STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055099	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Healthcare Center	1900 Church Lane San Pablo, CA 94806

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50146 Based on observation, interview, and record review, the facility failed to accurately assess one of four sampled residents (Resident 322) for right forearm swelling. This failure resulted in Resident 322 experiencing pain and limited range of motion of the right arm, and placed Resident 322 at risk of untreated edema, further pain skin damage, and fluid overload. Findings: During a review of Resident 322's Face Sheet (a document used to communicate important information about a resident), undated, the record indicated Resident 322 was admitted to the facility in May 2024. During a review of Resident 322s Data Collection (a document used to collect data upon admission for a resident), dated 5/13/24, the record indicated Resident 322 had [right upper extremity] swelling present upon admission to the facility. During a concurrent observation and interview with Resident 322 on 5/20/24 at 10:05 a.m., Resident 322 stated his right arm was swollen and painful to the touch. Resident 322 was laying in bed with the head of the bed elevated, with a pillow under his head. Resident 322's right forearm and hand were noticeably swollen, and Resident 322 was not able to effectively make a fist with his right hand due to the swelling. Resident 322 stated it had been like this for weeks now. Resident 322 stated the facility had not done anything to decrease the swelling or pain in his right arm. Resident 322 stated it made him feel like I want to jump off a bridge. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 1 on 5/22/24 at 11:50 a.m., CNA 1 stated Resident 322's right arm definitely looks swollen. CNA 1 stated Resident 322 complained of pain in the right arm the day prior, and that was reported to Registered Nurse (RN) 1. CNA 1 stated the risks of untreated pain were further pain and discomfort for the affected resident. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with RN 1 on 5/22/24 at 12:27 p.m., in Resident 322's room, RN 1 stated Resident 322 had edema (a result of excess fluid buildup in the body, causing swelling; when pressure is applied to the swollen area, a pit, or indentation, will remain) in the right arm. RN 1 stated Resident 322's right arm edema had increased as it was 1+ (a scoring system for edema; 1+ means the edema formed a pit at least 2 millimeters deep) the day before, however the edema was at least a 2+ (a score indicating the edema formed a pit at least 4 millimeters deep) that day. RN 1 stated Resident 322 also complained of some pain in the right arm the day before. RN 1 stated she did not inform Resident 322's physician for pain and/or edema she noted on 5/21/24. During a concurrent interview and record review with RN 1 on 5/22/24 at 12:41 p.m., Resident 322's Treatment Administration Record (TAR, a document used to log treatments and observations for a specific resident) and Nursing Progress Notes, dated 5/21/24, were reviewed. RN 1 stated the documents indicated Resident 322 did not have any swelling and/or pain in the right arm on 5/21/24. RN 1 stated not completing an accurate assessment for edema placed Resident 322 at risk for untreated edema leading to further pain, increased limited range of motion, and complications such as fluid overload. During a review of the Care Plan (a document used to indicate problems a resident is facing along with goals and measures to achieve them) for Resident 322, dated 5/13/24, the record indicated Resident 322 had impaired skin integrity . RFA (right forearm) and that approaches to this included monitor daily for pain, skin breakdown, or signs of worsening condition. Notify MD/NP Once a Day.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42766 Based on observation, interview, and record review, the facility failed to provide an environment and a safe transfer to prevent accident for one of eight sampled (Resident 2) when Resident 2 fell from the Hoyer lift during transfer from bed to chair by a Certified Nurse Assistant (CNA) and a Licensed Vocational Nurse (LVN). This deficient practice resulted in Resident 2 sustaining a superficial scalp laceration and hematoma due to the witnessed fall from the Hoyer lift. Findings: During a review of Resident 2's Admission Record, undated, the Admission Record indicated medical diagnoses that included Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), dementia (a general term for memory loss and other cognitive abilities serious enough to interfere with daily life), aphasia (a language disorder caused by damage to parts of the brain that control speech and understanding of language), chronic kidney disease, sensorineural hearing loss (happens when there is damage in the inner ear), and high blood pressure. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 3/18/24, the MDS indicated no score for Resident 2's Brief Interview for Mental Status (BIMS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), indicative of severe cognitive impairment. During a review of the MDS for functional activities of daily living (ADL, the activities needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating), the MDS indicated Resident 2 was dependent indicating a helper does all of the effort. Resident 2 required the assistance of two or more helpers to complete ADLs. During a review of Resident 2's Interdisciplinary Team (IDT) Summary of Investigation, dated 5/1/24, the IDT Summary indicated, On 4/30/24, 11 am, resident was being assisted by an LVN and a CNA to transfer from bed to wheelchair. While the resident was already up on the sling, the LVN was adjusting the wheelchair to prepare for the next step to transfer, while the CNA was steadily holding the Hoyer lift machine, when the resident accidentally slid down to the floor. Both staff were unable to break the fall. Resident sustained a laceration and a bump on the back of her head and was transferred to the hospital via 911 . During a review of Resident 2's hospital x-ray report, dated 4/30/24, the report indicated moderate left parietal scalp hematoma is seen . During a review of Resident 2's Post Fall Risk Observation (FRO), dated 5/22/24, the FRO indicated Resident 2 received a fall risk score of 20; a fall risk score of ten or higher, represents a high risk for fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Comprehensive Care Plan. dated 9/13/13, reviewed/revised 5/22/24, the comprehensive care plan included approaches to provide assistance as identified in transfer and mobility . During an interview on 5/21/24, at 2:52 p.m. with CNA 3, CNA 3, stated Resident 2 fell from the Hoyer lift and had a bump in the middle of her head. CNA3 stated she was the one operating the Hoyer lift. During an interview on 5/22/24 at 2:17 p.m. with LVN 2, LVN 2 stated CNA 3 was operating the Hoyer lift, while he was fixing Resident's wheelchair. LVN 2 stated he was looking down as he tried to release the WC brakes and he did not witness the fall. LVN 2 stated he did not get a training for the Hoyer lift prior to the incident. During an interview on 5/23/24 at 1:10 p.m. with the Director of Staff Development (DSD), DSD stated the incident was reported to her. DSD stated she has trained staff on how to use a Hoyer lift properly and safely, and the chair must be placed in the right position. During a concurrent interview and record review on 5/23/24 at 1:20 p.m. with DSD, DSD stated all staff are trained, including licensed nurses (LNs), on use of the Hoyer lift upon hire, but not a requirement for LNs. DSD could not find a training record for the Hoyer lift for LVN 2. During an observation and interview on 5/24/24 at 9 a.m. with Resident 2, Resident 2 was nonverbal. Resident 2 was able to communicate using the basic communication chart. A bump with a scar was observed on the crown of Resident 2's head. After the bump was touched, Resident 2 nodded to pain when showed on the communication chart. During a review of the facility's policy and procedure (P&P) titled Resident Transfer: Mechanical Lift, undated, the P&P indicated, .Manufacturer's instructions and recommendation should always be followed, including the number of staff needed for a safe transfer. Mechanical lifts require at least a 2- person assist, or as per manufacturer's instructions . Both care givers will steady the resident as the lift is being moved. The second caregiver will guide the resident's body while the first caregiver moves the lift .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42766 Based on observation, interview, and record review, the facility failed to provide adequate pharmaceutical services when Resident 1's medication, amlodipine (medication used to treat high blood pressure) was not available and not administered as ordered. This failure had the potential to result in uncontrolled high blood pressure for Resident 1 During a review of Resident 1's Admission Record, undated, the Admission Record indicated Resident 1 was admitted in December 2019 with diagnoses that included hypertension, chronic kidney disease, and dementia. During a concurrent medication pass observation and interview on 5/22/24 at 9:18 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 checked Resident 1's blood pressure and stated Resident's BP was 125/58. LVN stated order indicated to hold if Systolic BP is less than 100. LVN 2 prepared medications for Resident 1 for the 9 am administration time. LVN 2 unable to find amlodipine, the bubble pack was empty. LVN 2 stated it was supposed to be supplied by pharmacy and doesn't why they do not have it. LVN 2 stated they usually request in advance when there are just few remaining in the pack. During a concurrent interview and record review on 5/22/24 at 11:38 a. m. with LVN 2, the Physician Order was reviewed. The Physician Order indicated amlodipine 10 mg tablet. Amount to administer: 1 tab oral once a day for hypertension. Hold for systolic blood pressure less than 100. LVN 2 stated the amlodipine was not available. During a review of Resident 1's Electronic Medication Administration Record (EMAR) on 5/23/24, the EMAR for amlodipine was not signed off on 5/22/24. During an interview on 5/23/24 at 8:48 a.m. with LVN 2, LVN 2 stated the amlodipine for Resident 1 was delivered by pharmacy later during the day yesterday but was not administered. During a concurrent interview and record review on 5/24/24 with DON at 10:30 a.m., DON stated the licensed nurse would notify the doctor if not delivered on time by pharmacy. During a review of the facility's policy and procedure (P&P) titled, Medication Pass Guidelines, undated, the P&P indicated, To ensure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, ant timely, .manner. To systematically distribute medications to residents in accordance with state and federal guidelines .If the medication is not available during the medication pass, the Licensed Nurse (LN) will check the medication room if available. If the medication is still not available in the medication room/medication storage area, the LN will notify the pharmacy for delivery. If the medication will be administered later than the original schedule as a result of the pharmacy delivery time, the LN will notify the physician for further orders or recommendations . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the P&P titled, Pharmaceutical Services, undated, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed .All medication orders will be supported by appropriate care processes and practices.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50146 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 68) received quetiapine (an antipsychotic medication, a class of medication that affects brain activities associated with mental processes and behavior) without an appropriate indication for use or appropriate behavior monitoring. This failure resulted in Resident 68's behavior not being appropriately monitored for the use of quetiapine and placed Resident 68 at risk of experiencing untreated psychosocial distress. Findings: During a review of Resident 68's Resident Face Sheet, the record indicated Resident 68 was admitted to the facility in March 2024 with a diagnoses to include unspecified dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) without behavioral disturbance (a condition where a person behaves in a manner that may put themselves or others at risk), psychotic disturbance (a condition where a person's thinking is disconnected from reality), mood disturbance (a condition where a person's mood is negatively impacted), and anxiety (a feeling of fear or dread). During a review of Resident 68's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 4/25/24, the record indicated Resident 68 did not have any unsafe behaviors or mood disturbances during the seven days look back period. During a review of Resident 68's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information), Resident 68 had a BIMS score of 5, indicating cognitive impairment. During an observation on 5/20/24 at 11:32 a.m., Resident 68 was observed sitting on the edge of the bed with feet dangling over the floor. Resident 68 was eating a piece of bread and stated she was here in a rental home. Resident 68 showed no signs of agitation or distress. During an interview with Certified Nursing Assistant (CNA) 2 on 5/22/24 at 9:58 a.m., CNA 2 stated Resident 68 wandered (walking aimlessly) at times but did not try to leave the facility. CNA 2 stated Resident 68 did not have any other behavioral issues. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1 on 5/22/24 at 10:01 a.m., Resident 68's Physician's Orders and Treatment Administration Record (TAR), dated 5/2024 were reviewed. LVN 1 stated Resident 68 received quetiapine 12.5 milligrams (mg) every night for psychosis (A mental disorder characterized by a disconnection from reality) [manifested by] noncompliant to [plan of care] since 4/30/24. LVN 1 stated she was unable to find any record of attempting to refuse or deny care documented in Resident 68's TAR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Nursing (DON) on 5/22/24 at 10:08 a.m., Resident 68's Medication Regimen Review (MRR), dated 5/10/24, was reviewed. DON stated noncompliance with plan of care was not an appropriate diagnosis or indication for use of quetiapine for Resident 68. The MRR indicated to request clarification on use of quetiapine for refusal of care . as it is not an appropriate indication for use. DON stated the risks of not having an appropriate indication to use quetiapine included not accurately capturing the behaviors or symptoms Resident 68 was experiencing and could result in making it hard to determine the actual need for the psychotropic medication's usage for Resident 68. During a phone interview with Resident Representative (RR) 1 on 5/23/24 at 10:38 a.m., RR 1 stated Resident 68 experienced auditory hallucinations (a condition where a person hears sounds that do not exist) and wanders around frequently, attempting to leave home without reason in the past. These symptoms led to the resident being prescribed quetiapine prior to the admission to the facility. RR 1 stated DON had called her on 5/22/24 to discuss the reason Resident 68 was prescribed quetiapine, and that this was the first time anyone from the facility had asked for this information. During a review of the policy and procedure (P&P) titled Psychotropic Medication Assessment & Monitoring, undated, the P&P indicated the behavior of residents receiving antipsychotic medication will be monitored by the licensed nurse every shift.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 42766 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5 %. During the medication pass, three medication errors were observed out of 32 opportunities for three of six residents, resulting in an error rate of 9.38%. 1. Amlodipine (medication for management of high blood pressure) for Resident 1 was unavailable and not administered as ordered. This failure had the potential to result in uncontrolled high blood pressure. 2. Semglee pen U-100 insulin (Insulin Glargine, a long acting insulin) subcutaneous injection was administered to Resident 45 without following manufacturer's recommendation. This failure had the potential to affect the insulin dose's effectiveness and the resident's blood sugar. 3. Humulin R Regular U-100 insulin (a short acting insulin) subcutaneous injection was administered to Resident 19 without following the manufacturer's recommendation. This failure had the potential to affect the insulin dose's effectiveness and the resident's blood sugar. Findings: 1. During a review of Resident 1's Admission Record, undated, the Admission Record indicated Resident 1 was admitted in December 2019 with diagnoses that included high blood pressure, chronic kidney disease, and dementia. During a concurrent medication pass observation and interview on 5/22/24 at 9:18 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 checked Resident 1's blood pressure (BP) and stated Resident's BP was 125/58. LVN stated the order indicated to hold if Systolic BP is less than 100. LVN 2 prepared medications for Resident 1 for the 9 a.m. administration time. LVN 2 was unable to find the amlodipine. Its bubble pack was empty. LVN 2 stated it was supposed to be supplied by pharmacy. During a concurrent interview and record review on 5/22/24 at 11:38 a. m. with LVN 2, the physician order indicated Amlodipine 10 mg tablet Amount to administer; amount to administer: 1 tab oral once a day for hypertension. Hold for systolic blood pressure less than 100, LVN 2 stated Amlodipine was not yet available. During a review of Resident 1's Electronic Medication Administration (EMAR), the EMAR for amlodipine was not signed off on 5/22/24. During an interview on 5/23/24 at 8:48 a.m. with LVN 2, LVN 2 stated the amlodipine for Resident 1 was delivered by pharmacy later in the day yesterday but was not administered. 2. During a review of Resident 45's Admission Record, undated, the Admission Record indicated Resident 45 was admitted in January 2023 with diagnoses that included diabetes and chronic kidney disease. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication pass observation on 5/22/24 at 10.27 a.m. with Registered nurse (RN) 1, RN 1 administered 18 units of Semglee U-100 insulin to resident 45 via subcutaneous injection. RN 1 immediately removed the needle from the skin after delivering the injection. The manufacturer's recommendation is to hold the needle in place for 10 seconds after administering. During a concurrent record review interview on 5/22/24 at 11:55 a.m. with RN 1, the Physician Order was reviewed. The Physician Order indicated Semglee Pen U-100 Insulin (Insulin glargine); 100 unit/ml (3ml) Amount to Administer: 18 units; subcutaneous once a day for DM (diabetes) at 7:30 am. RN 1 confirmed it was not administered within the time frame. RN 1 stated she was supposed to hold the needle in place for 10 seconds before removing it, so the resident may not be getting the full dose. During a review of the manufacturer's insert for Semglee, the insert indicated once injected, continue to depress the button until the dial has returned to 0 and for an additional 10 seconds. 3. During a review of Resident 19's Admission Record, undated, the Admission Record indicated Resident 19 was admitted in February 2024 with diagnoses that included diabetes and polyneuropathy. During a medication pass observation on 5/22/24 at 11:31 a.m. with LVN 2, LVN 2 administered 12 units of Humulin R insulin to Resident 19 via subcutaneous injection. LVN 2 immediately removed the needle from the skin after delivering the injection, instead of holding it in place for at least five seconds as recommended by the manufacturer's insert and standard injection protocol. During a concurrent interview and record review on 5/22/24 at 11:38 a.m. with LVN 2, the Physician Order was reviewed. The Physician Order indicated Humulin R Regular U-100 Insulin (Insulin Regular human) solution; 100/unit/ml; Amount to Administer: 12 units injection Before meals for DM. During an interview on 5/22/24 at 1:40 pm with LVN 2, LVN 2 confirmed that he did not hold the insulin syringe in place for the recommended five seconds during the subcutaneous injection. He admitted to immediately withdrawing the needle from the resident's skin after administering the insulin; he stated the resident may not get the full dose. During a review of the manufacturer's insert for Humulin R insulin, the insert indicated once injected, continue to depress the button until the dial has returned to 0 and for an additional 5 seconds. During a review of the facility's policy and procedure (P&P) titled, Medication Pass Guidelines, undated, the P&P indicated, To assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, ant timely, .manner.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42766 Based on observation, interview, and record review, the facility failed to store medications and biologicals (a class of medications which are grown and then purified from large-scale cell cultures of bacteria or yeast, or plant or animal cells) in a safe condition when the temperature in one of two medication refrigerators was out of range in accordance with Federal, State, and CDC storage and handling guidelines. This failure had the potential to compromise the integrity and effectiveness of medications and biologicals and could potentially cause harm to the resident. During a concurrent interview and observation of medication refrigerator 2 (med fridge 2) on 5/21/24 at 11:55 a.m. with RN2, in medication storage room [ROOM NUMBER], the thermometer inside med fridge 2 indicated 32 degrees ( ) Fahrenheit (F). Inside med fridge 2, were two E kits (Emergency medication kits) with the same contents in each kit with a yellow sticker indicating Refrigerate. The label on the kit indicated the unopened contents included one Lantus insulin, Levemir insulin, one Novolin N insulin, one Novolin R insulin, one Novolog insulin, and two Lorazepam (medication to relieve anxiety) injection vials. There were multiple Lorazepam vials in small plastic bags labeled with a Resident's name (Resident 55). There was an intravenous reconstituted vancomycin (Antibiotics) one gram injection labeled with a Resident's name (Resident 59), and other medications. During an interview with RN 2 at 12 p. m. with RN 2, RN 2 stated that the temperature was 32 F. RN 2 stated she did not know what the normal range for the medication refrigerator temperature was supposed to be. During another observation of the med fridge 2 on 5/21/24 at 2:30 p.m. with RN 4, med fridge 2 thermometer indicated temperature of 29 F. RN 4 acknowledged it was 29 F. RN 4 provided a recorded temperature log from 1st to AM of 21st. However, there was no month and year indicated on it. The log titled, Medication Refrigerator Temperature Log- Done Twice Daily Normal Temperature: 36-46 /Normal Freezer Temperature: 0-32 F. Notify DON if Temperature is out of range. The undated log had records and initials as of 21st and indicated 36 F recorded for AM (morning of the 21st) ref. RN 4 stated the normal range for the med fridge temperature was indicated on the log. During a review of the temperature log, the log indicated the temperatures were 34 F on the 14th, 32 F on the 15th, and 34 F on the 17th of May 2024. During two observations on 5/22.24 at 12:32 pm and at 3:20 pm, with LVN 3 medication room [ROOM NUMBER], med fridge 2 temperature was 32 F. LVN 3 stated the temperature of med fridge 2 was 32 F. The multiple medications were still in med fridge 2. (continued on next page)

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	055099	A. Building B. Wing	05/24/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 10:40 am with RN 4 and RN 3, RN 3 stated she checked the thermometer yesterday and it was okay and recorded the temperature in the log. When asked why the temperature was below the normal range during multiple observations, RN 3 stated sometimes it is okay, sometimes it is not okay, but most of the time, it is okay. When asked what effect that would have on the medications inside med fridge 2, especially the insulin and lorazepam injections, RN 3, and RN 4 were unable to answer. During an interview on 5/23/24 at 3p.m. with Director of Nursing (DON), DON stated the temperature for the fridge should be within range, and they must follow the manufacturer's recommendations for efficacy of the medications. DON stated if the temperature is below the range, medication could freeze. A review on 5/23/24 of the manufacturer's inserts for the insulin vials in med fridge 2: The manufacture's insert for Lantus (Insulin glargine-medication used for diabetes) indicated, Lantus .should not be allowed to freeze .Not-in-use (unopened Refrigerated (36 F-46). The manufacturer's insert for Levemir insulin (for diabetes) indicated, Not-in-use (unopened) Refrigerated (36 F to 46 F). The manufacturer's insert for Novolin N (for diabetes) indicated, Not-in-use (unopened) Refrigerated (36 F to 46 F). The manufacturer's insert for Novolin R (for diabetes) indicated, Not-in-use (unopened) Refrigerated (36 F to 46 F). The manufacturer's insert for Novolog (for diabetes) indicated, Do not freeze Novolog .All unopened vials: store unopened NovoLog vials in the refrigerator at 36 F to 46 F. During a review of the carton label for Lorazepam injection indicated to store in refrigerator 2 C to 8 C (36 F - 46 F). During a review of the manufacturer's insert for gabapentin oral solution indicated to store gabapentin oral solution refrigerated at 36 F to 46 F. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, Storage of Medication, dated 2007, the P&P indicated: medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to main integrity and to support safe effective drug administration . Medications requiring, refrigeration or temperatures between 2 C (36 F), and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring .

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 42766 Based on interview and record review, the facility failed to follow its policy and procedure to report the fall incident of Resident 2 to the California Department of Public Health (CDPH) and other appropriate agencies, as required by the federal or state regulations. This failure had the potential in delay of investigation and affects the health, safety, or welfare of residents. Findings: During a review of Resident 2's Admission Record, undated, the Admission Record indicated medical diagnoses that included Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), dementia (a general term for memory loss and other cognitive abilities serious enough to interfere with daily life), aphasia (a language disorder caused by damage to parts of the brain that control speech and understanding of language), chronic kidney disease, sensorineural hearing loss (happens when there is damage in the inner ear), and high blood pressure. During a review of Resident 2's Interdisciplinary Team (IDT) Summary of Investigation, dated 5/1/24, the IDT summary indicated, On 4/30/24, 11 am, resident was being assisted by an LVN and a CNA to transfer from bed to wheelchair. While the resident was already up on the sling, the LVN was adjusting the wheelchair to prepare for the next step of transfer, while the CNA was steadily holding the Hoyer lift machine, when the resident accidentally slid down to the floor, both staff were unable to break the fall. Resident sustained a laceration and a bump on the back of her head and was transferred to the hospital via 911 . During a review of the facility's policy and procedure (P&P), titled Unusual Occurrence Reporting, undated, the P&P indicated, As required by federal or state regulations, our facility reports unusual occurrences or other reportable events .other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees, or visitors.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on interview and record review, for three of three sampled residents (Resident 49, Resident 65 and Resident 68) reviewed for arbitration (a private process where disputing parties agree that one or several other individuals can make a decision about the dispute [disagreement or claim among parties where one party claims to have been harmed] after receiving evidence and hearing arguments) agreement, the facility failed to ensure the arbitration agreement was explained in a manner they understood. This failure had the potential to result in violation of the residents' right to make informed decisions and choices about important aspects of healthcare and welfare. Findings: 1. During a review of Resident 49's Resident Face Sheet, the Resident Face Sheet indicated Resident 49 was readmitted to the facility in April 2024, Resident Representative (RR) 1 was listed as Resident 49's Representative. During a review of Resident 49's Minimum Data Set Assessment (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 4/7/24, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of nine. (A BIMS score of 8-12 is an indication of moderate cognitive impairment). During an interview on 5/23/24 at 10:05 a.m. with RR 1, RR 1 stated he/she asked to sign Resident 49's admission documents/admission packet a few days after Resident 49 was readmitted from the hospital. RR 1 stated he/she was not aware that an arbitration agreement was one of the documents that was signed. RR 1 stated he/she did not know what the arbitration agreement was about and was not told he/she could rescind the agreement within 30 days of signing. RR 1 stated even if he/she knew what it was now, It would be too late [to rescind]. During a review of Resident 49's ARBITRATION AND DISPUTE RESOLUTION AGREEMENT (arbitration agreement), the arbitration agreement indicated it was signed by RR 1 and Admissions Director (AD) on 4/3/24. 2. During a record review of Resident 65's Resident Face Sheet, the Resident Face Sheet indicated Resident 65 was admitted to the facility in April 2024, Resident 65 was listed as Responsible Party. During a review of Resident 65's MDS, dated [DATE], the MDS indicated a BIMS score of nine. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 65's ARBITRATION AND DISPUTE RESOLUTION AGREEMENT, the arbitration agreement indicated, while it was signed by Resident 65, there was no signed acknowledgment that a copy of the Dispute Resolution Program information and Frequently Asked Questions handout were received by Resident 65. The arbitration agreement indicated Admissions Assistant (AA) as the Facility Representative who also signed the agreement. During an interview on 5/23/24 at 9:33 a.m. with Resident 65, Resident 65 stated she did not understand what an arbitration agreement was and what it was for. During an interview on 5/23/24 at 11:44 a.m. with AA, AA stated she asked the resident or the resident representative to sign the admission packet upon admission or return from the hospital. AA stated the arbitration agreement would be included in the admission packet for the resident or resident representative to sign. AA was not able to answer what the arbitration agreement was about and was not able to provide what information was given to the residents or their representative before signing. During a telephone interview on 5/23/24 at 11:46 a.m. with Admissions Director (AD), AD stated during the admission process, the resident or the resident representative would sign the admission packet as soon as possible or within 72 hours of admission. AD stated the admission packet included bed-hold notice, primary insurance information, standard admission agreement, personal funds, and arbitration agreement. AD stated her role was making sure the residents had signed the admission packet and that every document was completed but AA was the assigned Coordinator for the facility, who would oversee the signing of the admission documents in AD's absence. 3. During a review of Resident 68's Resident Face Sheet, the Resident Face Sheet indicated Resident 68 was admitted to the facility in March 2024. RR 2 was listed as Resident 68's representative. During a review of Resident 68's MDS, dated [DATE], the MDS indicated a BIMS score of four (severe cognitive impairment). During a review of Resident 68's ARBITRATION AND DISPUTE RESOLUTION AGREEMENT, the arbitration agreement indicated the arbitration agreement was signed by both RR 2 and AD on 4/1/24. During a telephone interview on 5/23/24 at 10:37 a.m. with RR 2, RR 2 stated she was made to sit in the conference room to sign for Resident 68's admission to the facility. RR 2 stated she heard about the arbitration agreement for the first time during the interview and stated she did not know the implications of such an agreement and would not have given up Resident 68's right to litigation in a court proceeding if she had known.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50146 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for flies and gnats in three of three units designated for resident care. A dead kitten was found outside Resident 24's window for more than 22 hours. The failure to effectively treat flies and gnats and leaving the dead kitten outside Resident 24's room resulted in Resident 24 feeling ugly and grossed out and had the potential to result in infection for all residents residing at the facility. Findings: During an observation on [DATE] at 10:05 a.m., three flies were observed in Resident 322's room. During a concurrent observation and interview on [DATE] at 10:24 a.m., three flies were observed in Resident 42's room. Resident 42 stated that the facility has numerous flies and that the flies made him feel unsanitary. During a concurrent observation and interview on [DATE] at 11:20 a.m., in Resident 34's room, there were five flies in Resident 34's room on the overbed table, the wall, the curtain, and the ceiling. Resident 34 stated that there are flies all over and they drive me crazy. Resident 34 stated that staff often came in to use a chemical spray on Resident 34's room to kill any flies around, and that despite Resident 34 asking, nothing had been done to address the source of the flies. During an observation on [DATE] at 12:43 p.m., a fly was observed on Resident 42's lunch plate, directly on the food being served, when Resident 42 was about to eat his lunch. During a concurrent observation and interview on [DATE] at 11:50 a.m. with Certified Nursing Assistant (CNA) 1, outside of Resident 24's room on Unit 2, CNA 1 pointed out a dead kitten, outside in the bushes next to Resident 24's window. The cat had only its head, paws, spine, and tail left, and the rest of its organs were open and exposed. CNA 1 stated she noticed that another cat had been coming repeatedly to eat the deceased kitten. During a concurrent observation and interview on [DATE] at 9:26 a.m. with Resident 24, the dead kitten was still observed outside Resident 24's window, with further decomposition noted and more of the kitten's head missing. The dead kitten's remains were closer to the window than they were the previous day. A notable foul smell was coming through the window into Resident 24's room. Two flies were observed on the wall to the right of Resident 24's bed. Resident 24 stated, there were gnats all over the room . they get into [Resident 24]'s food and land in my [briefs] and bite my buttocks.' Resident 24 stated it made her feel ugly and grossed out. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on [DATE] at 9:34 a.m. with Housekeeper (HSK) 1, multiple flies were observed on Resident 34's doorframe in Unit 1. HSK 1 stated she had been noticing flies around the building coming in and out. HSK 1 stated that housekeeping staff attempt to kill the flies with a spray, and that sometimes the spray works, but does not work at other times. HSK 1 stated the housekeeping staff typically let the Maintenance Director know about the issue. When asked what the risks are to uncontrolled pests like flies, HSK 1 sated that the flies could land in residents' food and get them sick. During an observation on [DATE] at 9:38 a.m., one fly was observed on Resident 45's door in Unit 3. During an interview on [DATE] at 9:44 a.m. with the Maintenance Director (MND), the MND stated that there were lots of gnats in some rooms, and facility used fly traps and sprays to keep the pest levels down. The MND stated he was not aware of any dead animals on facility grounds. During a concurrent observation and interview on [DATE] at 9:46 a.m., with MND, outside Resident 24's room window, the dead kitten was still there. MND stated the risks from having dead animals on facility grounds and close to resident care areas was that the remains could create more flies and create greater risk for residents becoming sick. During an interview on [DATE] at 10:18 a.m. with the Director of Nursing (DON), DON stated that pests like flies posed a risk to residents and that the pests could get into resident food and cause infection. DON stated facility's Administrator (ADM) was responsible for pest control services. During a concurrent interview and record review on [DATE] at 10:21 a.m., with ADM and MND, the facility's Maintenance Request Log for February, March, April, and May of 2024 was reviewed. The ADM stated facility staff reported issues related to maintenance in the maintenance log. The ADM stated she was also unable to locate any reports of dead animals from [DATE]. The ADM stated facility was aware of gnats and flies being an issue since February 2024. However, ADM was unable to find any record in the maintenance log. ADM stated the facility hired an outside vendor to perform cleaning to control the gnat issue on [DATE] and [DATE], however the pest issue was not effectively resolved. A review of facility's policy and procedure titled Pest Control, undated, indicated that the facility staff should report the following insect or pest related information: type of problem, location, person reporting, and time reported . and that the facility should maintain a written report of pest sightings and remedial actions.