STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055129	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Terrace Health Care Center	12000 MT Vernon Avenue Grand Terrace, CA 92313

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43820 Based on interview and record review, the facility failed to ensure timely completion of the Comprehensive Admission Minimum Data Set (MDS - a federally mandated resident assessment tool) assessments for one of 17 sampled residents (Resident 350). This deficient practice had the potential to delay the care planning process to meet Resident 350's comprehensive and individualized care needs. Findings: During an initial screening observation on November 18, 2024, at 11:42 AM, inside resident's room, Resident 350 was lying on her bed, awake, and covered with blanket. Resident 350 was observed with scattered purplish brown discolorations on both forearms. A review of Resident 350's Admission Record (document which contains demographic and medical information) indicated she was admitted to the facility on [DATE]. During a concurrent interview and record review with the MDS Nurse (MDSN) on November 20, 2024, at 9:48 AM, the MDSN reviewed Resident 350's Comprehensive Admission MDS Assessment with an Assessment Reference Date (ARD) of November 8, 2024, and stated it was not completed yet. MDSN also stated the Comprehensive Admission MDS Assessment should have been completed within 14 days of admission and was now six days overdue. MDSN stated in this situation, the facility did not follow its policy and procedure on Resident Assessment and the RAI (Resident Assessment Instrument- comprehensive assessment and care planning process used by nursing home) guidelines. MDSN also stated it was important the Comprehensive Admission Assessment be completed in a timely manner to identify care areas that need to be addressed in the care plan. During a concurrent interview and record review with the Director of Nursing (DON), on November 20, 2024, at 10:06 AM, the DON reviewed Resident 350's Comprehensive Admission MDS Assessment and acknowledged that it was not completed timely. The DON stated she missed signing the assessment on November 14, 2024. The DON stated the facility's policy and procedure, and RAI guidelines were not followed. (continued on next page)

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

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 350's Comprehensive Admission MDS Assessment, with an ARD of November 8, 2024, indicated Section Z0500B. Date RN Assessment Coordinator signed assessment as complete 11-20-2024 (6 days overdue). A review of the facility's policy and procedure titled, Resident Assessment and Associated Processes, dated 1, 2022, indicated, POLICY: It is the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record. Procedure . 3. Comprehensive Assessment will be conducted within 14 days of admission .8. A Registered Nurse will electronically sign and certify that the assessment is completed . The Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual, dated October 2024, indicated, Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred .01. Admission Assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed on the end of day 14, counting the date of admission to the nursing home as day 1 .The MDS completion date (item Z0500B) must be no later than day 14 .

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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 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** 43820 Based on observation, interview, and record review, the facility failed to ensure the Comprehensive Admission Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment was accurately completed per Resident Assessment Instrument (RAI- comprehensive assessment and care planning process used by nursing home) guidelines for one of 17 sampled residents (Resident 351) when: 1. Resident 351's hearing abilities and limitations was not accurately coded. 2. Resident 351's antiplatelet medication (medication to prevent blood clot) was not coded. These deficient practices had the potential for Resident 351 not to receive the necessary care, treatment, and/or services to attain his highest practicable level of functioning. Findings: 1. During a concurrent observation and interview with Resident 351, on November 20, 2024, at 2:54 PM, inside the resident's room, Resident 351 was leaning forward toward the Surveyor and stated he had hearing difficulties for three years now and used hearing aids. Resident 351 also stated both ears were affected, but more pronounced in his left ear. During an interview with Resident 351's Family Member (FM), on November 20, 2024, at 3:00 PM, inside resident's room, the FM stated Resident 351 had hearing difficulties for a while now. FM stated someone had to move closer or speak louder for Resident 351 to hear better. FM also stated the resident had a scheduled audiology (hearing) appointment on November 22, 2024. A review of Resident 351's Admission Record (document which contains demographic and medical information) indicated Resident 351 was admitted to the facility on [DATE]. A review of Resident 351's History and Physical dated September 12, 2024, indicated Resident 351 had the capacity to understand and make decisions. A review of Resident 351's Activity-Admission Evaluation dated September 10, 2024, indicated, Hearing G. Communication & [and] Cognition .2. Moderate Difficulty (speaker has to increase volume and speak distinctly) .G.1 Hearing Aid or other appliance used .1. Yes . A review of Resident 351's LN [Licensed Nurse]- Initial Admission Record dated September 9, 2024, indicated .3. EENT [Eyes, Ears, Nose and Throat] .D. Ability to hear .1. Minimal Difficulty [Difficulty in some environments, when person speaks softly, or setting is noisy] . A review of Resident 351's Order Summary Report (a document with a list of physician's orders), dated September 9, 2024, indicated, Audiology eval (evaluation) and treat PRN [as needed] . A Physician's Order dated November 21, 2024, indicated HEARING AIDE CHECK AT 1:00 PM . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 351's Comprehensive Admission MDS Assessment with an ARD (Assessment Reference Date) of September 16, 2024, indicated, Section B. Hearing Speech, and Vision .B0200. Hearing Ability was coded 0 [Adequate] - no difficulty in normal conversation, social interaction, listening to TV . During an interview with the MDS Nurse (MDSN), on November 21, 2024, at 10:07 AM, the MDSN stated that the coding decision to determine resident's hearing abilities was based on interview with the resident, family, and interdisciplinary assessments. MDSN also stated Section B of the MDS was based on RAI guidelines. During a concurrent interview and record review with the MDSN on November 21, 2024, at 10:17 AM, MDSN reviewed Resident 351's Comprehensive Admission MDS Assessment Section B0200 and stated it was incorrectly coded. MDSN also reviewed CMS' RAI Version 3.0 Manual and stated the guidelines for coding resident's hearing status were not followed. The Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual, dated October 2024, indicated B0200: Hearing .Steps for Assessment .2. Interview the resident and ask about hearing function in different situations .3. Observe the resident during your verbal interactions and when they interact with others throughout the day .5. Review the medical record. 6. Consult the resident's family, caregivers, direct care staff, activities personnel, and speech, or hearing specialists . 2. During an initial tour observation on November 18, 2024, at 12:07 PM, inside dining area, Resident 351 was observed sitting on his wheelchair while waiting for lunch meal to be served. Resident 351 had scattered reddish-purple discolorations on both forearms. A review of Resident 351's Admission Record indicated Resident 351 was admitted to the facility on [DATE]. A review of Resident 351's Order Summary Report dated September 9, 2024, indicated, Resident 351 was taking the following antiplatelet medication: Aspirin 81 Oral Tablet Chewable (Aspirin) Give 1 tablet by mouth one time a day for CVA [Cerebrovascular Accident- a disease that occurs when blood flow to the brain is suddenly cut off] prophylaxis [prevention] . During a review of Resident 351's comprehensive admission MDS assessment with an ARD (Assessment Reference Date) of September 16, 2024, indicated, Section N0415I box was left blank (indicating the resident did not receive any antiplatelet medication during the 7-day look-back period [observation period]). A review of Resident 351's Medication Administration Record (MAR- summary report of medicines/interventions received by an individual)) for September 1-30, 2024, revealed Resident 351 received Aspirin daily during the Comprehensive Admission MDS assessment's look-back period (September 10-16, 2024). During an interview with the MDSN, on November 21, 2024, at 10:22 AM, the MDSN stated the resident's MAR was used in coding Section N0415. MDSN also stated Section N0415 items were marked x in column 1 if the resident received these medications during the 7-day look-back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent interview and record review with the MDSN on November 21, 2024, at 10:24 AM, MDSN reviewed Resident 351's Comprehensive Admission MDS assessment Section N0415 and stated the Comprehensive Admission MDS assessment was not coded correctly because item N0415I was left blank. MDSN also reviewed CMS's RAI Version 3.0 Manual and stated she did not follow the guidelines for coding resident's medication use. During an interview with the Director of Nursing (DON), on November 21, 2024, at 10:39 AM, the DON stated that her expectation was for the staff to accurately complete the MDS assessment and follow the RAI guidelines in coding. The DON also stated these were important in the development of resident's plan of care. A review of the facility's Minimum Data Set's (MDS Coordinator) Job Description, dated December 17, 2021, indicated POSITION SUMMARY: To conduct and coordinate the development and completion of the Resident Assessment Instrument (RAI), that is, the Minimum Dat Set (MDS), and Care Plan with State and Federal requirements .ESSENTIAL DUTIES AND RESPONSIBILITIES .Monitors overall the documentation in the medical record to validate that it supports MDS coding . The Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual, dated October 2024, indicated N0415: High-Risk Drug Classes: Use and Indication . N0415I. Antiplatelet: Check if an antiplatelet medication (e.g., [example] aspirin .) was taken by the resident at any time during the 7-day observation period . A review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processes, dated January 2022, indicated, POLICY: It is the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident .Procedure: A Comprehensive Assessment will be made of the resident's needs, strength, goals, life history and preferences, using the RAI (Resident Assessment Instrument) .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41707 Based on observation, interview and record review, the facility failed to develop a baseline care plan that addressed Left Ventricular Assist Device (LVAD - a device implanted in the chest that helps to pump blood from the lower chambers of the heart to the rest of the body) for one of 17 sampled residents (Resident 297). This deficient practice had the potential for not receiving necessary care and treatment related to resident's medical, physical, mental, and psychosocial needs. Findings: During an initial tour observation, in Resident 297's room, on November 18, 2024, at 8:26 AM, Resident 297 was lying in bed, awake, and verbally responsive. Resident 297 was noted with an LVAD connected to the machine on the bedside. During an interview with Resident 297, on November 18, 2024, at 8:49 AM, Resident 297 stated that LVAD was a battery-operated machine with a tubing connected to resident's heart to help pump the blood to the rest of the body. Resident 297 also stated that it was very important to check the battery and setting of the machine in able for the machine to work properly A review of Resident 297's Admission Record (contains a summary of basic information about the resident), indicated Resident 297 was admitted to the facility on [DATE]. A review of Resident's 297 Skilled Nursing Facility H&P [History and Physical] dated November 18, 2024, indicated a past medical history of LVAD. A review of Resident 297's Care Plan (individualized outline of specific care, interventions, and goals for a patient), on November 20, 2024, at 2:48 PM, noted no care plan was developed to reflect Resident 297's LVAD related to its cardiovascular (heart and the blood vessels) functions and risks. During an interview and concurrent record review with Registered Nurse Supervisor (RNS) 2, on November 21, 2024, at 9:07 AM, RNS 2 verified there was no baseline care plan developed for Resident 297's LVAD. RNS 2 stated Resident 297 should have a baseline care plan addressing the LVAD to monitor the risks of malfunction and to determine what interventions to implement if any problem would arise related to Resident 297's cardiovascular condition. During an interview with the Director of Nursing (DON), on November 21, 2024, at 9:39 AM, the DON confirmed and verified Resident 297's LVAD should have a baseline care plan as it was a very important device connected to Resident 297's cardiovascular system to monitor if the device was working properly. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Care Planning undated, indicated, POLICY: It is the policy of the this facility that the interdisciplinary team (IDT) shall develop and implement a comprehensive person-centered care plan or each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. PROCEDURES: 1. A baseline care plan shall be developed within 48 hours of admission .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41707 Based on observation, interview, and record review, the facility failed to ensure the gastrostomy tube (g-tube - a tube inserted through the wall of the abdomen directly into the stomach that can be used to give food and medication to a person) was flushed before and after medication administration as ordered by the physician for one of one observed resident (Resident 12) with g-tube during medication administration observation. This deficient practice posed a risk of not maintaining patency (open or unobstructed) of Resident 12's g-tube which could lead to ungiven medications, hydration, and nutritional feedings to meet Resident 12's needs. Findings: During medication pass observation and concurrent interview with Licensed Vocational Nurse (LVN) 2, on November 20, 2024, at 11:02 AM, in Resident 12's room, LVN 2 did not flush the g-tube with water before administering the medications to Resident 12. LVN 2 proceeded to administer the medications and flushed the g-tube with 15 milliliter (ml - unit of measurement) of water after administering all medications to Resident 12. LVN 2 stated Resident 12 did not have an order to flush the g-tube with water before medication administration. During an interview and concurrent record review with LVN 2, on November 20, 2024, at 11:09 AM, the Electronic Medication Administration Record (E-MAR - an electronic system to record medication administration documentation) indicated Resident 12 had an order to flush the g-tube with 30 ml of water before and after medication administration. LVN 2 verified the order and acknowledged flushing of the g-tube was missed before medication administration, and an inaccurate amount of water was flushed after medication administration. LVN 2 stated it was important to flush the g-tube per physician's order with an accurate amount of water to prevent clogging the g-tube and to provide hydration. During an interview with the Director of Nursing (DON), on November 20, 2024, at 11:12 AM, the DON confirmed the importance of flushing the g-tube before and after medication administration was to maintain the g-tube's patency. A review of Resident 12's Admission Record (document which contains demographic and medical information), indicated Resident 12 was admitted to the facility on [DATE]. A review of Resident 12's Order Summary Report (a document with list of physician's orders), dated November 20, 2024, showed a physician's order dated on October 22, 2024, for Enteral Feed [a way of delivering nutrition directly to the stomach] Order every shift FLUSH TUBE WITH 30-50cc [cubic centimeter - unit of volume equivalent to milliliter] PRE [before] AND POST [after] MEDICATION ADMINISTRATION VIA TUBE. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, ENTERAL TUBE MEDICATION ADMINISTRATION PROCEDURES, undated, indicated, Policy: Oral medication (s) are administered through an enteral tube in a safe and accurate manner .Procedure .Flush the tube with 30 mL of water prior to medication administration .Flush the tube with 30 mL of water or as directed .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43820 Based on observation, interview, and record review, the facility failed to adequately monitor two of 17 sampled residents (Residents 350 and 297) for adverse consequences of anticoagulant (used to prevent or treat blood clots) medication therapy. This failure had the potential to result in unidentified care concerns, inconsistent care coordination, and delay of treatment which could adversely affect the health and safety of these residents. Findings: 1. During an initial tour observation on November 18, 2024, at 11:42 AM, inside resident's room, Resident 350 was lying on her bed, awake, and covered with a blanket. Resident 350 was observed with scattered purplish brown discolorations on both forearms. Resident 350 was unable to explain how she got those skin discolorations. A review of Resident 350's Admission Record (document which contains demographic and medical information) indicated Resident 350 was admitted to the facility on [DATE] with diagnoses of unspecified atrial fibrillation (irregular and rapid heart rate) and thrombocytopenia (condition where there is a low platelet [blood cell that helps blood to clot] count causing bleeding). A review of Resident 350's Order Summary Report (a document with a list of physician's orders), indicated, Resident 350 was taking the following anticoagulant medication: Apixaban Oral Tablet 2.5 mg [milligram- unit of measure for weight]. Give 1 tablet by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILLATION. A review of Resident 350's Care Plan (individualized outline of specific care, interventions, and goals for a patient), indicated, Focus: Anticoagulant therapy (APIXABAN) r/t [related to] atrial fibrillation dated November 18, 2024 .Goal: Will be free from discomfort or adverse reactions related to anticoagulant use . Interventions/Tasks: .Monitor/document/report to MD [Medical Doctor] PRN [as needed] s/sx [signs and symptoms] of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, .bruising, bleeding . During an interview with the Treatment Nurse (TN) 2, on November 20, 2024, at 11:20 AM, the TN 2 stated residents on anticoagulant therapy were monitored for signs and symptoms of bleeding. TN 2 also stated the monitoring was documented in the MAR (Medication Administration Record- summary report of medicines/interventions received by an individual). During a concurrent interview and record review with the Registered Nurse Supervisor (RNS) 1 on November 20, 2024, at 11:38 AM, RNS 1 reviewed Resident 350's Order Summary Report and MAR for the month of November 2024. RNS 1 stated there was no order to monitor for anticoagulant side effects and there was no documented evidence in the MAR that the monitoring was done by staff. RNS 1 also stated Resident 350 required anticoagulant therapy monitoring the day the apixaban order was placed, and monitoring the resident for any complications related to the use of medication was important. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON), on November 20, 2024, at 11:44 AM, the DON stated Resident 350 should have an order to monitor for anticoagulant therapy side effects. The DON also stated staff should have obtained the order to monitor for the use of the anticoagulant medication from the doctor on the day Resident 350 started using the medication, and should continue during the duration of medication use. The DON further stated her expectation was for staff to monitor the resident for anticoagulant complications every shift and document it in the MAR. A review of the facility's Licensed Nurse's Job Description, dated December 17, 2021, indicated ESSENTIAL DUTIES AND RESPONSIBILITIES .Examine the resident and his/her records and charts to distinguish between normal and abnormal findings in order to recognize early stages of serious physical, emotional, or mental problems .Implement and maintain established policies, procedures, objectives, safety .Chart nurses' notes in professional and appropriate manner that is timely, accurately, and thoroughly reflects the care provided to the resident, as well as the resident's response to the care . 41707 2. During an initial tour observation, in Resident 297's room, on November 18, 2024, at 8:26 AM, Resident 297 was observed lying in bed and noted multiple purplish skin discoloration on Resident 297's bilateral arms and right hand. During an interview with Resident 297, on November 18, 2024, at 8:49 AM, Resident 297 stated that a medication named Coumadin (a brand name of anticoagulant medication) made Resident 297's skin bruised easily. A review of Resident 297's Admission Record indicated Resident 297 was admitted to the facility on [DATE]. A review of Resident 297's Order Summary Report, showed a physician's order dated November 17, 2024, for Warfarin Sodium [a generic name of anticoagulant medication] Oral Tablet 1 MG Give 0.5 tablet by mouth one time a day for A-FIB [Atrial Fibrillation]. No monitoring of complications was ordered and implemented to reflect Resident 297's anticoagulant therapy. A review of Resident 297's Care Plan, indicated, Focus Anticoagulant Therapy (WARFARIN) r/t: Atrial Fibrillation At risk for side effects from medication dated November 18, 2024 .Interventions/Tasks Monitor and report s&sx of thromboembolism [blood clot that blocks the flow of blood through the veins] . Monitor/document/report to MD PRN s/sx of anticoagulant complications . During an interview and concurrent record review with RNS 2, on November 21, 2024, at 9:26 AM, RNS 2 verified Resident 297 was on an anticoagulant therapy. RNS 2 also verified Resident 297's care plan reflected monitoring and documenting anticoagulant complications should be implemented. RNS 2 stated that Resident 297 was high risk for bleeding, and the nurses should monitor signs and symptoms of bleeding every shift. During an interview with the DON, on November 21, 2024, at 9:39 AM, the DON acknowledged there was no monitoring of complications on anticoagulant therapy for Resident 297. The DON stated the importance of monitoring was to check for adverse reactions and complications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure titled, Section: Quality of Care; Subject: Anticoagulation Therapy indicated, POLICY: It is the policy of this facility to ensure that anticoagulation therapy is provided to residents who require such services, consistent with the professional standards of practice .Signs and Symptoms of Bleeding: Licensed nursing staff will monitor all residents on anticoagulant recognizing signs and symptoms of bleeding, including, but is not limited to, bruising, gum bleeding, dark stools, and hematuria and document in the medical record.

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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 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** 43820 Based on observation, interview, and record review, the facility failed to ensure medications were stored properly and securely when: 1. The Intravenous cart (IV cart - mobile cart that carries and stores medications, supplies, and equipment for administering medications through a vein) was left unlocked with key hanging from the cart lock. 2. The IV and medication carts were left unlocked and not under direct observation by authorized staff. 3. Three expired topical (applied to skin) medications were found inside the treatment cart. These had the potential to allow unauthorized access to medications and supplies which could cause undetected misuse, diversion (distribution, abuse, or use of drugs for purposes not intended by the prescriber), and unsafe use of medications intended for 54 residents. Findings: 1. During an initial tour observation on November 18, 2024, at 11:54 AM, in the facility hallway in front of rooms [ROOM NUMBERS], the IV cart was observed unlocked and unattended. The cart lock was not pushed in, and the key was hanging from the lock. During a concurrent observation and interview with the Treatment Nurse (TN) 1, on November 18, 2024, at 11:55 AM, TN 1 acknowledged these findings and stated the cart should be kept locked when unattended. During an interview with the Registered Nurse Supervisor (RNS) 1, on November 18, 2024, at 12:33 PM, RNS 1 stated it was not acceptable to leave the IV cart unlocked and key unattended. RNS 1 also stated the expectations were for the RNS to always keep key with them and the IV cart locked when not in use. RNS 1 stated these were important to ensure only authorized individuals have access to the contents of the IV cart. During an interview with the Director of Nursing (DON), on November 18, 2024, at 12:53 PM, the DON stated her expectations were for the IV cart to be locked when out of staff's sight and key be kept by the RNS on duty. The DON also stated these were important to ensure safety by preventing unauthorized individuals having access to the IV cart. A review of the facility's Registered Nurse's Job Description, dated 12/17/21, indicated, Our expectation is that you will perform your job in a manner consistent with our Core Values .ACCOUNTABILITY . OWNERSHIP .ESSENTIAL DUTIES AND RESPONSIBILITIES .Implement and maintain established policies, procedures, objectives, quality assurance, safety . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled, IV. MEDICATION STORAGE IN THE FACILITY undated, indicated, STORAGE OF MEDICATIONS Policy: Medications and biologicals are stored safely, securely, and properly .The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure: .Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, medication carts, and medication supplies are locked or attended by persons with authorized access. 41707 2. During medication pass observation with RNS 1, on November 20, 2024, at 9:20 AM, RNS 1 went inside Resident 347's room to administer the IV medication to Resident 347. RNS 1 did not lock the IV cart located in front of Resident 347's room. There were staff and residents observed passing by the unlocked IV cart. During an interview with RNS 1, on November 20, 2024, at 9:28 AM, RNS 1 stated the importance of locking the IV cart at all times was to prevent unauthorized access of medications from residents, staff, and visitors. During an interview with the DON, on November 20, 2024, at 9:47 AM, the DON confirmed medication carts should always be locked when out of sight for safety purposes. During a medication pass observation with Licensed Vocational Nurse (LVN) 1, on November 20, 2024, at 11:22 AM, LVN 1 went inside Resident 7's room to administer insulin injection (a hormone that removes excess sugar from the blood given artificially via medication) to Resident 7. LVN 1 did not lock the medication cart located in front of Resident 7's room. There were staff and residents observed passing by the unlocked medication cart. During an interview with LVN 1, on November 20, 2024, at 11:35 AM, LVN 1 stated the importance of locking the medication cart when out of sight was to prevent residents from accessing the medications. A review of facility's undated policy and procedure titled, Policy and Procedures for Med (medication) Pass, indicated IV. MEDICATION STORAGE IN THE FACILITY STORAGE OF MEDICATIONS .Procedure: . Medication rooms, medication carts, and medication supplies are locked or attended by persons with authorized access. 3. During medication storage observation in the facility Treatment Cart, with TN 1, on November 20, 2024, at 2:50 PM, the following outdated topical medications were noted: a. Aspercreme Lidocaine Pain Relief Spray (a topical spray works to temporarily reduce minor pain) - expired date June 2024. b. Antiseptic Skin Cleanser (helps to prevent skin infections) - expired date September 2024. c. Hydrogen Peroxide (used on skin to prevent infection of minor cuts, scrapes, and burns) with opened date of April 1, 2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with TN 1, on November 20, 2024, at 2:53 PM, TN 1 stated any expired skin medications should be discarded and not given to residents to prevent cross contamination. TN 1 also stated skin medication that was opened for over a year should also be discarded. During an interview with the DON, on November 21, 2024, at 9:39 AM, the DON stated expired medications should be disposed and should not be in the treatment cart to prevent from giving to residents. A review of facility's undated policy and procedure titled, Policy and Procedures for Med (medication) Pass, indicated IV. MEDICATION STORAGE IN THE FACILITY STORAGE OF MEDICATIONS . Procedure: . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46110 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. There were food crumbs, [NAME], and trash under the stove. 2. A tray lined with parchment paper stored condiments (oil, vinegar, soy sauce) had spills. 3. Seven food packages and fruit were found opened and undated inside the kitchen's walk-in refrigerator, freezer, and tray condiments area. 4. One bottle of drink was found inside the walk-in refrigerator which belonged to staff. These failures had the potential to cause foodborne illnesses (any illness resulting from eating contaminated/spoiled foods) to 50 medically compromised residents who receive food served by the kitchen. Findings: 1. During an initial observation tour of the kitchen and interview with Dietary Aide (DA), on November 18, 2024, at 8:05 AM, food crumbs, black grime, and trash were found on the floor under the kitchen stove. The DA stated areas in the kitchen should be kept clean and free of crumbs, trash, and dirt. He further stated the kitchen floor and under the stove area should be swept up and mopped out after breakfast trays were distributed out from the kitchen. An interview and record review with Dietary Services Supervisor (DSS) on November 21, 2024, at 9:38 AM, the DSS reviewed and confirmed the facility's undated policy and procedure (P&P), titled, General Cleaning of Food & Nutrition Services Department, indicated, Floors, floor mats .must be scheduled for routine cleaning and maintained in good condition .1. Floors must be mopped at least once per day .2. Sweep the floor .use a dustpan to remove and dispose of debris as it accumulates .7. Mop the floor .use a scraper to remove stubborn stains. During a phone interview with the Registered Dietitian (RD), on November 21, 2024, at 2:57 PM, RD stated kitchen floors and under kitchen tables should always be kept clean. The RD acknowledged the floor area under the stove should be swept up regularly as recorded on the daily cleaning log-in sheet. A review of the Foof and Drug Administration (FDA) Federal Food Code 2022, 4-601.11 titled Equipment, Food- Contact Surfaces, Nonfood- Contact Surfaces and Utensils, indicated, .(C) Nonfood- contact surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue and other debris. In addition, 4-602. 13, indicated The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an initial observation tour of the kitchen and interview with the DA, on November 18, 2024, at 8:15 AM, a tray lined with parchment paper which stored condiments (oil, vinegar, soy sauce) had spills. The DA stated the condiments area should be kept clean and free of crumbs, stains, and spills for it may produce bacteria. The DA confirmed kitchen staff were not able to do the regular cleaning. A concurrent interview and record review with the DSS on November 21, 2024, at 9:38 AM, the DSS reviewed and confirmed the facility's undated policy and procedure (P&P), titled, Sanitation, indicated, .There shall be adequate equipment for cleaning and disposal of waste and general storage .11. All utensils, counters, shelves, and equipment shall be kept clean. During a phone interview with the RD, on November 21, 2024, at 2:57 PM, the RD acknowledged tray liners should be removed and cleaned underneath and stored areas should always be kept clean. A review of the FDA Federal Food Code 2022, 4-601.11 titled Equipment, Food- Contact Surfaces, Nonfood-Contact Surfaces and Utensils, indicated, .(C) Nonfood- contact surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue and other debris. In addition, 4-602.13, indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 3. During an initial observation tour of the kitchen and interview with DA, on November 18, 2024, at 8:25 AM, the DA inspected the kitchen stored condiments area, walk-in refrigerator, and freezer, and found the following food items: I. One gallon of vegetable cooking oil, opened, half empty, found in the walk-in refrigerator undated. II. One gallon of milk, opened, more than half empty found in the walk-in refrigerator undated. III. One gallon of soy sauce, opened, half empty, found in the walk-in refrigerator undated. IV. One gallon of honey mustard, opened, more than half empty, found in the walk-in refrigerator undated. V. One gallon of Worcestershire sauce, opened, half empty, found in the walk-in refrigerator undated. VI. Half of a watermelon was found inside the walk-in refrigerator undated. VII. One pack of hotdog buns opened with no delivery received date found in the freezer. During a concurrent interview and record review with the DSS on November 21, 2024, at 9:38 AM, the DSS reviewed and confirmed the facility's undated policy and procedure (P&P), titled, Labeling and dating of Foods, indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for food safety .Food delivered to facility needs to be marked with a delivery or received date .The individual opening or preparing a food shall be responsible for date marking at the time of processing and/or storage . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a phone interview with the RD, on November 21, 2024, at 2:57 PM, the RD stated the opened and undated food packages should be thrown away for they did not know when it was opened. The RD further stated the expectation was the dietary staff should follow infection control precautions for food safety. A review of the FDA Federal Food Code 2022, 3-101.11 titled Safe, Unadulterated, and Honestly Presented . Labeling-General, indicated, .Sources of packaged food must be labeled in accordance with law. Proper labeling of foods allows consumers to make informed decisions about what they eat. Many consumers, as a result of an existing medical condition, may be sensitive to specific foods or food ingredients . 4. During an initial observation tour of the kitchen and interview with DA, on November 18, 2024, at 8:55 AM, an open bottle of tea drink found inside the kitchen walk-in refrigerator. The DA stated it belonged to staff, and it should not be kept in the refrigerator. A concurrent interview and record review with the DSS on November 21, 2024, at 9:38 AM, DSS reviewed and confirmed the facility's undated policy and procedure (P&P), titled, Employee Meals, indicated, Food brought by employees from outside the facility should not be kept in the facility's refrigerator in the kitchen . Food may be kept in a refrigerator supplied for the employees in the employee lounge. During a phone interview with the RD, on November 21, 2024, at 2:58 PM, the RD stated, staff food and beverage should not be kept inside the kitchen walk-in refrigerator. RD acknowledged it was not appropriate to keep staff food inside kitchen refrigerators.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41707 Based on observation, interview, and record review, the facility failed to maintain infection control practices when: 1. A Certified Nurse Assistant (CNA) 1 did not wear appropriate PPE (Personal Protective Equipment - which includes gowns and gloves) during direct care contact with Resident 297 who was on Enhanced Barrier Precaution (EBP - an infection control intervention that involves wearing gown and gloves during high-contact resident care activities). 2. Visitor (V) 1 did not wear appropriate PPE during direct contact with a Resident who was on EBP. 3. V 2 and V 3 did not wear appropriate PPE while inside a resident room on Contact Precautions (CP - an infection control intervention that involves wearing gown and gloves to be avoid direct contact with the patient and indirect contact with the surfaces and objects in the room). 4. Contract Phlebotomist (CPH) 1 and CPH 2 did not complete hand hygiene and did not wear appropriate PPE when completing a blood draw on a resident on EBP. 5. A Registered Nurse Supervisor (RNS) 1 did not wear the required PPE while flushing the Peripherally Inserted Central Catheter (PICC) line (a thin, soft tube that is inserted into a vein in the arm, leg or neck for long-term IV antibiotics, nutrition, medications, and blood draws) of a resident (Resident 28) on EBP. 6. A Licensed Vocational Nurse (LVN) 1, failed to disinfect (clean something, especially by using a chemical substance that kills all germs and bacteria) the blood pressure (BP) cuff (a device to check blood pressure) before and after resident use during medication pass for Resident 298. These failures had the potential for cross contamination and spread of infection which can adversely affect the health and well being of 54 medically compromised residents, staff, and visitors. Findings: 1. During an initial tour observation, on November 18, 2024, at 8:26 AM, in Resident 297's room, CNA 1 was observed lifting the gown of Resident 297, and noted Resident 297 had a clean and dry dressing on the right lower chest area. Resident 297 was observed with a Left Ventricular Assist Device (LVAD - a device implanted in the chest that helps to pump blood from the lower chambers of the heart to the rest of the body) connected to the machine on the bedside. CNA 1 was not wearing a gloves and gown. During an interview with CNA 1, on November 18, 2024, at 8:39 AM, CNA 1 confirmed Resident 297 was on EBP, and staff should wear gloves and gown during close contact with residents on EBP to protect from cross contamination. CNA 1 acknowledged the use of appropriate PPE was missed during direct contact with Resident 297. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Licensed Vocational Nurse (LVN) 1, on November 18, 2024, at 8:49 AM, LVN 1 stated the importance of wearing gloves and gown during direct care contact with residents on EBP was to minimize the contact of infection. During an interview with the Infection Preventionist (IP), on November 19, 2024, at 8:46 AM, the IP confirmed Resident 297 was on EBP due to an incision site on the chest area for an LVAD connecting to Resident 297's heart. The IP stated it was very important for staff to wear gloves and gown during direct care contact with any residents on EBP, and to prevent staff and residents from infection. A review of Resident 297's Order Summary Report (a document with list of physician's orders), dated November 21, 2024, showed a physician's order dated on November 18, 2024, for ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: LVAD every shift. A review of facility's policy and procedure (P&P) titled, IPCP (Infection Prevention and Control Plan) Standard and Transmission-Based Precautions, revised March 2024, indicated, Policy. It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions .3. Enhanced Barrier Precautions (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities . 48431 2. During an observation on November 20, 2024, at 2:30 PM, in a resident room on EBP, V 1 touched the resident's gown, foot cradle, beddings, and blanket while not wearing gloves or a gown. During an interview on November 20, 2024, at 2:31 PM, V 1 stated they were aware gloves, and a gown should be worn while in the room but forgot. During an interview on November 20, 2024, at 2:39 PM, TN 1 stated staff and visitors should wear PPE for a resident on EBP to prevent the resident from getting any bacteria or an infection. During an interview on November 21, 2024, at 2:10 PM, the IP stated she recommended visitors to wear gowns, gloves, and other PPE to prevent the introduction of any bacteria or infection from the outside. During an interview on November 21, 2024, at 2:19PM with the Director of Nursing (DON), the DON confirmed family and visitors should wear PPE if they are touching or providing care to the resident on EBP. 3. During a concurrent observation and interview on November 18, 2024, at 9:39 AM, V 2 and V 3 were seen in the resident room without any PPE and resident was on contact precautions. TN 2 was in the room passing medications, and stated the resident was on contact precautions. TN 2 stated visitors must wear PPE while in the room, but the Facility did not reinforce visitors to wear PPE. During an interview on November 20, 2024, at 2:35 PM, the DON stated visitors needed to wear PPE when visiting a resident room on CP. The DON stated TN 2 should have educated the family members to put on PPE and reinforced the CP policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and facility policy and procedure review on November 22, 2024, at 9:35 AM, the IP stated visitors should be wearing PPE when in a resident room is on contact precautions. The IP stated failure to wear PPE would violate the Facility's Infection Control policy. Review of the facility policy and procedures titled, IPCP Standard and Transmission-Based Precautions revised March 2024, indicated, Contact precautions/isolation are used with a known infection that is spread by direct or indirect contact with the resident or the resident's environment. b. i. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. ii. [NAME] PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens . The IP confirmed the above findings. 4. During a concurrent interview and observation on November 19, 2024, at 8:34 AM, CPH 1 and CPH 2 entered a resident room who was on EBP, and did not perform hand hygiene (practice of cleaning your hands). CPH 1 and CPH 2 put gloves on and performed the blood draw without putting on any other PPE. CPH 1 and CPH 2 proceeded with hand hygiene when exiting the room. CPH 1 stated the Facility informed him a gown was only worn in an EBP room when collecting a resident's urine sample. During a concurrent observation and interview on November 19, 2024, at 8:45 AM with RNS 1, RNS 1 confirmed the resident's room, which CPH 1 and CPH 2 entered, was on EBP. RNS 1 stated CPH 1 and CPH 2 should have worn appropriate PPE while performing a blood draw on a resident who was on EBP. During an interview on November 19, 2024, at 12:03 PM, with the DON, the DON stated CPH 1 and CPH 2 should have worn a gown and performed hand hygiene prior to entry of the resident's room. The DON stated when a resident is on EBP, the proper PPEs must be worn. During a concurrent interview and facility policy and procedure review on November 20, 2024, at 2:40 PM, the DON verified CPH 1 and CPH 2 violated the Facility's Infection Control Policy. Review of the facility policy and procedure titled, IPCP Standard and Transmission-Based Precautions revised March 2024, indicated, Enhanced Barrier Protection (EBP) used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities . The DON confirmed the above findings. 48985 5. During a concurrent observation and interview with RNS 1, on November 18, 2024, at 11:41 AM, RNS 1 was not wearing gown (a type of PPE clothing that is worn or used to provide protection against hazardous substances and/or environments) while flushing Resident 28's PICC. RNS 1 confirmed Resident 28 was on EBP, and proper PPE such as gown and gloves were required during high contact resident care activities. During an interview with the IP on November 19, 2024, at 8:52 AM, the IP stated all residents on EBP required staff to wear PPE during high contact resident care activities to prevent the spread of infection between the residents, staff, and visitors. (continued on next page)

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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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48431 Based on observation, interview, and record review, the facility failed to ensure two rooms (rooms [ROOM NUMBERS]) accommodate no more than four residents per room when rooms [ROOM NUMBERS] had 5 beds in each room. This failure had the potential for the residents housed in rooms [ROOM NUMBERS] to not have the ability to move about freely if the five beds limited their personal space. Findings: During a concurrent interview and record review with the Administrator (ADM), on November 18, 2024, at 8:47 AM, the ADM reviewed the Entrance Conference Checklist, and stated the facility had room waivers for rooms [ROOM NUMBERS], with five beds each. During an environmental tour with the Maintenance Supervisor (MS), on November 21, 2024, at 2:09 PM, resident room [ROOM NUMBER] had five beds each. The residents' room measurements of livable space were noted as follows: i. room [ROOM NUMBER] (5 beds) measured: 643.97 sq. ft. [square feet] (128.80 sq. ft. per resident) During an environmental tour with the MS, on November 21, 2024, at 2:14 PM, resident room [ROOM NUMBER] had five beds each. The residents' room measurements of livable space were noted as follows: i. room [ROOM NUMBER] (5 beds) measured: 636.39 sq. ft. [square feet] (127.28 sq. ft. per resident) During a follow up interview with the ADM, on November 21, 2024, at 2:23 PM, the ADM confirmed the measurements for two of the 23 residents' rooms and two of these did not meet the accommodation requirement per each room. Acknowledged that any room with more than four beds needs a waiver. The rooms were not crowded and did not impose any safety hazards to the residents. There were no complaints of space or room issues from the residents occupying these rooms. The survey team recommends the approval of the room waiver request for the rooms listed in this deficiency.