| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555432 | A. Building<br>B. Wing | 12/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Solheim Senior Community | 2236 Merton Ave.<br>Los Angeles, CA 90041 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity and respect for five (5) of five sampled residents (Resident 55, 39, 27, 28 and 67) reviewed for dignity care area when:1. Resident 55's clothes had brownish to blackish stain on the resident's shirt and black, ash-like fibers on the chest area.2. Resident 39's clothes had a brownish stain on her shirt. 3. Certified Nursing Assistant 1 (CNA 1) used labels when addressing Resident 27 during breakfast on 12/16/2025.4. Resident 28's clothes had strands of white hair and dried whitish and yellowish material on the chest and shoulder areas.5. Resident 67's activities of daily living (ADLs-fundamental self-care tasks performed daily, like bathing, dressing, eating, using the toilet, and moving around) were not provided timely. These deficient practices had the potential to affect Resident 55, 39, 27, 28 and 67's sense of self-worth and self-esteem which could result in problems with emotional and mental well-being.Findings:<br><br>1. During a review of Resident 55's admission Record, the admission Record indicated Resident 55 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 55's diagnoses included benign prostatic hyperplasia (BPH, also known as an enlarged prostate, is a noncancerous condition in which the prostate gland becomes larger than normal), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), onychogryphosis (ram's horn nails, is a nail condition where nails become thickened, hardened, opaque, and curved like a ram's horn, often affecting the big toenail) and history of tobacco use.<br><br>During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool) dated 10/23/2025, the MDS indicated Resident 55 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, 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, toilet transfer and tub shower transfer.<br><br>During an observation on 12/15/2025 at 9:17 AM in Resident 55'S room, Resident 55 was sitting up on bed, sleeping. Resident 55 had some dry black, ash-like fibers on his chest area, and his shirt had brownish to blackish stains.<br><br>(continued on next page) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 12/16/2025 at 9:33 AM with CNA 2 inside Resident 55'S room, Resident 55 was awake sitting up on his bed. CNA 2 stated Resident 55 had been chewing tobacco and had some blackish - colored dry particles on his chest, as well as coffee stains (brownish to blackish stain) on his shirt.<br><br>During a concurrent observation and interview on 12/17/2025 at 10:44 AM with Director of Staff Development (DSD), DSD stated Resident 55 having tobacco particles (blackish colored dry particles) and brownish to blackish stain on the resident's shirt were not acceptable. The DSD stated staff should use clothing protector to prevent dirt and spills on Resident 55's clothes. DSD stated the facility staff need to keep the residents' clothes clean for their dignity<br><br>2. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 39's diagnoses included chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), congestive heart failure (is a long-term condition in which your heart cannot pump blood well enough to meet your body needs) and dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 39's MDS, dated 10/202025, the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 39 was dependent on toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, chair/ bed-to-chair transfer, and tub shower transfer.<br><br>During a concurrent observation and interview on 12/15/2025 at 9:54 AM inside Resident 39'S room, Resident 39 was awake and lying on her bed. Resident 39's shirt had brownish colored stain on her chest area. Resident 39 stated she does not know what happened or how she got the stain.<br><br>During a concurrent observation and interview on 12/17/2025 at 10:46 AM with DSD, DSD stated Resident 39's clothes were dirty. DSD stated Resident 39 had brownish colored stain on the chest area of the resident's shirt. The DSD stated, facility staff should always keep Resident 39's clothes clean for the resident's dignity<br><br>3. During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 27's diagnoses included chronic atrial fibrillation (an irregular and often very rapid heartbeat), chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should), and dementia<br><br>During a review of Resident 27's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 39 was dependent on toileting hygiene, shower/bathe self, lower body dressing, personal hygiene, toilet transfer, and tub shower transfer. The MDS also indicated Resident 27 needed setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) on eating.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 12/16/2025 at 8:26 AM in Resident 27's room, Resident 27 was observed sleeping. The food tray was placed on top of the overbed table in front of Resident 27. CNA 1 stated Do you need a straw for your favorite drink my love? [NAME], wake up. Honey, I need to feed you.<br><br>During an observation on 12/16/2025 at 8:31 AM in Resident 27's room, Resident 27 stated I said bye, do not talk to me anymore. CNA 1 replied to Resident 1 and said, Honey, we are going to eat now. Your food is getting cold.<br><br>During an interview on 12/18/2025 at 9:35 AM with CNA 1, CNA 1 stated she was not supposed to call Resident 27 Honey or other names like [NAME] or my love. CNA 1 stated, addressing Resident 27 with labels can persuade Resident 27 to eat the resident's breakfast. CNA 1 stated facility staff are not supposed to address the residents with labels, and they must address the residents with the resident's name to show respect and to keep the resident's dignity.<br><br>During an interview on 12/17/2025 at 10:50 AM with DSD, DSD stated the staff should not address the residents by calling them Baby, Sweetie, Sunshine, or Honey. The DSD stated, the staff should treat the residents with dignity and respect by calling the residents by their last name or name that the resident prefers.<br><br>During a review of the facility's undated Policy and Procedure (P&P) titled, Quality of Life - Dignity, the P&P indicated Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.<br><br>4. During a review of Resident 28's admission Record, the admission Record indicated the facility admitted Resident 28 on 12/2/2025 with diagnoses that included but not limited to generalized muscle weakness, difficulty walking, urinary tract infection (UTI-any infection in any part of the urinary system), hypoosmolality (the blood's overall concentration of solutes [like sodium or glucose] is too low, making it too dilute) and hyponatremia (amount of sodium in the blood is low).<br><br>During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28 has intact cognitive skills for daily decision making. The MDS indicated Resident 28 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and oral hygiene. The MDS indicated resident 28 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and personal hygiene. The MDS indicated Resident 28 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear.<br><br>During a review of Resident 28's care plan for self-care deficit: bathing, dressing, feeding, the care plan indicated an intervention to provide assistance with ADLs.<br><br>During an observation on 12/15/2025 at 12:05 PM, at Resident 28's bedside, Resident 28 was lying in bed and observed with multiple strands of white hair and dried whitish and yellowish material on Resident 28's clothes on the chest and shoulder areas. Resident 28 stated she has not gotten out of bed yet. Resident 28 stated she needs help cleaning up and getting out of bed.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/17/2025 at 2:35 PM with the DSD, the DSD stated morning care should have been done by the CNA by 10 AM. The DSD stated it was not acceptable that Resident 28 to have strands of hair and dried particles on her clothes. The DSD stated this would affect Resident 28's dignity.<br><br>5. During a review of Resident 67's admission Record, the admission Record indicated the facility initially admitted Resident 67 on 1/10/2025 and was readmitted on [DATE] with diagnoses that included but not limited to wedge compression fracture (type of spinal fracture [break in the bone] where the front of the vertebra [individual body segments that stack up to form the spine] collapses, while the back stays intact, often leading to back pain, height loss, and a forward spinal curve) of the spine, intervertebral disc degeneration (condition in which a damaged disc causes pain) of the lumbar spine, generalized muscle weakness, and abnormality of gait and mobility (any irregular walking pattern or movement style that deviates from what is considered typical).<br><br>During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 67 had intact cognitive skills. The MDS indicated Resident 67 required supervision or touching assistance with eating. The MDS indicated Resident 67 required partial/moderate assistance with oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 67 required partial/moderate assistance with rolling left and right, sitting- to- lying, lying-to- sitting on side of the bed, sit to stand from chair/wheelchair/bed, chair/bed to chair transfer, and toilet transfer. The MDS further indicated Resident 67 was dependent with tub/shower transfer and walking 10 feet (standard unit of length used for measuring height, length and distance.<br><br>During a concurrent observation and interview on 12/16/2025 at 9:20 AM with Resident 67, inside her room, Resident 67 was observed lying in bed, and Resident 67 stated she does not know if the CNA will give her a shower or just change her clothes. Resident 67 stated she was waiting for the CNA to come in to assist her with brushing her teeth since Resident 67 woke up. Resident 67 stated she wished the staff would come into the room in the morning to inform her what the day's schedule was or what time she would be assisted with Resident 67's ADLs.<br><br>During a concurrent interview and record review on 12/17/2025 at 11:08 AM with the DSD, the P&P titled Activities of Daily Living, dated 2022, was reviewed. The P&P indicated residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The DSD stated the P&P was not followed. The DSD stated that staff should inform residents as to the schedule for the day at the start of their shift, during their initial rounds. The DSD stated that if residents were still asleep during the staff's initial rounds, staff should check back to inform them of the schedule, so residents were not kept waiting and the residents should have been provided with ADLS in the morning and not wait until lunchtime.<br><br>During a review of the facility's P&P titled, Quality of Life – Dignity, undated, the P&P indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The P&P indicated residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). |

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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>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, interview, and record review, the facility failed to maintain a comfortable sound level (sound that does not interfere with resident's hearing and enhance privacy when privacy is desired, and encourage interaction when social participation is desired, resident's control over unwanted noise) for one of twenty sampled residents (Resident 31). This deficient practice had the potential to negatively impact Resident 31's quality of life.During a review of Resident 31's admission Record, the admission Record indicated the facility admitted Resident 31 on 1/13/2021 and readmitted the resident on 7/11/2023 with diagnoses that included, but not limited to hypertension (elevated blood pressure), heart failure (the heart cannot pump enough oxygen-rich blood to meet the body's needs), and insomnia (common sleep disorder making it difficult to fall asleep, stay asleep, or wake up too early, leaving one feeling unrested). During a review of Resident 31's Minimum Data Set (MDS-a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 31 had adequate hearing ability (no difficulty hearing in normal conversation, social interaction, and listening to television) without any hearing aid or appliance. The MDS indicated Resident 31 had intact cognitive (mental abilities that helps us think, learn and solve problems) skills for daily decision making. The MDS indicated Resident 31 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral, and personal hygiene. The MDS indicated Resident 31 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for upper body dressing. The MDS indicated Resident 31 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or two or more helpers are required for the resident to complete the activity) with toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear. The MDS also indicated that Resident 31 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) for rolling left to right on the bed and was dependent with sit to lying, lying to sitting on side of the bed, chair/bed to chair transfer and tub/shower transfer. During an observation in Resident 31's room and interview on 12/16/2025 at 2:56 PM, Resident 31 was observed awake in bed. Resident 31 stated the handheld radios (devices that transmit and receive voice over radio waves) carried by the staff disturb her. Resident 31 stated that on more than one occasion, the radio of the Certified Nurse Assistant (CNA) assigned to her, kept going off asking the CNA to go to another room to pick up a tray while providing her morning care. Resident 31 stated she felt upset and did not have the full time and attention of the staff. During an interview on 12/18/2025 at 10:41 AM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated the radios were used everyday for staff communication. LVN 5 stated staff carry them all the time including while inside the residents' rooms. LVN 5 stated that residents had complained or asked what the noise was when the radios go off. LVN 5 stated that the noise the radios create can be disruptive to the residents' everyday lives. LVN 5 stated that the residents have the right to have the noise under control or at a comfortable level. During an interview on 12/18/2025 at 11:07 AM with CNA 1, CNA 1 stated when the radio goes off while in the middle of morning care or changing diapers, the caller would have to call again until it was answered. CNA 1 stated that the noise could cause disturbance to the resident she was taking care of. CNA 1 stated that it could potentially make the residents feel they are not important or not receive the care that they need. During a concurrent interview and record review with the Administrator (ADM), the policy and procedure (P&P) titled, Accommodation of Needs, dated 1/2021, was reviewed. The ADM stated P&P indicated that staff should conduct rounds and visual inspections to see how the environment accommodates the resident's needs. While conducting rounds, staff will gather information as to whether or not the individual needs and preferences are being addressed. The ADM stated accommodating the needs of the residents includes maintaining a comfortable sound level for the residents not to be bothered or disturbed by the noise of the radios. During a review of the P&P titled, Accommodation of Needs, dated 1/2021, the P&P indicated that staff should conduct rounds and visual inspections to see how the environment accommodates the resident's needs. The P&P also indicated that while conducting rounds, staff will gather information as to whether or not the individual needs and preferences are being addressed. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two (2) of 2 sampled residents (Resident 55 and 39) reviewed for 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) were provided care and services to maintain good grooming and personal hygiene when:1. Resident 55's fingernails on both hands were long, untrimmed and had blackish brown discolorations.2. Resident 39's fingernails on both hands were long, untrimmed and had brownish discolorations. This deficient practice had the potential for Resident 55 and 39 to develop infection and skin breakdown which could result in the decline of the residents' wellbeing.Findings:1. During a review of Resident 55's admission Record, the admission Record indicated Resident 55 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 55's diagnoses included benign prostatic hyperplasia (BPH, also known as an enlarged prostate, is a noncancerous condition in which the prostate gland becomes larger than normal), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), onychogryphosis (ram's horn nails, is a nail condition where nails become thickened, hardened, opaque, and curved like a ram's horn, often affecting the big toenail) and history of tobacco use. During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool) dated 10/23/2025, the MDS indicated Resident 55 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, 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, toilet transfer and tub shower transfer. During a concurrent observation in Resident 55's room and interview on 12/15/2025 at 9:17 AM, Resident 55 was observed awake and lying on the bed. Both of Resident 55's hands were resting on his abdomen. All of Resident 55's fingernails were long, untrimmed and had blackish-brown debris underneath. Resident 55 stated he was scratching both his arms because they were dry and itchy. Resident 55 stated he also scratches his chest and abdomen. Resident 55 stated, My nails were long and sharp, so it hurts me when I scratch myself. During a concurrent observation in Resident 55's room and interview on 12/16/2025 at 9:33 AM with Certified Assistant 2 (CNA 2), CNA 2 stated Resident 55 fingernails were long, sharp, untrimmed, and dirty. CNA 2 stated Resident 55 scratches himself frequently and accumulates dry skin debris when he does so. During a concurrent observation in Resident 55's room and interview on 12/17/2025 at 9:56 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 55's fingernails had blackish-brown debris underneath. LVN 2 stated it is not acceptable for Resident 55 to have dirty fingernails because it can cause infection. During a concurrent observation in Resident 55's room and interview on 12/17/2025 at 9:57 AM with CNA 3, CNA 3 stated Resident 55's fingernails were dirty. CNA 3 stated Resident 55's fingernails should be kept clean by the facility staff to prevent resident skin damage when the resident scratches himself and to avoid infection. 2. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 39's diagnoses included chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), congestive heart failure (is a long-term condition in which your heart cannot pump blood well enough to meet your body needs) and dementia (a progressive state of decline in mental abilities) During a review of Resident 39's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 39 was dependent on toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, chair/ bed-to-chair transfer, and tub shower transfer. During an observation in Resident 39's room on 12/15/2025 at 9:37 AM , Resident 39 was awake and lying on the bed. Both of the resident's hands were resting on her chest, and the fingernails on both hands were long, untrimmed, and had blackish-brown debris underneath. During a concurrent observation in Resident 39's room and interview on 12/16/2025 at 8:43 AM with CNA 4, Resident 39 was lying on her bed. CNA 4 stated that Resident 39's fingernails were long, dirty, and had blackish-brown debris underneath. CNA 4 also stated |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<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 accurately monitor the fluid intake for one of one sampled resident (Resident 33) under hydration care area. This deficient practice had the potential to cause fluid overload (when the body has too much water, causing fluid to build up in blood vessels and tissues, leading to swelling, high blood pressure, shortness of breath, and increased strain on the heart and kidneys) and/or increase edema ( swelling caused by excess fluid trapped in the body's tissues and shortness of breath). Findings: During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 33's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (brain damage, affecting left side of the body [arm, leg, face] due to blocked blood flow, depriving brain cells of oxygen and causing cell death), chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), hypoxemia ( a serious medical condition where there is abnormally low oxygen in the arterial blood), and chronic diastolic (congestive) heart failure (the heart's main pumping chamber (left ventricle) becomes stiff and thick, preventing it from relaxing and filling properly with blood between beats, leading to symptoms like shortness of breath, fatigue, and swelling, despite the heart's normal contraction strength). During a review of Resident 33's Minimum Data Set (MDS, a resident assessment tool) dated 9/24/2025, the MDS indicated Resident 33 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 33 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, Resident 33 needs supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for eating and oral hygiene. During a review of Resident 33's Physician Orders, dated 8/21/2025, the Physician's Order indicated Resident 33's fluid restriction of 1600 milliliter (ml, a volume unit) per 24 hours as follows:- Dietary 720 ml (for meals): 240 ml breakfast, 240 ml lunch, 240 ml dinner- Nursing 880 ml: 300 ml for 7AM -3PM shift, 300 ml for 3PM to 11 PM shift, and 280 ml for 11PM to 7AM shift. During an observation on 12/16/2025 at 2:57 PM in Resident 33's room, there were three (3) cups, each containing eight (8) fluid ounces (fl. Oz, a unit of volume used in the imperial system equal to 30 ml per fluid oz) of drinking water observed on the resident's side table. During an interview on 12/16/2025 at 3:16 PM with Licensed Vocational Nurse 3 (LVN 3 ), LVN3 stated Resident 33 is on fluid restriction and on monitoring for oral intake, LVN 3 stated Resident 33 was not supposed to have three 8 fluid ounces cups of water at bedside. LVN 3 stated, the staff should have removed the extra water at resident's bedside table to prevent the resident from fluid overloaded ( when there is too much fluid in the body, causing swelling (edema) and strain on organs like the heart and lungs, often due to heart, kidney, or liver issues, or excessive fluid/sodium intake) due to the resident's heart condition. During an observation and interview on 12/17/2025 at 8:29 AM in Resident 33's room, observed Resident 33 eating her breakfast. Resident 33 was drinking her coffee, eating her yogurt and she had finished her orange juice. Resident 33 breakfast meal ticket 6 fl. Oz of coffee, 2 fl. oz coffee creamer, 4 fl. oz orange juice, 6 oz strawberry yogurt and 6 oz of cream of wheat. Resident 33 stated she did not know she was on fluid monitoring. During a concurrent observation and interview on 12/17/2025 at 12:48 PM in the dining hall, observed Resident 33 eating lunch. Resident 33 had an 8 oz cup of juice and a 12 oz cup of water in front of her. Certified Nursing Assistant 5 (CNA 5) stated Resident 33 did not have a meal ticket to indicate fluid restrictions. CNA 5 confirmed they did not record Resident 33's fluid intake during meals. CNA 5 stated Resident 33's fluid intakes should have been recorded. CNA 5 stated she does not know that Resident 33 has an order for fluid restriction and fluid intake monitoring for her daily intake. During a concurrent interview and record review on 12/17/2025 at 4:24 PM with the Registered Dietitian (RD), RD confirmed that Resident 33 was on fluid restriction per physician's order. RD stated Resident 33's fluid intake for breakfast was supposed to be 240 ml. RD stated Resident 33's amount of fluid allowed for breakfast was over the limit of 240 ml per physician's order. RD stated Resident 33 was supposed to be monitored for her fluid intake for all meals including lunch and dinner. RD stated fluid restriction monitoring can prevent Resident 33 from getting fluid overloaded, edema, and heart failure. During an interview on 12/18/2025 at 12:24 PM with Director of Nursing (DON), the DON stated CNAs should have removed all extra water from Resident 33's bedside to properly monitor and |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement treatment for the prevention of pressure ulcer (PU, painful wound caused as a result of pressure or friction) by failing to ensure that the low air loss mattress (LALM, mattress used for residents who are at risk for developing sores or already have pressure ulcer designed to circulate a constant flow of air for the management of pressure sores) was on the correct settings for two (2) of two sampled residents (Residents 24 and 37) under pressure ulcer care area, in accordance with the facility's policy and procedure (P&P) and physician's order. This deficient practice had the potential for Residents 24 and 37 to develop pressure ulcers. Findings:1. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 24's diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), polyneuropathy (the most common form of a group of disorders known as peripheral neuropathy, is caused by damage to peripheral nerves [all nerves beyond the brain and spinal cord]) and bilateral osteoarthritis (a type of arthritis [inflammation or swelling of one or more joints] that only affects the joints, usually in the hands, knees, hips, neck, and lower back) of the hip. During a review of Resident 24's Minimum Data Set (MDS, a resident assessment tool), dated 11/6/2025, the MDS indicated Resident 55 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, 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, chair/ bed-to-chair transfer, and tub shower transfer. The MDS also indicated Resident 24 was at risk for pressure ulcers and using pressure relieving devices for bed. During a review of Resident 24's Physician's Order (PO), dated 1/30/2025. The PO indicated to monitor LALM every shift for placement/setting may adjust to resident's weight/comfort every shift. During a review of Resident 24's Care Plan (CP), revised 9/29/2025, the CP indicated Resident 24 had Parkinson's affecting posture, muscles, and polyneuropathy. The CP interventions included were to use adaptive devices as recommended by therapy or physician, monitor for safe use, and to monitor/document to ensure appropriate use of safety/assistive devices. During a review of Resident 24's Braden Scale Assessment (BSA), dated 11/5/2025, the BSA indicated Resident 24 had a score of 13 which indicated Resident 24 had a moderate risk for developing pressure ulcer. During an observation on 12/15/2025 at 9:01 AM in Resident 24's room, Resident 24 was lying on the bed with a LALM, which was set up at 340 pounds (lbs., unit of measurement). During a review of Resident 24's Medical Records, the Medical Records indicated Resident 24's weight was 113 lbs. on 12/11/2025. During a concurrent observation and interview on 12/17/2025 at 9:45 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 24's LALM was set up at 340 lbs., which was incorrect. LVN 1 stated the LALM should be set based on Resident 24's weight. LVN 1 added, if the LALM was set up too high, it would be too hard, and Resident 24 might develop a PU. LVN 1 stated, this will not be effective for Resident 24's skin maintenance. 2. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE], Resident 37's diagnoses included peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel), peripheral neuropathy (happens when the nerves that are located outside of the brain and spinal cord [peripheral nerves] are damaged, dementia (a progressive state of decline in mental abilities) and muscle weakness During a review of Resident 37's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 37 was dependent on oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying-to- sitting on the side of the bed, sit to stand, chair/ bed-to-chair transfer, and tub shower transfer. The MDS also indicated Resident 37 was at risk of developing pressure ulcers and using pressure relieving devices for chair and bed. During a review of Resident 37's BSA, dated 9/24/2025, the BSA indicated Resident 37 had a score of 15 which indicated Resident 37 was at risk for developing pressure ulcers. During an observation on 12/15/2025 at 9:56 AM in Resident 37's room, Resident 37 was lying on her bed sleeping. Resident 37's LALM was set up at 200 lbs. During a review of Resident 37's Medical Records, the Medical Records indicated Resident 37's |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide interventions to prevent accidents (any unexpected or unintentional incident, which results or may result in injury or illness) such as for aspiration (happens when food, liquid, or other material enters a person's airway and eventually the lungs by accident) and/ or choking (when food or another object gets stuck in your airway) for one (1) of seven sampled residents (Resident 39) from the accidents care area by failing to ensure Resident 39's head of the bed (HOB) was upright or elevated to 90-degree angle (a unit for measuring angles, where a full circle is 360 ) and properly positioned during mealtimes. This deficient practice placed Residents 39 at risk for aspiration and choking which had the potential to result in serious consequences like aspiration pneumonia (is a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs), hospitalization, and death.Findings:During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 39's diagnoses included chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), congestive heart failure (is a long-term condition in which your heart cannot pump blood well enough to meet your body needs) and dementia (a progressive state of decline in mental abilities). During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 10/20/2025, the MDS indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 39 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, chair/ bed-to-chair transfer, and tub shower transfer. The MDS also indicated Resident 39 needs setup or clean up assistance when eating. During a review of Resident 39's undated Care Plan (CP) for Activities of Daily Living (ADLs, 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) self- care performance deficit related to disease process acute respiratory failure. The CP indicated interventions include Resident 39 requires set up/ supervision by 1 staff to eat. During an observation and interview on 12/16/2025 at 8:38 AM with Resident 39 inside Resident 39'S room, Resident 39 was awake and lying on her bed. Resident 55 stated I am trying to eat but the head of my bed (HOB) was too low. Can you please sit me up a little bit? Resident 39's HOB was low, elevated to a 60-degree angle. During an observation and interview on 12/16/2025 at 8:40 AM with Certified Nursing Assistant 4 (CNA 4) inside Resident 39's room, Resident 39's HOB was low, positioned below 90 degree angle. CNA 4 came inside Resident 39's room and stated Resident 39's HOB was too low and should be placed at 90 degrees angle. During an interview on 12/16/2025 at 3:14 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the HOB below 90 degrees was too low for Resident 39 to eat her food. The HOB should be upright to 90-degree angle when Residents are eating or drinking water, because Residents are at risk for aspiration and can cause aspiration pneumonia. During an interview on 12/18/2025 at 11:44 AM with MDSN, MDSN stated Resident 39 should be positioned correctly and should be sitting up and elevating the HOB on 90-degree and position the overbed table closer to Resident 39's chest. Resident 39's HOB needs to be sitting up to prevent aspiration and choking when resident is eating. During a review of the facility's undated Policy and Procedure (P&P) titled, Preparing the Resident for a Meal, the P&P indicated Residents whose meals are served in bed should be properly positioned by using wedges and pillows to achieve a nearly upright position and having the resident in the sitting position, with the head slightly forward, will lessen the possibility of choking. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the food was prepared by methods that conserved the flavor, was palatable and served at a safe and appetizing temperature for five of five (Residents 2, 56, 13, 28, and 34) sampled residents during lunch time. This deficient practice had the potential to impact on the residents' nutritional status and quality of life, and can lead to insufficient food intake that could potentially lead to weight loss.Findings:<br><br>1. During a review of Resident 2 's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included hypertensive chronic kidney disease (a medical condition referring to damage to the kidney due to chronic high blood pressure), paroxysmal atrial fibrillation ( a type of irregular heartbeat where episodes start and stop suddenly, usually within 7 days, either on their own or with treatment, returning the heart to a normal rhythm) and unspecified severe protein-calorie malnutrition (a serious lack of enough protein and energy [calories] for the body's needs).<br><br>During a review of the Minimum Data Set (MDS- a resident assessment tool) dated 10/30/2025, the MDS indicated Resident 2 had intact cognitive (ability to think, learn, remember, use judgement and making decisions) skills for daily decision making. The MDS also indicated Resident 2 need setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene and personal hygiene. The MDS indicated Resident 2 is dependent, (helper does all of the effort) with the toileting hygiene, shower, bathe self, lower body dressing, putting on/ taking off footwear, change of position, and transfer.<br><br>During an interview on 12/15/2025 at 12:05 PM with Resident 2, Resident 2 stated, My foods were cold, and they are not even lukewarm, nor warm, I have to ask my certified nurse aid (CNA) to help me warm up my coffee, soup, and my foods. In addition, Resident 2 stated there was spice in some foods here, Resident 2 stated she did not understand why the cook needed to add spices to some of the food. Resident 2 said, I'm tired of eating it. At times I just won't eat because it's not a good experience.<br><br>During an observation on 12/15/2025 at 12:55 PM in Resident 2's room, Resident 2's lunch tray was delivered by a CNA to Resident 2. Resident 2 stated, My food was just warm, they were not as hot as I expected and wanted it to be.<br><br>2. During a review of Resident 56 's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included acute respiratory failure with hypoxia (a severe, sudden condition where the lungs fail to get enough oxygen into the blood, leading to dangerously low oxygen levels and impairing organ function, pneumonia, [unspecified organism -lung inflammation is present, but doctors haven't identified the specific germ causing it]), and paroxysmal atrial fibrillation ( a type of irregular heartbeat where episodes start and stop suddenly, usually within 7 days, either on their own or with treatment, returning the heart to a normal rhythm).<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the MDS dated [DATE], the MDS indicated Resident 56 had intact cognitive skills for daily decision making. The MDS also indicated Resident 56 need setup or clean-up assistance with oral hygiene and personal hygiene and Resident 56 need supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating. The MDS indicated Resident 56 is dependent, with the toileting hygiene, shower, bathe self, lower body dressing, putting on/ taking off footwear, change of position, and transfer.<br><br>During an interview on 12/15/2025 at 12:55 PM in Resident 56's room, Resident 56 stated she got her lunch tray near 12:51 PM today and her food was served cold at times.<br><br>During a sample of the facility's lunch test tray (sampling of food), a regular texture tray, on 12/17/2025 at 12:48 PM, observed the test tray to have three grilled shrimp with chopped sweet potato, iced tea, salad and dessert. The temperature of three shrimps was 125 Degree Fahrenheit (F, a unit for measuring temperature).<br><br>During a sample of the facility's lunch test tray (sampling of food), a pureed texture (food that has been blended, ground, or mashed into a smooth, lump-free, pudding-like consistency, making it easy to swallow for people with chewing or swallowing difficulties) tray, on 12/17/2025 at 12:50 PM with pureed texture teriyaki chicken tasted normal and the pureed texture sweet potato tasted sour.<br><br>During a test of the facility's lunch tray with Registered Dietitian (RD) on 12/17/2025 at 1:10 PM, RD stated the grill shrimp's temperature should be at 135 F, RD also state the pureed potato did not taste sour, but it tasted like the cook added more spice today.<br><br>3. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 8/23/2025 with diagnoses that included but not limited to hypoosmolality (a condition where the levels of electrolytes [minerals like sodium, potassium, calcium essential to help your body function], proteins, and nutrients in the blood are lower than normal) and hyponatremia (abnormally low sodium level in the blood) and iron deficiency anemia (happens when the body does not get enough iron or loses too much iron).<br><br>During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had intact cognitive skills for daily decision making. The MDS indicated Resident 13 required set up or clean up assistance for eating, oral and personal hygiene. The MDS indicated Resident 13 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing. The MDS indicated Resident 13 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, lower body dressing and putting on/taking off footwear and was dependent with shower/bathing self.<br><br>During an interview on 12/15/2025 at 11:30 AM with Resident 13, inside the resident's room, Resident 13 stated the resident's food usually was served cold at lunch. Resident 13 stated she preferred to eat in her room and preferred to eat warm food.<br><br>During a concurrent observation and interview on 12/15/2025 at 12:50 PM, inside Resident 13's room, lunch tray was not yet delivered. Resident 13 stated staff help other residents to eat first and that was why the lunch tray when delivered to the room, food was already cold.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. During a review of Resident 28's admission Record, the admission Record indicated the facility admitted Resident 28 on 12/2/2025 with diagnoses that included but not limited to generalized muscle weakness, difficulty walking, urinary tract infection (UTI-any infection in any part of the urinary system), hypoosmolality and hyponatremia.<br><br>During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28 has intact cognitive skills for daily decision making. The MDS indicated Resident 28 required supervision or touching assistance with eating and oral hygiene. The MDS indicated Resident 28 required partial/moderate assistance with upper body dressing and personal hygiene. The MDS indicated Resident 28 required substantial/maximal assistance with toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear.<br><br>During an interview on 12/15/2025 at 12:05 PM, inside resident's room, Resident 28 stated food gets to the resident cold and not good. Resident 28 stated, at breakfast (resident could not remember exact day), she was served fried potatoes and toast that was so hard (Resident was observed tapping her left hand on the bedside table while saying the toast was so hard like this), and she could not eat it. Resident 28 stated she filled out the menu for food she wanted to get served but she did not get the food that she chose (unable to recall exact date).<br><br>5. During a review of Resident 34's admission Record, the admission Record indicated the facility admitted Resident 34 on 6/19/2025 with diagnoses that included but not limited to hypertensive chronic kidney disease, unspecified protein calorie malnutrition, vitamin D deficiency (lack of vitamin D [a crucial nutrient for absorbing calcium to build stronger bones, supporting immune function, and maintaining muscle and nerve health]), and prediabetes (higher than normal blood sugar level).<br><br>During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 had intact cognitive skills. The MDS indicated Resident 34 required supervision or touching assistance with eating. The MDS indicated Resident 34 required partial/moderate assistance with oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear.<br><br>During a review of Resident 34's care plan (undated) focused on nutritional status, the care plan intervention included to modify diet as appropriate according to resident food tolerances and preferences.<br><br>During an interview on 12/15/2025 at 11:40 AM with Resident 34, inside the resident's room, Resident 34 stated she did not need help with eating but liked to get her meal tray on time and the food warm. Resident 34 stated the food gets to her room past 12:30 PM and the food is already cold. Resident 34 stated when food was cold, it was no longer that appetizing. Resident 34 stated she still ate the food because she needed to eat.<br><br>During a concurrent sample of the facility's lunch tray test on 12/17/2025 at 12:48 PM, observed the test tray with three fried breaded shrimps, purple- and orange-colored sweet potatoes. The Registered Dietician and Director of Dining Services (RD) took the temperature of the fried breaded shrimps, and it was 120 F. The RD stated ideally the temperature should be 135 F or more for fried breaded shrimp. The RD stated the fried breaded shrimp was cold.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedures (P&P) titled, Resident Meal Service, revised 1/2025, P&P indicated to provide each resident with a nourishing, palatable, well-balanced, attractive meal, at a safe and appetizing temperature that meets their daily nutritional needs. |

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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>(continued on next page) |

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| | 555432 | A. Building<br>B. Wing | 12/18/2025 |

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| Solheim Senior Community | 2236 Merton Ave.<br>Los Angeles, CA 90041 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices in accordance with its policy and procedure (P&P) by failing to ensure food was labeled and discarded after its use by date. These deficient practices had the potential to result in food born illness (any sickness that is caused by the consumption of foods or beverages that are contaminated with certain infectious or noninfectious agents) to 64 residents. Findings:During a concurrent observation and interview on 12/15/2025 at 7:49 AM in the facility kitchen with the Registered Dietitian (RD), the following food items were observed in the freezer: a. Four (4) frozen bags of mini empanada without a label to indicate an open or use by date.b. One (1) frozen bag of ravioli without a label to indicate open or use by date.c. 1 frozen bag of Asian Noodle without a label to indicate open or use by date.d. Two (2) frozen bags of chocolate chips cookies without a label to indicate open or use by date. e. 1 frozen bag of tuna labeled with a use by date of 12/14/2025.f. 2 frozen bags of frozen banana with a use by date of 12/11/2025.During a concurrent observation and interview on 12/15/2025 at 8:03 AM in the facility kitchen with the Registered Dietitian (RD), the following food items were observed in the refrigerator: a. 1 tray of chopped honeydew without a label to indicate preparation date and use by date.b. 1 tray of chopped cantaloupe without a label to indicate preparation date and use by date.c. 1 tray of chopped carrot without a label to indicate preparation date and use by date.d. 1 tray of chopped tomato without a label to indicate preparation date and use by date.e. 2 trays of salad dressing without a label to indicate preparation date and use by date.f. 2 trays of cheese without a label to indicate preparation date and use by date. During a concurrent observation and interview on 12/15/2025 at 8:15 AM in the facility kitchen with the Registered Dietitian (RD), the following food items were observed in the refrigerator: a. 1 opened container of hamburgers patty without a label to indicate use by date.b. 2 opened containers of chicken breast without a label to indicate use by date.c. 1 opened container of bacon without a label to indicate use by date.d. 1 container of thawing minced meat without a label to indicate the name of the item and use by date.e. 1 container of turkey sandwich without a label to indicate the name of the item and use by date.f. 1 container of cut apples soaked in water without a label to indicate the name of the item and use by date.g. 1container of pumpkin sauce with a use by date of 12/7/2025.h. 1 container of Marinara sauce labeled with a use by date of 12/14/2025.i. 1 container of cranberry sauce labeled with a use by date of 11/30/2025.j. 1 container of turkey slice labeled with a use by date of 12/12/2025k. 1 container of chicken noodle soup labeled with a use by date of 12/11/2025l. 1 bag of parmesan cheese with a use by date of 12/14/2025m. 1 uncovered tray of rice crispy without a label to indicate preparation date and use by date. During a concurrent observation and interview on 12/15/2025 at 8:40 AM in the facility kitchen with the Registered Dietitian (RD), the following food items were observed in the dry food storage area: n. 1 container of Chocolate fudge icing without a label to indicate open date and use by date. o. 1 bag of mini mush marrow without a label to indicate open date and use by date. p. 1 container of Cajun seasoning without a label to indicate open date and use by date. q. 1 container of old bay seasoning without a label to indicate open date and use by date. r. 1 container of low-fat cultured buttermilk without a label to indicate open date and use by date. s. 1 container of light amber honey without a label to indicate open date and use by date.t. 1 container of mayonnaise without a label of open date and use by date. RD stated in accordance with the facility policy, all food items should be labeled with an open and a use by date once opened. RD stated the use by date is the last day the item can be used and must be discarded after that date. RD also stated the food items should be labeled with their specific name and when they were prepared. RD stated it was important to label, store, and discard food items per policy to ensure that the food items are safe to eat for the residents. During a review of the facility's P&P titled, Food and Supply Storage, revised January 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. The P&P also indicated to cover, label and date unused portions and open packages. Use the Medvantage/Freshdate ( food labeling system that uses direct thermal printers and software to automate date/time stamping, nutrition info, and barcodes for food safety compliance, eliminating handwriting, reducing waste, and simplifying inventory in foodservice) labeling system or complete all sections on a [NAME] orange label (is to ensure proper food rotation and prevent the use of expired products), Products are good through the close of business on the date noted on the label. Refer to the Food Storage Chart in this policy to determine discard |

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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 of two garbage containers (dumpster) lids remained closed as indicated in the facility's policy and procedure (P&P) titled, Garbage Disposal & Waste Management,. This failure had the potential to result in the attraction and spread of vermin (animals that are believed to be harmful, or that carry diseases, e.g., rodent's parasitic worms or insects) that could potentially enter the facility and spread diseases to the residents. During an observation on 12/16/2025 at 1:53 PM in the facility's alley dumpsters area, there were two dumpsters (one Black and one blue) with lids left open. In addition, the black dumpster area gate was not closed. During an observation on 12/18/2025 at 8:24 AM in the facility's alley dumpsters area, the black dumpster was observed with lids open exposing the contents inside. The dumpster area gate was not closed. During an interview on 12/18/2025 at 8:52 AM with the Maintenance Supervisor (MS), MS stated per the facility's P&P, all the dumpsters' lids were supposed to be kept closed at all time and kept clean to keep out flies and rodents and to prevent transfer of disease. During a review of the facility's Policy and Procedure (P&P) titled, Garbage Disposal & Waste Management, dated 11/1/2019, the P&P indicated dumpsters and compactors shall remain closed when not in use. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate and complete record for one (1) of 20 sampled residents (Resident 30) as indicated in the facility's policy and procedure. This deficient practice had the potential to result in miscommunication, improper delivery of care and inaccurate information of the care provided to the Resident, which could negatively affect the overall wellbeing of Resident 30. Findings:During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 30's diagnoses included osteomyelitis (inflammation or swelling that occurs in the bone) of the right ankle/ foot, congestive heart failure (is a long-term condition in which your heart cannot pump blood well enough to meet your body needs), chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and dementia (a progressive state of decline in mental abilities) During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool), dated 11/17/2025, the MDS indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 30 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, 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, chair/ bed-to-chair transfer, and tub/shower transfer. During a review of Resident 30's Physician's Orders, the Physician's orders indicated:1. Started on 1/21/2025, Xarelto (Rivaroxaban, is a prescription anticoagulant [blood thinner] medication used to treat and prevent blood clots in various conditions) 15 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) Prophylaxis (prevention). Administer with dinner. Discontinued on 7/22/2025. 2. Started on 7/22/2025, Apixaban (Eliquis, a prescription medicine used to treat blood clots in the veins of the legs or lungs) 2.5 mg, give 1 tablet by mouth two times a day for atrial fibrillation (Afib, an irregular and often very rapid heartbeat) During a concurrent interview and record review on 12/18/2025 at 10:55 AM with MDS Nurse (MDSN), Resident 30's Physician's order dated 12/18/2025 was reviewed. MDSN stated the Apixaban was ordered on 7/22/2025 but the Licensed staff did not and should have changed the risk for bleeding monitoring order for the anticoagulant from Xarelto to Apixaban. During a concurrent interview and record review on 12/18/2025 at 10:59 AM with MDSN, the facility's undated Policy and Procedure (P&P) titled, Charting and Documentation, was reviewed. MDSN stated the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. MDSN stated the staff did not follow the policy because the monitoring for risk for bleeding for Resident 30 was for the wrong medication name. The staff did not update the medication for the anticoagulant monitoring, which means the monitoring order was inaccurate. During a review of the facility's undated P&P titled, Charting and Documentation, the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. |

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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 and/or disease in the healthcare setting) were followed for two (2) of five (5) sampled residents under the infection control area in accordance with the facility's policy and procedure when:1 Resident 56's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was found connected to the breathing treatment machine (turns liquid medicine into a fine, breathable mist [aerosol] that is inhaled directly into the lungs through a mouthpiece or mask) was not stored in a clean bag, labeled with resident's name and date of first use and left hanging in between the nightstand and the curtain close to the floor area. 2 Resident 5's nasal cannula and handheld nebulizer mask (delivers medicines in the form of aerosols to add moisture and help control respiratory symptoms) and its tubing connection were not stored in clean bag and left hanging on the wall, not labeled with resident's name and date of first use. These deficient practices had the potential to result in residents developing an infection that could potentially lead to hospitalization.<br><br>Findings:<br><br>1. During a review of Resident 56 's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included acute respiratory failure with hypoxia (a severe, sudden condition where the lungs fail to get enough oxygen into the blood, leading to dangerously low oxygen levels and impairing organ function, pneumonia, unspecified organism [lung inflammation is present, but doctors haven't identified the specific germ causing it], and paroxysmal atrial fibrillation ( a type of irregular heartbeat where episodes start and stop suddenly, usually within 7 days, either on their own or with treatment, returning the heart to a normal rhythm).<br><br>During a review of the Quarterly Minimum Data Set (MDS- a resident assessment tool), dated 10/16/2025, the MDS indicated Resident 56 had intact cognitive (ability to think, learn, remember, use judgement and making decisions) skills for daily decision making. The MDS also indicated Resident 56 need setup or clean-up assistance (helper sets up or cleans up) with oral hygiene and personal hygiene and Resident 56 need supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating. The MDS indicated Resident 56 is dependent, (helper does all of the effort) with the toileting hygiene, shower, bathe self, lower body dressing, putting on/ taking off footwear, change of position, and transfer.<br><br>During a review of Resident 56's Physician Orders, dated 5/23/2025, the Physician's Order indicated Resident 56 has an order for Ipratropium-albuterol (a prescription combination medication used to treat airway narrowing) solution 3 milligram (mg a unit of measurement)/3 milliliter, (ml- a metric unit for measuring liquid volume) inhale orally every six hours as needed for acute respiratory failure with hypoxia.<br><br>During an observation on 12/15/2025 at 12:50 PM in Resident 56's room, observed Resident 56's nasal cannula connected to the breathing treatment machine and hanging in between of the nightstand and the curtain close to the floor area. The nasal cannula was not labeled with the resident's name, date it was opened/ first use and it was not stored in a clean bag when not in use.<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 12/16/2025 at 11:05 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the breathing treatment and nasal cannula were supposed to be inside a clean bag when not in use and it should have been labeled with the resident's name and date it was opened or first use. LVN 3 stated it can help prevent infection and cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) when the treatment nasal cannula is properly stored inside a labeled clean bag.<br><br>During an interview on 12/17/2025 at 10:45 AM with the Infection Prevention Nurse (IPN), the IPN stated the nasal cannula should be labeled with Resident 56's name and the date it was opened or first use so the staff would know when the nasal cannula and nebulizer mask were opened and first used and when to discard or change them. The IPN stated if the nasal were left exposed or not kept in a clean bag and/ or not changed as scheduled, it would put Resident 56 at risk for infection that could result in illness and potential hospitalization.<br><br>2 During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body) and systolic congestive heart failure (the heart becomes weak or enlarged and can't pump enough oxygen rich blood to the body leading to fluid back up [congestion] in the lungs, legs, and abdomen, causing shortness of breath, fatigue, and swelling).<br><br>During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had intact cognitive (ability to think, learn, remember, use judgement and making decisions) skills for daily decision making. The MDS indicated Resident 5 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating. The MDS indicated Resident 5 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral and personal hygiene. The MDS indicated Resident 5 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathing self, and upper body dressing. The MDS indicated Resident 5 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) with lower body dressing and putting on/taking off footwear.<br><br>During a review of Resident 5's Order Summary, the Order Summary indicated orders dated 10/12/2025 for oxygen administration as needed per nasal cannula to titrate oxygen saturation (simple measure of how much oxygen the red blood cells are carrying, expressed in percentage, indicating how well the lungs are getting oxygen to the body) to 92% and above; and oxygen tubing and humidifier change one time a day every Tuesday for oxygen administration.<br><br>During an observation on 12/15/2025 at 11:16 AM in Resident 5's room, the nasal cannula tubing and nebulizer mask were observed hanging on the wall without any labels of Resident 5's name and date the tubings were opened and used). The nasal cannula tubing and nebulizer mask were hanging exposed and was not stored in a clean bag.<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 12/17/2025 at 10:42 AM with the Infection Prevention Nurse (IPN), the IPN stated the nasal cannula, nebulizer mask and its tubing connection should not be hanging by the wall uncovered or not placed in a clean bag when not in use. The IPN stated the nasal cannula and nebulizer mask should be labeled with Resident 5's name and the date when it was opened so the staff would know when the nasal cannula and nebulizer mask were opened and first used and when to discard or change them. The IPN stated if the nasal cannula and nebulizer mask were left exposed or not changed as scheduled, it would put Resident 5 at risk for infection that could result to illness and potential hospitalization. The IPN also stated, if the nasal cannula and nebulizer mask were not labeled with Resident 5's name, there will be a risk of potentially other resident or staff using it for another resident which places other resident at risk for cross contamination/ infection.<br><br>During a concurrent interview and record review on 12/17/2025 at 11:17 AM with the IPN, the policy and procedure (P&P) titled Nebulizers (Updraft), dated 9/10 was reviewed. The IPN stated the P&P indicated to store the nebulizer mask (after rinsing and completely dried) in a plastic bag with the resident's name and the date of first use on the nebulizer mask. The IPN stated the P&P also indicated to change equipment and tubing per nursing facility policy.<br><br>During an interview on 12/18/2025 at 4:50 PM with the Director of Nursing (DON), the DON stated the facility does not have a policy for changing oxygen and nebulizer tubing and/or mask. The DON stated that changing the nasal cannula and nebulizer mask including its tubing connection should be included in the physician's orders. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement a program that monitors antibiotic use.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's Antibiotic Stewardship Program (coordinated interventions designed to improve and measure the appropriate use of antibiotic agents by promoting the selection of the optimal drug regimen including dosing, duration of therapy, and route of administration) for the antibiotic (medication used to treat infection) use for two (2) of three (3) sampled residents (Residents 26 and 68) by failing to:1. Ensure Resident 26's laboratory test was done such as culture (test to check for bacteria or yeast, helping identify the specific germs causing infection, and find the best antibiotic to treat it) and sensitivity (a medical laboratory test identifying germs [like bacteria or fungi] causing the infection, in a sample and the best antibiotics to kill them) to ensure the appropriate use of antibiotic. 2. Ensure Resident 68 has an indication for the use of antibiotic and urine culture and sensitivity test was done to ensure the appropriate use of antibiotic. This deficient practice had the potential for Residents 26 and 68 to develop infection that is resistant (organism that is not able to be killed and continue to grow) to antibiotics or develop multiple drug resistant organism (microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents) that is difficult to treat due to unnecessary or inappropriate antibiotic use.1 During a review of Resident 26's admission Record, the admission Record indicated the facility admitted Resident 26 on 11/14/2025 with diagnoses that included but not limited to abscess of the liver (pus [thick, yellowish fluid the body makes during an infection at an infected site] filled pocket in the liver, usually caused by bacterial, parasitic, or fungal infections that spread from the abdomen or blood stream), severe sepsis (life threatening emergency that happens when your body's response to infection damages vital organs and, often, causes death), and bacteremia (bacteria [tiny, single celled living things that can cause sickness] are present in the bloodstream). During a review of Resident 26's Minimum Data Set (MDS-resident assessment tool), dated 11/19/2025, indicated Resident 26 had intact cognitive (ability to think, learn, remember, use judgement and making decisions) skills for daily decision making. The MDS indicated Resident 26 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating. The MDS indicated Resident 26 required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with oral and personal hygiene, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 26 was dependent with toileting hygiene and shower/bathing self. The MDS indicated Resident 26 was receiving antibiotics and had a peripherally inserted central catheter (PICC-a long, thin, flexible tube inserted into a vein in the upper arm and guided into a large vein near the heart used for long term intravenous [within a vein, referring to the method of delivering fluids, medicine, or nutrition] treatments). During a concurrent interview and record review on 12/17/2025 at 4:21 PM with the Infection Prevention and Control Nurse (IPN), the Order Summary for Resident 26 dated 11/15/2025 was reviewed. The Order Summary indicated Ertapenem Sodium (antibiotic used to treat moderate to severe bacterial infections) injection one (1) gram (unit of measurement of mass [weight]) intravenously, one time a day for liver abscess for four (4) weeks. The IPN stated the medication was started from the acute hospital and the physician from the facility ordered to continue administration of the medicine when Resident 26 was admitted at the facility. The IPN stated she was not familiar with the antibiotic stewardship program in terms of what to check when a physician ordered antibiotics. The IPN stated she did not bother to review Resident 26's laboratory studies such as culture and sensitivity test and any studies pertinent to the indication for the use of antibiotic. During the same interview on 12/17/2025 at 4:21 PM with IPN, the IPN stated the antibiotic stewardship surveillance included new admissions, not just current residents of the facility. The IPN stated that Resident 26's antibiotic use, laboratory test results such as culture and sensitivity and physician documentation of the indication for the antibiotics (the specific bacterial infection or situation where these medicines are medically approved and necessary to kill bacteria or stop them from growing) should have been reviewed, completed and documented when Resident 26 was admitted in the facility in accordance with the facility's antibiotic stewardship program. 2. During a review of Resident 68's admission Record, the admission Record indicated the facility admitted Resident 68 on 12/12/2025 with diagnoses that included but not limited to unstageable pressure ulcer (serious bed sore where the wound's base is hidden by yellow, brown, or black dead tissue, making its true depth and stage impossible to determine until the dead tissue is removed) of the sacral (lower back) region. During a review of Resident 68's MDS dated [DATE], the MDS |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 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 for three (3) of four sampled residents (Resident 55, 36, and 33) as indicated in the facility's policy and care plan.This deficient practice had the potential not to meet Resident 55, 36 and 33's needs and preferences.<br><br>Findings:<br><br>1. During a review of Resident 55's admission Record, the admission Record indicated Resident 55 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 55's diagnoses included benign prostatic hyperplasia (BPH, also known as an enlarged prostate, is a noncancerous condition in which the prostate gland becomes larger than normal), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), and muscle wasting/ atrophy (decrease in size and wasting of muscle tissue)<br><br>During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool) dated 10/23/2025, the MDS indicated Resident 55 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, 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, toilet transfer and tub shower transfer.<br><br>During a review of Resident 55's undated Care Plan (CP) for high risks for falls related to impaired safety awareness associated with resident's confusion and impaired mobility status, the CP indicated interventions were to ensure that the resident's call light is within reach and encourage the resident to use it for assistance as needed. The CP also indicated that the resident needs prompt response to all requests for assistance.<br><br>During an observation on 12/15/2025 at 9:17 AM in Resident 55's room, Resident 55 was sitting on his bed sleeping. Resident 55's call light was observed hanging at the back of the resident's bed frame and was not within Resident 55's reach.<br><br>During a concurrent observation on 12/15/2025 at 9:21 AM with Director of staff Development (DSD), DSD took the call light that was hanging at the back of Resident 55's bed and placed it on Resident 55's hands.<br><br>During an interview on 12/17/2025 at10:40 AM with DSD, DSD stated Resident 55's call light was hanging behind his bed. DSD stated if the call light was hanging at the back of the bed or on the floor, the resident would not be able to use the call light to call for help.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555432 | A. Building<br>B. Wing | 12/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Solheim Senior Community | 2236 Merton Ave.<br>Los Angeles, CA 90041 |

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

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 36's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting the left side of the body, heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body needs for blood and oxygen) and history of falling.<br><br>During a review of Resident 36's MDS, dated 10/22025, the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 36 was dependent on oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying-to sitting on the side of the bed, sit-to stand, chair/ bed-to-chair transfer, and tub shower transfer.<br><br>During an observation on 12/15/2025 at 2:48 PM in Resident 36's room, Resident 36 was observed sleeping but suddenly woke up and was asking for his call light. Resident 36's call light was observed on the floor.<br><br>During a concurrent observation on 12/15/2025 at 2:49 PM with Certified Nursing Assistant 6 (CNA 6) in Resident 36's room, CNA 6 picked up the call light on the floor and placed it within Resident 36's reach.<br><br>During an interview on 12/18/2025 at 2:58 PM with CNA 6, CNA 6 stated that Resident 36 presses his call light if he needs help. CNA 6 stated it was important for residents to have their call light within their reach so they can press it to call for help and staff can assist with their needs.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Nurse Call System, approved date 11/1/2017, the P&P indicated to be sure the call system is plugged in and within the resident's reach at all times. For those residents who are unable to operate the call system, be sure to check on them frequently.<br><br>3. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 33's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (brain damage, affecting left side of the body [arm, leg, face] due to blocked blood flow, depriving brain cells of oxygen and causing cell death), chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), and hypoxemia ( a serious medical condition where there is abnormally low oxygen in your arterial blood).<br><br>During a review of Resident 33's MDS, dated [DATE], the MDS indicated Resident 33 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 33 was dependent on toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear. Resident 33 needed supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for eating and oral hygiene.<br><br>(continued on next page) |

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| | 555432 | A. Building<br>B. Wing | 12/18/2025 |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 12/17/2025 at 8:33 AM in Resident 33's room, Resident 33's call light was observed next to the nebulizer (a medical device that turns liquid medicine into a fine mist, allowing it to be inhaled directly into the lungs to treat respiratory conditions) on the nightstand which was not within Resident 33's reach. Resident 33 was observed asking for the call light and stated that it was too far for her to reach.<br><br>During a concurrent observation and interview on 12/17/2025 at 8:37 AM with CNA 4, CNA 4 took the call light from the nightstand and put it on Resident 33's hands. CNA4 stated that the call light should be within Resident 33's reach so that the resident can request assistance, and keeping the call light accessible can help prevent the resident from falling<br><br>During an interview on 12/17/2025 at 10:40 AM with DSD, DSD stated Resident 33's call light was not supposed to be left on her nightstand. DSD stated that the call light should be within the resident's reach so the resident can use it to request assistance in a timely manner, which can also help prevent falls.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Nurse Call System, dated 11/1/2017, the P&P indicated, the purpose procedure is to provide residents a safe place to reside with timely response by staff in regard to their needs. This policy will provide guidance on how to utilize the nurse call system. The P&P indicated to Be sure the call system is plugged in and within the resident's reach at all times. |