's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 10/29/2025, the MDS indicated resident can independently make decisions regarding daily life tasks and needs maximum assistance (helper does more than half the effort) with transfers.<br><br>During an observation on 12/2/2025 at 8:45 AM in Resident 31's room, an open box of medium-sized disposal gloves was on top of Resident 31's dirty linen hamper. Staff entered and exited the room without addressing the box of gloves.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 12/2/2025 at 8:57 AM with Registered Nurse Supervisor 2 (RNS 2), in Resident 31's room, an open box of medium-sized disposal gloves was on top of Resident 31's dirty linen hamper. RNS 2 stated it is an infection control issue because the gloves are no longer clean.<br><br>During a concurrent interview and record review on 12/4/2025 at 10:33 AM with the Infection Preventionist Nurse (IPN), the facility's P&P titled, Infection Prevention & Control Program, dated 6/2025 was reviewed. The P&P indicated personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) are worn to protect residents from cross-contamination. The IPN stated there is cross-contamination between the box of gloves and dirty linen hamper. IPN stated using contaminated PPE can spread germs to the residents.<br><br>During a concurrent interview and record review on 12/5/2025 at 11:30 AM with the Director of Nursing (DON), the facility's P&P titled, Personal Protective Equipment, revised 7/2020 was reviewed. The P&P indicated, [PPE] is maintained at each nurses' station or nearby designated location. DON stated it is not appropriate to store the gloves on top of the dirty linen hamper.<br><br>2. During a review of Resident 36's admission Record, the admission Record indicated the facility admitted the resident on 10/30/2025, with diagnoses including but not limited to bronchiectasis (a condition where damage causes the tubes in your lungs to widen), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and history of falls.<br><br>During a review of Resident 36's MDS, dated [DATE], the MDS indicated resident was moderately impaired in cognitive skills for daily decision making and needs partial assistance (helper does less than half the effort) with transfers.<br><br>During a review of Resident 36's Order Summary Report, dated 12/2025, the report indicated, resident needed oxygen at 2 liters per minute via nasal cannula as needed for COPD.<br><br>During a concurrent observation and interview on 12/5/2025 at 9:03 AM with the Occupational Therapist (OT), in the hallway, OT assisted Resident 36 to walk towards the Therapy Room. The OT pushed a wheelchair behind Resident 36. There was an oxygen tank in the rear storage basket of the wheelchair. A nasal cannula was connected to the oxygen tank and the other end of the nasal cannula which was meant to be placed in the resident's nostrils, was left on the seat of the wheelchair. OT stated the nasal cannula should have been stored in a pouch.<br><br>During a concurrent observation and interview on 12/5/2025 at 9:05 AM with the IPN, in the Therapy Room, Resident 36's nasal cannula was left on the seat of the wheelchair. IPN stated that leaving oxygen tubing on the wheelchair is improper handling and increases risk of infection for the resident.<br><br>During a concurrent interview and record review on 12/5/2025 at 12:20 PM with the DON, the facility's P&P titled, Oxygen Therapy, revised 7/2022 was reviewed. The P&P indicated, When nasal cannula or oxygen mask is not in use, place in a plastic bag or other infection prevention pouch to prevent contamination. DON stated staff did not follow the policy. DON stated staff should have put the oxygen tubing in a bag during therapy to prevent contamination.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and re-admitted on [DATE], transient ischemic attack (TIA, is a temporary blockage of blood flow to the brain), functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and pneumonia (a lung infection).<br><br>During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 1 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 5 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral and toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer, and toilet transfer.<br><br>a. During an observation on 12/2/2025 at 8:45 AM inside Resident 5's room, Resident 5's tube feeding machine had a beige colored stain on the top surface of the machine. The IV pole where the tube feeding machine was attached had beige colored splatter on the body and feet part of the pole. Resident 5's tube feeding machine was placed next to the resident's bed.<br><br>During a concurrent observation and interview on12/3/2025 at 9:49 AM with LVN 2, LVN 2 stated it was a dried tube feeding formula on the top of the tube feeding machine. LVN 2 stated, It was not supposed to be there. The staff should always clean the tube feeding machine because bacteria can grow from it. LVN 2 stated Resident 5 can become a high risk for getting sick.<br><br>During an interview on 12/3/2025 at 4:28 PM with Infection Preventionist Nurse (IPN), IPN stated Resident 5's spilled tube feeding formula should not be left on the top of the tube feeding machine because bacteria can grow on it and Resident 5 can have infection from it. IPN stated the staff should not have left the feeding formula at the foot of the IV Pole, because bacteria can grow from it and it was not safe practice for Resident 5.<br><br>During a concurrent observation and interview on 12/4/2025 at 8:11 AM with IPN, IV pole was observed to have dried beige colored splatter stains on the pole and at the base of the stand. IPN stated the IV pole had dried formula on the surface of the TF machine and IV Pole. IPN stated the staff should keep it clean because of infection control causing bacteria to harbor and make the resident sick.<br><br>During a concurrent review and record review of the facility's P&P titled, Housekeeping Cleaning Protocol, revised 7/2021, the P&P indicated, housekeeping services will routinely provide a clean environment which prevents the spread of infection. Employees are to pick up paper, debris and minor spills when they see them. Standard Room Cleaning in Resident Room Area-Use a hospital-grade disinfectant/germicide wipe or apply hospital-grade disinfectant/germicide to a clean cloth and wipe the medical equipment such as IV, GT machines and poles, oxygen concentrators, etc.<br><br>b. During an observation on 12/3/2025 at 2 PM inside Resident 5's room, there were bundled soiled white towels on top of the trash bin. The used Hoyer Lift sling was left in the corner of the room, next to Resident 5's wheelchair which was full of resident's personal belongings.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 12/3/2025 at 2:01 PM with CNA 1 inside Resident 5's room, CNA 1 stated the clean linens were on top of Resident 5's wheelchair and should have been placed inside Resident 5's closet. CNA 1 stated the Soiled Hoyer lift sling should have been in the dirty linen cart. CNA 1 stated he was going to put it in a bag and put it away in the dirty linen cart earlier, but he forgot.<br><br>CNA 1 stated the soiled towels, and dirty linens should have been placed inside the dirty linen cart. CNA1 stated Residents' room should be kept clean to avoid spread of infection.<br><br>During an interview on 12/3/2025 at 4:32 PM with IPN, IPN stated the soiled towels on top of the trash bin should not be there because it can spread germs. IPN stated the staff should have put it inside the dirty linen cart and not on top of the trash bin.<br><br>During an interview on 12/3/2025 at 4:34PM with IPN, IPN stated the staff should not leave dirty Hoyer lift sling laying around the resident's room. The soiled Hoyer lift sling can spread germs and residents can have infection.<br><br>During an interview on 12/5/2025 at 12:13 PM with the DON, the DON stated if the Hoyer lift sling was dirty, the staff should have put it inside the soiled linen cart. The DON stated the soiled towels should not have been left at the top of the trash bin. The DON stated the staff was not following the infection control policy.<br><br>During a concurrent interview and record review on 12/5/2025 at 12:23 PM with the DON, the facility's P&P titled, Linen Handling, initiated 11/2024, indicated to prevent contaminating surfaces, after handling soiled linen or transferring soiled linen bags into the soiled linen cart. Treat all soiled linen as being infectious and contaminated. The DON stated the Staff should have collected the soiled towels and should be placed in a plastic bag and put in a dirty linen cart. The staff should not put the soiled towel on top of the trash bin because that was dirty.<br><br>4. During a review of Resident 5's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), aphasia (a disorder that makes it difficult to speak) and encounter for gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).<br><br>During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. The MDS also indicated Resident 5 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.<br><br>During a concurrent medication observation via GT and interview on 12/4/2025 at 8:15 AM in Resident 5's room, LVN 1 was observed with a gown, which was opened from the back, showing LVN 1's scrubs. LVN 1 was then observed touching his scrubs and back with used gloves while untying his gown to remove his PPEs. LVN 1 stated he was touching his clothes which can transmit infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/4/2025 at 11:15AM, the Infection Preventionist Nurse (IPN) stated, It is not ok to reach behind your back with used gloves on because you can touch your clothes and back, which can spread infection. IPN also stated the staff should remove the gown and gloves together per Centers for Disease Control and Prevention (CDC) guidelines.<br><br>During an interview on 12/5/2025 at 11:46 AM, the DON stated for PPE doffing, the facility uses the CDC guidelines. The DON also stated the gloves should be removed first prior to removing the gown for infection control reasons.<br><br>During a review of the CDC undated guidelines, the guidelines indicated an example of removing PPEs in the following sequence:<br><br>1. Gown and Gloves (grasp the gown in the front with used gloves and pull away from the body so ties break)<br><br>2. Goggles or Face Shield<br><br>3. Mask or Respiratory<br><br>4. Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE.<br><br>5. During an observation on 12/5/2025 at 9:02 AM in the medication room, the following personal items and medications were found in the medication room:<br><br>1 opened box of expired N95 (a type of respirator that filters at least 95% of airborne particles). Expired 6/10/2022.<br><br>1 used toothbrush with a dry white substance on bristles wrapped in brown paper<br><br>1 used toothbrush with dry white substance on bristles and used toothpaste wrapped in brown paper.<br><br>Five (5) cans of a V8-Bloody [NAME] spicy drink.<br><br>1 pink and yellow bag unmarked with the following items inside:<br><br>1 unmarked black case with 2 hearing aids with brown crust residue.<br><br>seven (7) battery packets.<br><br>2 unknown white boxes in a clear bag.<br><br>1 business card.<br><br>1 open box of cereal marked Honey Bunches of Oats with a half empty clear bag with cereal inside. Expired 3/26/2025.<br><br>1 red and white box of KN95 (a protective face mask that conforms to the other standards for respiratory protection) with no expiration date.<br><br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1 pack of gold colored birthday candles.<br><br>1 gold and silver colored celebration sign marked Happy New Year.<br><br>1 clear blue container lid.<br><br>1 brown Christmas ornament.<br><br>1 open box of blue face masks with no expiration date.<br><br>1 open box of Honeywell N95 masks with no expiration date.<br><br>1 white box with 8 clear bags with Niosh N95 masks with no expiration date.<br><br>During an interview on 12/5/2025 at 9:15 AM with RNS 1, RNS 1 stated it is not ok to have personal items in the medication room because it can cause an infection to the residents. RNS 1 stated food does not belong in the medication room. RNS 1 stated, The food was for the staff and not the residents, it should not be in the medication room.<br><br>During a concurrent interview and record review on 12/5/2025 at 12 PM with the Director of Nursing (DON), the P&P titled, Medication Storage—Storage of Medication, dated 1/2023 was reviewed. The P&P indicated, the medication storage room should be clean and free of clutter. The DON stated anything that was expired should have been thrown away.<br><br>During a review of the facility's P&P titled, Medication Storage—Storage of Medication, dated 1/2023, indicated, Medication storage should be kept clean, well lite, organized and free of clutter. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555429 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa Gardens Health Care Unit | 842 East Villa Street<br>Pasadena, CA 91101 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its protocol for Antibiotic (medication used to kill bacteria and to treat infections) Stewardship Program by failing to ensure a culture ( growing microorganism like bacteria from a resident ) in a laboratory to diagnose infections, identify the specific germs, and tests which antibiotics effectively kill or stop it) was obtained before ordering antibiotic for one (1) of 1 sampled resident (Resident 36).This deficient practice had the potential for Resident 36 to be prescribed inappropriate antibiotics and increased the risk for developing antibiotic-resistant organisms (bacteria that are not controlled or killed by antibiotics) and suffer adverse side effects from unnecessary or inappropriate antibiotic use.Findings:During a review of Resident 36's admission Record, the admission Record indicated the resident was admitted on [DATE] with the following but not limited to diagnoses of Disseminated Mycobacterium Avium-Intracellulare Complex (DMAC - a severe opportunistic infection causing fever, sweats, weight loss and anemia), carrier of other infectious diseases, and antineoplastic chemotherapy (uses drugs to kill or stop cancer cells from growing, working by targeting rapidly dividing cells).During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool), dated 11/6/2025, the MDS indicated the resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear but was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene. During a review of Resident 36's Discharge Instructions from the General Acute Care Hospital (GACH), dated 10/30/2025, the Discharge Instructions indicated the facility was one of the recipients who received the residents medical report on 10/30/2025 at 4:54PM.During a review of Resident 36's Physician Orders, dated 10/30/2025, the physician orders indicated the following:1. Azithromycin (antibiotic) tablet 500 milligrams (mg - unit of measure) - Give 1 tablet by mouth one time a day every Monday, Wednesday, and Friday for mycobacterium avium complex (MAC)2. Ethambutol Hydrochloride (HCL) oral tablet 400mg (Ethambutol HCL) - Give 2 tablets by mouth one time a day every Monday, Wednesday, and Friday for mycobacterium avium complex (MAC).During a review of Resident 36's Physician Orders, dated 11/3/2025, the Physician Orders indicated Rifampin (antibiotic) oral capsule 300mg - Give 2 capsules by mouth one time a day every Monday, Wednesday, and Friday for mycobacterium avium complex (MAC). Give on empty stomach.During a concurrent interview and record review of Resident 36's medical records on 12/3/2025 at 11:55AM, Infection Preventionist Nurse (IPN) stated Resident 36 did not have a culture done. IPN also stated all infections should have a lab/culture (procedure used to check microorganisms from resident tissue or fluid sample) done before administering an antibiotic but for Resident 36, it was not done.During an interview on 12/4/2025 at 3 PM, the facility's Policy and Procedure (P&P) titled Antibiotic Stewardship Program, dated 4/2016, was reviewed. IPN stated Resident 36 did not obtain a culture. IPN also stated that neither the hospital nor physician was followed up as to whether a culture was obtained or not. IPN stated the policy does indicate that Resident 36 needs to have a lab/culture prior to administering an antibiotic.During a review of the facility's P&P titled Antibiotic Stewardship Program, dated 4/2016, the P&P indicated the Infection Preventionist (IP) will collect and review whether a culture was obtained before ordering antibiotic. |