STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review the facility failed to ensure seven (7) of 7 sampled residents (Residents 7, 19, 21, 34, 37, 49, and 16) had a completed Advanced Directive (AD, a written instruction, such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated)acknowledgment form. This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident's wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: 1. During a review of Resident 16's Admission Record, indicated the facility admitted Resident 16 on 1/30/2024 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - type of obstructive lung disease characterized by long-term poor airflow). During a review of Resident 16's History and Physical (H&P), dated 12/18/2023, indicated, Resident 16 did not have has the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/13/2024, the MDS indicated Resident 16 required moderate assistance with eating, oral hygiene, shower, body dressing, and personal hygiene. During a concurrent interview and record review on 3/17/2024 with Social Services Director (SSD) of Resident 16's medical records (chart). SSD stated, she was unable to find Resident 16's Advance Directive). SSD stated, upon admission Resident Representative or Resident 16 should be informed the option to formulate advance directive. DSS stated, she was not aware that AD Acknowledgement Form should be placed in Resident 16 ' s clinical records. During an interview on 3/17/2024 at 1:01 pm, with the facility ' s Director of Nursing (DON), the DON stated, AD needed to be placed in Resident 16 ' s chart to retrieve easily. The DON stated, it was the residents right to formulate AD for the facility to provide care and treatment to meet their wishes. 42854 (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
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 19's Admission Record indicated an admission to the facility on [DATE] with a diagnoses of anemia (not having enough healthy red blood cells (hemoglobin) to carry oxygen to the body ' s tissues), aftercare following joint replacement surgery and gastrostomy (a tube inserted through the belly that brings nutrition directly to the stomach). A review of Resident 19's History and Physical dated 2/9/2024 indicated Resident 19 had the capacity to understand and make decisions. A review of Resident 19's Physician Orders for Life-Sustaining Treatment (POLST) dated 3/17/2024 did not indicate an advance directive was discussed or offered to the resident or representative. 3. A review of Resident 21's Admission Record indicated a readmission to the facility on [DATE], with diagnoses that included Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) without dyskinesia (movement disorder that often appears as uncontrolled shakes, tics, or tremors), paranoid schizophrenia (a condition that affects thinking abilities, memories and senses, people commonly struggle to tell what is real and what is not and often have hallucinations and delusions), bipolar disorder. A review of Resident 21's History and Physical assessment dated [DATE] indicated Resident 21 had fluctuating capacity to understand and make decisions. A review of Resident 21's POLST dated 7/17/2021, did not indicate an advance directive was discussed or offered to the resident or representative. 4. A review of Resident 34's Admission Record indicated a readmission to the facility on [DATE] with a diagnoses of displaced transverse fracture of shaft of left femur, encounter for other orthopedic aftercare, and hyperlipidemia (high cholesterol, too many lipids (fat) in the blood). A review of Resident 34 ' s History and Physical dated 02/07/2024 indicated Resident 34 had the fluctuating capacity to understand and make decisions. 5. A review of Resident 37's Admission Record indicated an admission to the facility on [DATE] with a diagnoses of hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones that can disrupt heart rate, body temperature and metabolism), Chronic obstructive pulmonary disease (COPD, group of lung diseases that block airflow and make it difficult to breathe), and overactive bladder. A review of Resident 37's History and Physical dated 4/8/2023 indicated Resident 37 had fluctuating capacity to understand and make decisions. 6. A review of Resident 49's Admission Record indicated an admission to the facility on [DATE] with a diagnoses of influenza (contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs), urinary tract infection (UTI, common infections that happen when bacteria, often from the skin or rectum, enter the urethra (the tube through which urine leaves the body), and infect the urinary tract), and type 2 diabetes mellitus (condition that happens because of a problem in the way the body regulates and uses sugar fuel). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 49's History and Physical dated 1/12/2024 indicated Resident 49 had the capacity to understand and make decisions. During a concurrent interview and record review of Advance Directive Acknowledgment forms on 3/17/2024 at 10:15 AM, the Social Services Director (SSD) stated she had all the copies of Resident 19, 21, 34, 37, and 49's Advance Directive Acknowledgment forms. The SSD stated all the copies were placed in the SSD ' s office and not in the residents ' medical charts. The SSD could not recall why the forms were not in the resident ' s charts. 42878 7. A review of Resident 7 ' s Face Sheet indicated the resident was readmitted to the facility on [DATE] with diagnoses that included cellulitis (common and potentially serious bacterial skin infection) of back, juvenile rheumatoid arthritis (an autoimmune inflammatory disease, which means that your immune system [part of the body that fights infection] attacks healthy cells in your body by mistake, causing inflammation) A review of Resident 7's History and Physical dated 1/06/2024 indicated Resident 7 does not have the capacity to understand and make decisions. A review of Resident 7's Physician Orders for Life-Sustaining Treatment (POLST) dated 12/1/2022 indicated Resident 7 had an Advance Directive,dated 12/1/2022. During a concurrent interview and record review on 3/17/2024 at 11:05 AM with Social Services Director (SSD) of Resident 7's medical records (chart), the SSD stated, she was unable to find Resident 7's Advance Directive in Resident 7's clinical record. The SSD stated, upon admission Resident 7's representative informed the facility that Resident 7 had an Advance Directive, but the RP had not provided the AD to the facility. The SSD stated she had not followed up with Resident 7's representative because he would visit on the weekends and the SSD does not work on weekends. During an interview on 3/17/2024 at 4:40 PM, with Director of Nursing (DON), DON stated it was important to have Resident 7's Advance Directive on file in the resident ' s clinical record so that it was easily accessible in case of an emergency. During a review of the facility's Policy and Procedure titled, Advance Directives, revised 2/2017, the P&P indicated, the facility must document in the prominent part if the resident ' s clinical record whether the resident has issued an advance directive. The P&P indicated the facility ' s copy of the advance directive must be filed in the resident ' s clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42781 Based on interview and record review, the facility failed to check prior employers for three of five randomly selected employees Certified Nurse Assistant (CNA) 1, CNA 2, and Registered Nurse 1 (RN1) in accordance with the facility's policy and procedure, titled Abuse and Neglect Prohibition to prevent and protect residents from abuse. This deficient practice had the potential for the facility to hire employees with history of abuse, neglect or mistreatment of residents which put residents at risk for abuse and lead to possible physical and emotional harm residents. Findings: During a concurrent interview and record review with the Director of Staff Development (DSD) and review of the employee file of CNA 1 on 3/16/2024 at 11:32 am, the DSD stated CNA 1 was hired on 2/10/2024. The DSD stated there was no documented evidence that CNA 1 ' s previous employment was checked prior to hiring CNA 1. The DSD stated the previous employer of the employee must be verified prior to hiring to know if employee have abuse records in their previous employment. During a concurrent interview and record review of the employee file of CNA 2 on 3/16/2024 at 11:49 am, the DSD stated, CNA 2 was hired on 10/16/2020. The DSD stated, she did not attempt to verify CNA 2 ' s previous employment. The DSD stated there was no other documented evidence that CNA 2 ' s previous employment was checked prior to hiring CNA2. During a concurrent interview and review of the employee file of RN 1 on 3/16/2024 at 11:57 am, the DSD stated, she did not attempt to verify RN 1's previous employment. The DSD stated RN 1 ' s previous employment verification was needed to validate the applicant ' s experience and check any history of abuse in the previous employment which could lead to possible abuse of residents in the current facility. During an interview with the facility Director of Nursing (DON) on 3/16/2024 at 12:23 pm, the DON stated that there should had been an attempt to call the previous employer of the staffs before hiring the employees which was part of screening process for potential employees, to make sure the facility does not hire a staff with history of abuse which could lead to potential abuse residents. During an interview with the Administrator (Adm) on 3/17/2024 at 5:55 pm, the Adm stated, the previous employment was needed to be verified for each employee prior to hire at the facility, which was part of abuse screening for applicants for residents ' safety. A review of the facility's policy and procedure (P&P) titled, Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated that the facility would screen potential employees for a history of abuse, neglect, or mistreating residents. The P&P included attempts to obtain information from previous employers and/or current employers, including checking with the appropriate licensing boards and registries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42781 Based on interview and record review, the facility failed to ensure the Notice of Transfer and Discharge was provided to the resident's responsible party in accordance with the facility's policy titled Transfer and Discharge. for one of one resident (Resident 16) who was transferred to General Acute Care Hospital (GACH). This deficient practice had the potential for Resident 16's rights ensure for an appropriate discharge/transfer from the facility. Findings: A review of Resident 16 ' s Admission Record, indicated the facility admitted Resident 16 on 1/30/2024 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - type of obstructive lung disease characterized by long-term poor airflow to the lungs). A review of Resident 16's History and Physical (H&P), dated 12/18/2023, indicated, Resident 16 did not have the capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/13/2024, the MDS indicated Resident 16 required moderate assistance with eating, oral hygiene, shower, body dressing, and personal hygiene. A review of Resident 16's Order Summary Report (Physicians Order) dated 1/19/2024, the physician order indicated to send Resident 16 to GACH emergency room (ER) due to COPD exacerbation (symptoms become worse than the usual day to day variation). A review of Resident 16's Physicians Order, dated 1/23/2024, the order indicated to send Resident 16 to GACH emergency room for COPD exacerbation. A review of Progress Notes dated 1/23/2024, time at 2:26 PM, documented by Social Services Director (SSD), the notes indicated, SSD called Responsible Party 1 (RP 1) to inform RP1 regarding Resident 16 ' s hospital transfer order. SSD stated, she had a wrong number and there was no other number listed to be called. During a concurrent interview and record review of Resident 16 ' s Notice of Transfer/Discharge Form dated 1/23/2024 on 3/17/2024 at 12:56 PM, with the facility ' s Director of Nursing (DON), the DON stated the notice was not signed by Resident 16 ' s representative. The DON stated, the form should be filled up completely and signed. During an interview on 3/17/2024 on 2:33 PM with Responsible Party (RP 1), the RP 1 stated, he did not know that Resident 16 was transferred to GACH for shortness of breath. RP 1 stated, he did not receive a call from the facility Resident 16 ' s was transferred to GACH. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 16 ' s Notice of Transfer/Discharge Form on 3/23/2024 at 5:23 PM, with the facility's SSD, the SSD stated the notice was not signed by Resident 16's representative. The SSD stated, he did not follow up call to Resident 16's responsible party to notify that Resident 16 was transferred to GACH. The SSD stated there was no other clinical documentation that Resident 16's responsible party was notified of resident's transfer. A review of the facility's Policy and Procedure (P&P) titled Transfer and Discharge, revised on 12/2016, indicated at least 30 days prior to transfer or discharge, the facility will notify the family member or resident representative of the transfer. P&P indicated exception to the 30-day requirement apply when the transfer is affected because of: when a resident ' s urgent medical needs require more immediate transfer, in this case provide the notice as soon as practicable before the transfer/discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to complete the Bed Hold (holding the resident ' s bed while in the hospital or out for therapeutic leave) Notification form and inform the residents and/or their responsible party/ representative for three of three sampled residents (Resident 7, Resident 34 and Resident 16) regarding the Bed Hold in accordance with the facility ' s policy and procedures and federal and state regulations guidelines. This deficient practice had the potential for the resident not to be informed of their rights that they are able to return to the facility after hospitalization or therapeutic leave at a specified duration of time. Findings: 1. During a review of Resident 16 ' s Admission Record, indicated the facility admitted Resident 16 on 1/30/2024 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - type of obstructive lung disease characterized by long-term poor airflow). During a review of Resident 16's History and Physical (H&P), dated 12/18/2023, indicated, Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/13/2024, the MDS indicated Resident 16 required moderate assistance with eating, oral hygiene, shower, body dressing, and personal hygiene. During a concurrent interview and record review of Resident 16's medical records on 3/17/2024 on 11:10 AM, with the Social Services Director (SSD), the SSD stated, the Bed Hold Notification Form was not filled up (left blank). The SSD stated, the Bed Hold Notification form should be completed upon Resident 16's admission to notify the resident and/or the responsible party of the Bed Hold policy that the bed will be kept closed for admission and the be will be held for seven (7) days while resident stays in General Acute Hospital (GACH). During an interview on 3/17/2024 at 5:37 PM, with the facility's Director of Nursing (DON), the DON stated, Bed Hold Notification Form should be completed upon admission and transfer to save Resident 16 ' s bed for 7 days. 42854 2. A review of Resident 34's Admission Record indicated a readmission to the facility on [DATE] with a diagnoses of displaced transverse fracture of shaft of left femur, encounter for other orthopedic aftercare, and hyperlipidemia (high cholesterol, too many lipids (fat) in the blood). A review of Resident 34's History and Physical dated 02/07/2024 indicated Resident 34 had the fluctuating capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 34's MDS dated [DATE] indicated Resident 34 ' s cognition was severely impaired. During a concurrent interview and record review of Resident 34 ' s bed hold notification form on 3/17/2024 at 10:20 AM, the Social Services Director (SSD) confirmed the form was not filled out or complete. The SSD stated it was the responsibility between herself and the nurse on admission to ensure the bed hold notification form was completed. The SSD stated the purpose of the form is to hold the resident ' s bed for 7 days and ensure that the resident ' s bed is still available when returning from the hospital. The SSD stated she did not know who follows up to make sure the form was completed. 42878 3. A review of Resident 7's Face Sheet (an admission record) indicated the resident was readmitted to the facility on [DATE] with diagnoses that included cellulitis (common and potentially serious bacterial skin infection) of back, juvenile rheumatoid arthritis (an autoimmune inflammatory disease, which means the immune system [a part of the body that fights infection] attacks healthy cells in your body by mistake, causing inflammation) A review of Resident 7's History and Physical, dated 1/6/2024, indicated Resident 7 does not have the capacity to understand and make decisions. A review of Resident 7's MDS, dated [DATE], indicated Resident 7 had severe cognitive (ability to think and reason) impairment. During an interview and concurrent record review on 3/17/2024 at 11:16 AM of Resident 7's medical record with Social Service Director (SSD), SSD stated Resident 7's chart contained a blank Bed Hold Notification Form indicating to be completed on Admission. SSD stated Resident 7's responsible party (RP) comes into the facility on the weekends. The SSD stated she does not work on weekends, and she failed to follow up with Resident 7's Responsible Party to complete many of the admission documents including the Bed Hold Notification form that should have been provided and explained to the RP when Resident 7 was admitted to the facility. During an interview on 3/17/2024 at 4:45 PM with Director of Nursing (DON), DON stated all admission forms including Bed Hold Notification form should be completed by the resident or the RP when the residents are admitted to the facility. The DON stated it was important for Resident's 7 responsible party to be informed of the facility's Bed Hold Notification policy especially if Resident 7's needed to be transferred to the Acute Hospital during their stay at the facility. During a review of the facility's Policy and Procedure titled, Bed-Hold, dated 2/2016, the P&P indicated, the facility provides written notification to all residents, family members and/or legal representative of the bed hold policy upon admission, and at the time of transfer, in accordance with federal and state guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS- a resident assessment and care planning tool) dated 2/16/2024 assessment reflected an accurate assessment of the discharge destination for one of three sampled resident (Resident 55). Resident 55, who was discharged home was coded in the MDS assessment as being discharged to a General Acute Care Hospital (GACH). This deficient practice resulted in an inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential to result in Resident 55 not to receive interventions to address specific care concerns upon discharged to home. Findings: A review of Resident 55 ' s Admission Record indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty in swallowing) and hyperlipidemia (high level of fats in the blood), During a review of Resident 55's Physician ' s Order (PO), dated 2/13/2024, the physician ' s order indicated to discharge Resident 55 to home. During a review of Resident 55 ' s MDS, dated [DATE], the MDS indicated Resident 55 was discharged to GACH. During an interview on 3/16/2024 at 2:25 PM, with the facility ' s Minimum Data Set Nurse (MDSN), the MDSN stated Resident 55 was discharged home on 2/16/2024. The MDSN stated, Resident 55 ' s MDS assessment should have been coded discharged to home and not to GACH. The MDSN stated Resident 55 ' s MDS assessment should have been coded accurately to give accurate information to the Centers for Medicare and Medicaid services. During a review of the facility' s policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessment Schedule, dated 10/2023, P&P indicated, the facility conducts a comprehensive assessment to identify patient's needs per the guidelines set by RAI Manual The following assessments will be completed based on the guideline set by RAI Manual: Discharge Assessment. The P&P indicated OBRA required assessments and tracking record include discharge reporting and discharge assessment. The P&P indicated discharge refers to the date a resident leaves the facility a day begins at 12 AM and ends at 11:59 PM regardless of whether discharge occurs at 12 AM or 11:59 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review the facility failed develop a comprehensive, resident specific Care Plan for three of three sampled residents (Resident 21,27 and 42) 1. For Resident 21, develop a care plan to monitor the resident for side effects and specific behaviors to monitor for the use of Depakote (a medication used to treat seizures and bipolar disorder [disorder associated with episodes of mood swings ranging from depressive lows to manic highs]) as ordered by the physician. 2. For Resident 27, develop a care plan for the diagnosis of Chronic obstructive pulmonary disease (COPD, group of lung diseases that block airflow and make it difficult to breathe). 3. Resident 42 did not have a care plan for the management and monitoring of resident ' s G-tube (a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) when initially admitted to the facility. This deficient practice had the potential for the residents not to receive the necessary care and services needed to achieve their highest potential. Findings: 1. A review of Resident 21's Admission Record indicated a readmission to the facility on [DATE] with diagnoses that included Parkinson ' s Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) without dyskinesia (movement disorder that often appears as uncontrolled shakes, tics, or tremors), paranoid schizophrenia (a condition that affects thinking abilities, memories and senses, people commonly struggle to tell what ' s real and what isn ' t and often have hallucinations and delusions), bipolar disorder. A review of Resident 21's History and Physical assessment dated [DATE], indicated Resident 21 had fluctuating capacity to understand and make decisions. A review of Resident 21's Order Summary Report indicated on 9/18/2023 the physician ordered Resident 21 to receive Depakote oral tablet Delayed Release 250 milligrams (mg, unit of measure), give 1 tablet by mouth two times a day for bipolar disorder manifested by poor impulse control as evidenced by recurrent outburst. On 9/18/2023, indicated the physician order to monitor for side effects of bipolar medication, 0= none, 1= drowsiness, 2= confusion, 3= urinary retention, 4= ataxia, every shift for Depakote. On 9/19/2023, indicated the physician order to monitor for behavior of bipolar disorder manifested by poor impulse control tally with hash marks every shift for Depakote. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 21 ' s care plans on 3/17/2024 at 3:52 PM, the Minimum Data Set (MDS) Aide stated there was no documented evidence of a care plan for the use of Depakote. MDS Aide stated it was important to develop a care plan for the use of Depakote to have interventions of how to monitor and care for the resident. 2. A review of Resident 27 ' s Admission record indicated an admission to the facility on [DATE] with diagnoses that hyperlipidemia (high cholesterol, too many lipids (fat) in the blood), hypothyroidism (when the thyroid gland doesn ' t make enough thyroid hormones that can disrupt heart rate, body temperature and metabolism), and COPD. A review of Resident 27 ' s History and Physical assessment dated [DATE], indicated Resident 27 did not have the capacity to understand and make decisions. During a concurrent interview and record review of Resident 27 ' s care plans on 3/17/2024 at 3:55 PM, the MDS Aide stated there was no documented evidence of a care plan for COPD. MDS Aide stated all nurses can initiate a care plan. MDS Aide stated the importance of the care plan is to include how to care for a resident with COPD. 42878 3. A review of Resident 42 ' s Face Sheet indicated the resident was readmitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancerous tumor) of unspecified part of bronchus (a large airway) or lung, malignant neoplasm (cancerous tumor-an abnormal cell growth) of the brain. A review of Resident 42 ' s History and Physical dated 1/26/2024 indicated Resident 42 does not have to the capacity to understand and make decisions. A review of Resident 42 ' s Order summary report with active orders, dated 2/29/2024, indicated an order for enteral (into the stomach or intestine) feed order every shift check G-tube (gastrointestinal tube-surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) patency with an order start date 1/26/2026. A review of Resident 42's care plan developed on 1/26/2024, indicated no interventions related to the management and monitoring of Resident 42 with GT. A review of the care plan revised on 3/16/2024 (revised during the recertification survey) indicated Resident 42 has a G-tube feeding; Glucerna (a nutritional formula) 1.2 at 55 cubic centimeter (a unit of measurement) per hour for 20 hours to provide 1100/1320 KCAL (Kilo Calorie-amount of heat energy) in 24 hours. During an interview and concurrent record review of Resident 42 ' s care plans on 3/17/2024 at 3:45 PM with the MDS Assistant, the MDS Assistant stated Resident 42 ' s care plan should have been developed when the resident was initially admitted to the facility indicating Resident 42 has a G-tube on admission. MDS Assistant stated this was important for the staff to know specific focus, goals and interventions for Resident 42 ' s care beginning from admission to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s policy and procedure titled Person Centered Plan of Care, dated 12/2016 indicated the person-centered care plan must describe services that are provided to the resident to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being that will accommodate resident needs, request and refusal to treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42781 Based on observation, interview, and record review, the facility failed to ensure Resident 16's nasal cannula tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient ' s ears) was labeled with date as indicated in the facility ' s Policy and Procedure titled Oxygen Humidifiers. This deficient practice placed the Resident 16 at risk for infection. Findings: A review of Resident 16 ' s Admission Record, indicated the facility admitted Resident 16 on 1/30/2024 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - type of obstructive lung disease characterized by long-term poor airflow) A review of Resident 16 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/13/2024, the MDS indicated Resident 16 required moderate assistance with eating, oral hygiene, shower, body dressing, and personal hygiene. A review of Resident 16's Order Summary Report, dated 3/15/2024, indicated to administer oxygen at two (2) liters per minute (L/min) via nasal cannula as needed for shortness of breath or if oxygen saturation (is a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry) is below 93% related to COPD. During a concurrent observation and interview on 3/15/2024, at 5:05 PM, in the presence of Director of Staff and Development (DSD), unlabeled nasal cannula tubing was inside the storage bag next to Resident 16's bed. DSD stated nasal cannula should be labeled with date when the nasal cannula was first used and if not in use tubing should be placed in a storage bag with name of the resident and date labeled. During an interview on 12/16/2023, at 12:50 PM, with the facility's DON, the DON stated, NC tubing should be labeled when first used and it should be placed inside the bag when not in used for infection control. A review of the facility's policy and procedure titled, Oxygen Humidifiers dated 8/2017, indicated label the container and oxygen tubing with date change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42854 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen and label food in the kitchen, in accordance with the facility's policy and procedures on Food Storage: Dry Goods and Food Storage: Cold Foods. 1. A can of unopened Bread Crumbs with no label of date received was found in the Dry Storage Pantry. 2. Twenty one (21) packages of frozen hashbrowns with no label of date received was found in Freezer 4. These deficient practices had the potential to put residents at risk for foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During the initial observation of the kitchen on 3/15/2024 at 10:41 AM, a can of breadcrumbs was observed with no label date of when received in dry storage are. The Dietary Supervisor (DS) stated it was important to label with date received, use by and open date. The DS stated this was, so the kitchen staff knows first in first out, and to know when the food expires. During the initial observation of the kitchen on 3/15/2024 at 10:45 AM, 21 packages of frozen hashbrown stored in Freezer 4 were observed with no date when the packages were received. The DS stated shipment of hashbrowns was received this morning, and he was supposed to label the hashbrowns, but has not got around to it. The DS stated he was the one responsible for labeling the food. The DS stated the purpose of labeling the food was for kitchen staff to know when to throw the food out. A review of the facility's policy and procedure titled Food Storage: Dry Goods, dated 9/2017, indicated storage areas will be neat, arranged for easy identification, and date marked as appropriate. A review of the facility's policy and procedure titled Food Storage: Cold Foods, dated 4/2018 indicated all foods will be stored wrapped or in covered containers, labeled and dated and arranged in a manner to prevent cross contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 33 and 42) were appropriately assessed and completed the facility's Surveillance Data Collection Form to screen the residents for the adequate use of antibiotics (medications to treat infection). This deficient practice had the potential to result in the development of antibiotic-resistant organisms (organisms resistant [or not effectively treated] with antibiotics) and lead to unnecessary or inappropriate antibiotic use. Findings: 1.A review of Resident 33 ' s Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar), cellulitis (a bacterial skin infection) of left toe. A review of Resident 33 ' s History and Physical dated 2/23/2024 indicated Resident 33 has fluctuating capacity to understand and make decisions. A review of Resident 33's order summary report, dated 3/17/2024, indicated an order with a start date of 2/22/2024, to administer Zosyn (an antibiotic) IV (intravenous given into the vein) solution 4.5 gm (grams-a unit of measurement) IV 4x a day related to cellulitis of left toe until 3/3/2024 2.A review of Resident 42 ' s Face Sheet (an admission record) indicated the resident was readmitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancerous tumor-abnormal cell growth) of unspecified part of bronchus (a large airway) or lung, malignant neoplasm (cancerous tumor) of brain. A review of Resident 42 ' s History and Physical dated 1/26/2024 indicated Resident 42 does not have to the capacity to understand and make decisions. A review of Resident 42 ' s Order summary report, dated 3/17/2024, indicated an order to administer Bactrim DS (an antibiotic) tablet 800 milligrams (Sulfamethoxazone-trimethopin) give 1 tablet via G-tube two times a day for wound infection until 2/27/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 3/17/2024 at 9:32 AM with Director of Nursing (DON), the DON stated the purpose of the facility's antibiotic stewardship program is to make sure that the resident meets the criteria for antibiotic use. The DON stated the Infection Prevention Nurse (IPN) filled out the Surveillance Data Collection Form to make sure to identify if the resident who are on antibiotics meets the criteria for its use. The DON explained, if the residents do not meet the criteria for the use of antibiotics, we have to communicate with the doctor to prevent antibiotic resistance if antibiotics were administered without adequate indications for use. The DON reviewed Resident 33's and Resident 42's clinical record and facility ' s Definition of Infection in long term care facilities Form. The DON stated that Resident 33's and Resident 42's forms were observed to include on Resident 33 and Resident 42's name. The DON stated the Form was not completed accurately since the criteria was not marked for Resident 33 ' s and Resident 42's who were receiving antibiotics. The DON also stated that the facility's IPN should have completed the Surveillance form when Resident 33's and Resident 42' s antibiotics were ordered by the physician A review of the facility's policy and procedure entitled Antimicrobial Stewardship Program, dated December 2016, indicated the facility shall commit to quality of care by establishing an antimicrobial stewardship program that will monitor compliance with evidence-based guidelines and best practice with antimicrobial prescribing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft. unit of measurement) per resident for eight (8) out of twenty-eight (28) resident rooms (Rooms 1, 2, 4, 5, 7, 8, 9, 33). The 8 resident rooms consisted of seven (7) - two (2) bed capacity rooms and one (1)- four (4) bed capacity room. This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During an interview with the Administrator (ADM) on 3/15/2024 at 10:30 AM, the ADM stated the facility would like to request a room waiver for 8 resident rooms this year. The ADM stated nothing was changed and the number of bed occupancy in rooms 1, 2, 4, 5, 7, 8, 9, and 33 remained the same. A review of the facility ' s request for additional room waiver dated 3/15/2024 indicated the granting of the variance will not compromise the health, welfare, and safety of the residents. The request indicated the following resident bedrooms were: room [ROOM NUMBER] (2 beds) 0 residents 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (2 beds) 1 residents 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (2 beds) 1 residents 144 sq. ft. 72 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 137 sq. ft. 68.5 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 154 sq. ft. 77 sq. ft. room [ROOM NUMBER] (2 beds) 0 residents 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (4 beds) 4 residents 307 sq. ft. 76.75 sq. ft. During an interview on 3/17/24 at 3:15 PM and 3:20 PM, Residents in rooms [ROOM NUMBERS] stated they had no issues or problems with their room size. During a concurrent interview and record review of the facility's request for additional room waiver dated 3/15/2025 at 4 PM, the ADM stated there have been no complaints from residents, resident families, and staff about the room size. The ADM stated there was enough room to accommodate wheelchair and other medical equipment for adequate movement of ambulatory residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	03/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of the facility ' s Resident Census from the last Health Recertification Survey with exit date of 3/15/2022 indicated the residents that occupied Rooms 2, 4, 5, 7, and 8 were not the same residents that occupies Rooms 2, 4, 5, 7, and 8 during this current Health Recertification Survey for 3/15/2024 to 3/17/2024. During the Health Recertification Survey, from 3/15/2024 to 3/17/2024, there were no observed adverse effects as to the adequacy of space, nursing care, comfort, and privacy to the residents. The residents residing in the affected rooms (room [ROOM NUMBER], 4, 5, 7, 8, 9, and 33) with an application for variance were observed to have enough space for the residents to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (is a device that gives additional support to maintain balance or stability while walking,), or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents.