STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43238 Based on interview and record review, the facility failed to maintain dignity and respect for three out of 60 sampled residents (Resident 160, Resident 45, Resident 6) when: 1.Certified Nurse's Assistant 2 (CNA 2) made demeaning and rude comments to Resident 160 for using the commode rather than the restroom. This resulted in Resident 160 to feel humiliated and embarrassed. 2a. Certified Nurse 6 (CNA 6) was standing over Resident 45 while assisting him with his meal; and 2b. CNA 3 was standing over Resident 6 while assisting him with his meal. These failures caused embarrassment and had the potential to minimized the residents' feelings of self-worth. Findings: 1. A review of Resident 160's admission record indicated she was admitted to the facility on [DATE] with a diagnosis of Surgical Aftercare following surgery on the sense organs (surgery performed on organs related to the senses such as eyes or ears.) A review of Resident 160's Minimum Data Set (MDS- a federally mandated assessment tool), dated 3/10/25, indicated a Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident's) score of 15, which indicated no cognitive (relating to processes of thinking and reasoning) impairment. During an interview on 3/10/25, at 9:30. a.m., with Resident 160, Resident 160 stated that Earlier that morning [CNA 2-Certified Nursing Assistant 2] entered her room [Resident 160's room], looked in my commode which was full of urine from the night before, put the lid down and started to leave. I asked her to dump it, and she told me, while pointing to the bathroom, 'the bathroom is in there.' I told her that was not a nice thing to say, then she [CNA 2] told me 'You have a big mouth.' Resident 160 further stated, I am so embarrassed and humiliated. There is a bowel movement in the commode right now that she told me she would take care of after her break. I apologize for the smell in here. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/25, at 8:09 a.m., CNA 2 stated on the morning of 3/10/25, I did tell her [Resident 160] where the bathroom was because I saw her walking in the hallway earlier and didn't understand why she had a commode. CNA 2 stated she understood the comment she made could make Resident 160 feel bad and disrespected. During an interview on 3/13/25, at 8:21 a.m., the Director of Staff Development (DSD) stated he was unaware of the communication between Resident 160 and CNA 2. The DSD confirmed the interaction between Resident 160 and CNA 2 was inappropriate and disrespectful. 39489 2 a. A review of Resident 45's Admission Record indicated, Resident 45 was admitted in the facility on 10/1/22 with diagnosis that included Dysphagia (difficulty of swallowing), Adult Failure to Thrive (loss of appetite, eats and drinks less than usual, loses weight, and is less active), and Alzheimer's Disease (a brain disorder that gradually destroys memory and thinking skills). A review of Resident 45's MDS Section C, Cognitive Patterns, dated 12/25/24, showed a score of 7 which indicated severe impairment. During a concurrent observation and interview in the dining room with CNA 6 on 3/12/25 at 11:55 a.m., Resident 45 was reclined in a Geri chair and CNA 6 were standing over him while she assisted him with his meal. CNA 6 acknowledged she stood over Resident 45 when she assisted him with his meal, and stated she's supposed to sit down to promote respect. 2 b. A review of Resident 6's Admission Record indicated, Resident 6 was admitted in the facility on 7/8/20 with diagnosis that included Hemiplegia (paralysis of one side of the body), Hemiparesis (muscle weakness on one side of the body) and Failure to Thrive. A review of Resident 6's MDS Section C, Cognitive Patterns, dated 1/10/25, showed a score of 3 which indicated severe impairment. During a concurrent observation and interview in the dining room with CNA 3 on 3/12/25 at 12 p.m., Resident 6 was reclined in a Geri chair and CNA 3 was standing over him while she assisted him with his meal. CNA 3 acknowledged she stood over Resident 6 when she assisted him with his meal. CNA 3 stated she did not find an empty chair and decided to stand up. During a concurrent observation and interview in the dining room with the Director of Nursing, (DON) on 3/12/25 at 12:10 p.m., the DON confirmed that CNA 6 and CNA 3 were standing over the residents when they assisted Resident 45 and Resident 6 with their meals. The DON stated, CNA 6 and CNA 3 should sit down to promote dignity and respect for Resident 45 and Resident 6. A review of the facility's policy and procedure titled Resident Rights, revised on 1/25, indicated, Employees shall treat residents with kindness, respect, and dignity . During a record review of the facility's document titled Policy and Procedure on Resident's Rights/Dignity , dated 01/25, indicated, Each staff will comply and respect resident's rights and dignity during conversation or dealing with him/her.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 51387 Based on observation, interview, and record review, the facility failed to protect resident privacy and confidentiality when meal tray tickets were thrown into the trash for a census of 54 out of 60 residents who ate facility prepared meals. This failure had the potential for 54 residents' personal and protected health information to be exposed and unprotected from unintended access. Findings: During an observation and concurrent interview in the kitchen on 3/11/25 at 10 a.m., with Dietary Aide 2 (DA 2), DA 2 was observed washing the breakfast dishes. DA 2 removed the food trays from the cart, dumped leftover food, dropped a used resident meal tray ticket on the floor, then picked it up and discarded it into the regular kitchen trash garbage can. When questioned, DA 2 stated this was her usual process. During an interview in the kitchen on 3/11/25 at 10:05 a.m., with [NAME] 2 (CK 2), CK 2 confirmed after resident meals are served and consumed, meal trays are then returned back to the kitchen for washing, and when there are trays containing used resident meal tickets on them, his normal process is to throw the resident tray tickets in the regular kitchen trash, which is then delivered to the dumpsters in the back of the facility building. During an observation and concurrent interview on 3/11/25, at 10:09 a.m. with [NAME] 1 (CK 1), CK 1 demonstrated the path taken for trash from the kitchen to the outside dumpsters located in the parking lot behind the facility. The dumpster lid was observed to be overflowing, and the lid was unable to be closed. The parking lot was not gated or secured from the public. CK 1 acknowledged the dumpster was overflowing and the lid could not close. A review of facility policy and procedure revised 01/25 and titled Food Related Garbage and Rubbish Disposal indicated Outside dumpsters provided by garbage pick up services will be kept closed. During an Interview on 3/11/25 at 2:29 p.m., with the facility Registered Dietician (RD), the observation of resident meal tray tickets being thrown in the regular trash was communicated to the RD. The RD stated in response, resident meal tray tickets need to be shredded when they are no longer needed, not thrown in the regular trash. During an observation on 3/13/25 at 9 a.m. in the kitchen, resident meal tickets with identifiable information were observed inside the top of the kitchen trash bin located next to the dishwashing sink for Resident 30, Resident 40, Resident 49 and Resident 52. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/25 at 9:01 a.m., with CK 1, CK 1 acknowledged the observation and the presence of used resident meal tray tickets in the regular kitchen trash, and stated the used resident meal tray tickets are supposed to be shredded and the risk of not shredding the resident meal tray tickets, would be a possible violation of HIPPA (Health Insurance Portability and Accountability Act, a federal law that sets a national standard to protect medical records and other personal health information). Review of resident meal tray tickets dated 3/11/25 and 3/13/25 included the following information: name, dining location, assigned room number and bed, diet order, food and beverage texture requirements, notes such as need for assistive devices, portion sizes, allergies, and likes and dislikes. Review of facility policy and procedure (P&P) revised on 1/25, titled Tray Cards, indicated that A tray card will be issued for each resident Tray cards should list the resident's name, room number, diet order, location of meal service, and food preferences If computer generated tray cards are used, a new set will be printed for each meal The tray card should remain with the resident's plate until nursing staff has recorded the percentage of food consumed. Review of facility policy and procedure revised 01/25 titled Resident Rights indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: t. privacy and confidentiality The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues.

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 47197 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care to attain and maintain their highest practical wellbeing consistent with professional standards of practice and facility's policy and procedure (P&P) for nine out of 31 sampled residents (Resident 265, 60, 267, 264, 266, 160, 262, 263, and 48) when: 1. Resident 265's prescribed pain medication, and Resident 60 and Resident 267's prescribed medications were ordered late; 2. Resident 264's order for pain medication was sent to the pharmacy without a valid prescription order and another prescribed medication was ordered late; 3. Resident 266's order for pain medications were sent to the pharmacy without valid prescription orders and another prescribed medication was returned to the facility for a signature and additional authorization, which caused the delay; 4. Resident 160's order for pain medications and two other medications were authorized late; 5. Resident 262 and Resident 263 did not receive their prescribed medication in a timely manner in accordance with the physician's order; and, 6. When Licensed Nurse (LN) 2 did not safely administer medications via the gastrostomy tube (G Tube -a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for Resident 48 as per physician's orders and professional standards. These failures resulted in Resident 265, 60, 267, 264, 266, 160, 262, and 263 not receiving their medications on time which subsequently resulted in Resident 265, 264, 266, and 160 experiencing unnecessary pain and emotional distress that had negatively affected the residents' level of comfort, activity and sleep, and risk for Resident 48 to have an unsafe medication administration. Findings: 1a. A review of Resident 265's clinical record indicated Resident 265 was admitted February of 2025 and had diagnoses that included fracture (a break in the continuity of a bone) of left humerus (upper arm bone), neuralgia (pain caused by irritation or damage to a nerve) and neuritis (inflammation of a nerve), and need for assistance with personal care. A review of Resident 265's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns (mental process of acquiring knowledge and understanding)., dated 3/2/25, indicated Resident 265 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 265 had a moderately impaired cognition. A review of Resident 265's MDS Health Conditions, dated 3/2/25, indicated Resident 265 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, occasionally limited her participation in rehabilitation therapy sessions, and occasionally limited her day-to-day activities. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 265's progress notes, dated 2/19/25, indicated Resident 265 arrived at the facility on 2/19/25 at around 11:58 p.m. and has a pain level of 4/10 (numeric pain scale from 1 to 10; 1-3 is mild pain, 4-7 is moderate pain, 8-10 is severe pain). A review of Resident 265's physician's order, dated 2/19/25 at 12:13 p.m., indicated, MS Contin (Morphine Sulfate) [a strong medication used to treat moderate to severe pain] Oral Tablet Extended Release 30 MG [milligrams- unit of measurement] Give 1 tablet by mouth every 8 hours for Pain management. A review of Resident 265's care plan, initiated 2/19/25, indicated, At risk for pain or discomfort related to left humeral fracture due to ground fall at home. A review of Resident 265's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD (Medical Doctor) ordered .MS Contin Oral Tablet .for Pain management. A review of Resident 265's Medication Administration Record (MAR- a legal document used to record medications given to the residents), for the month of February 2025, indicated Resident 265's morphine sulfate was scheduled to be administered every 8 a.m., 4 p.m., and 12 midnight, with the first dose scheduled on 2/19/25 at 4 p.m. A further review of the MAR indicated the 4 p.m. of the morphine sulfate on 2/19/25 was marked with a chart code 5, which indicated the medication was held and not given to the resident. A review of Resident 265's Weights and Vitals Summary, dated 2/19/25 at 8:38 p.m., indicated Resident 265 had a pain level of 8 [severe pain]. During an interview on 3/10/25 at 9:42 a.m. with Resident 265, Resident 265 stated she did not receive her morphine medication on the day she was admitted in the facility. Resident 265 also stated her pain was so awful that day, it went to a level of 9 out of 10 (severe pain). Resident 265 further stated, Well, It [sleeping] was hard .I got hard time sleeping .I was in so much pain. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 265's MAR for February 2025 was reviewed. LN 6 confirmed that Resident 265's morphine sulfate was not given on 2/19/25 at 4 p.m. LN 6 stated there was a risk for Resident 265 to be in so much pain when the morphine sulfate was not given. During a concurrent phone interview and record review on 3/13/25 at 10:54 a.m. with the Pharmacist from the Facility's Pharmacy (PP), Resident 265's medication orders were reviewed. The PP stated they only received Resident 265's medication order for morphine sulfate on 2/19/25 at 7:41 p.m. and had filled and sent it on the next scheduled delivery time which was 10:30 pm. During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the Admissions Coordinator (AC), Resident 265's medication records were reviewed. The AC showed a fax receipt indicating Resident 265's prescription order of morphine sulfate was sent to their pharmacy on 2/19/25 at 5:53 p.m. The AC confirmed the prescription order was faxed after the scheduled administration. The AC stated that sometimes it would take 4 hours for nurses to transcribe medication orders which causes the delay in faxing medication orders. A review of the Shipping Manifest [receipt] for Resident 265's morphine sulfate indicated the facility received the medication on 2/19/25 at 10:35 p.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	1b. A review of Resident 60's clinical record indicated Resident 60 was admitted March of 2025 and had diagnoses that included thrombocytosis (a condition characterized by an abnormally high number of clotting components in the blood) and benign prostatic hyperplasia (BPH- the prostate gland grows larger than normal potentially causing urinary problems). A review of Resident 60's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, but Does not have the capacity to understand and make medical decisions. A review of Resident 60's progress notes, dated 3/5/25, indicated Resident 60 arrived at the facility on 3/4/25 at 3:05 p.m. A review of Resident 60's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Tamsulosin HCL(Hydrochloride) [a medication used to treat enlarged prostate] Oral Capsule 0.4 MG . Give 1 capsule by mouth at bedtime related to BENIGN PROSTATIC HYPERPLASIA . A review of Resident 60's physician's order, dated 3/4/25 at 4:43 p.m., indicated, Apixaban [a medication used to treat and prevent blood clots and to prevent stroke] Oral Tablet 2.5 MG . Give 1 tablet by mouth two times a day . A review of Resident 60's MAR for the month of March 2025, indicated Resident 60's tamsulosin was scheduled to be administered starting 3/4/25 every 9 p.m. and the apixaban was scheduled every 9 a.m. and 9 p.m., with first dose on 3/4/25 at 9 p.m. A further review of the MAR indicated the 9 p.m. doses for tamsulosin and apixaban on 3/4/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 60's progress notes, dated 3/5/25 at 6:56 a.m., indicated, .f/u [follow up] with pharmacy as medication not delivered.as per pharmacy they did not receive the face sheet and order. Refaxed all the order and face sheet. Requested stat [immediate] delivery of medication. endorsed to next shift . During an interview on 3/11/25 at 4:08 p.m. with Resident 60, Resident 60 stated he could not remember if he got all his medications when he was admitted in the facility. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 60's MAR was reviewed. LN 6 confirmed that 9 p.m. doses of Resident 60's tamsulosin and apixaban on 3/4/25 were not given. LN 6 stated there was a risk for Resident 60 to develop impaired circulation when the apixaban was not given and a risk to negatively affect Resident 60's health when the tamsulosin was not given. During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the Pharmacy Technician (PPT) from the Facility's Pharmacy, Resident 60's medication orders were reviewed. PPT stated they only received Resident 60's medication orders for tamsulosin and apixaban on 3/5/25 at 4:18 a.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 60's tamsulosin and apixaban indicated the facility received the medication on 3/5/25 at 10:30 a.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	1c. A review of Resident 267's clinical record indicated Resident 267 was admitted March of 2025 and had diagnoses that included asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe) and gastro-esophageal reflux disease (GERD- a condition where stomach acid flows back up into the esophagus causing symptoms like heartburn and regurgitation). A review of Resident 267's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, and Has the capacity to understand and make medical decisions. A review of Resident 267's progress notes, dated 3/4/25, indicated Resident 267 arrived at the facility at around at 3 p.m. A review of Resident 267's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Fluticasone-Salmeterol Inhalation [a combination medication used to treat asthma] .500-50 MCG/ACT [unit of measurement] .1 puff inhale orally one time a day for asthma . A review of Resident 267's physician's order, dated 3/4/25 at 6:29 p.m., indicated, Pantoprazole Sodium [a medication used to treat GERD] Oral Capsule 100 MG . Give 1 capsule by mouth two times a day for GERD . A review of Resident 267's MAR for the month of March 2025, indicated Resident 267's fluticasone-salmeterol inhalation was scheduled to be administered starting 3/5/25 every 9 a.m. and the pantoprazole was scheduled every 6:30 a.m. and 4:30 p.m., with first dose on 3/5/25 at 6:30 a.m. A further review of the MAR indicated the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 267's progress notes, dated 3/5/25 at 4:19 p.m., indicated, Fluticasone spray unable to give, waiting for pharmacy delivery . During an interview on 3/10/25 at 11:10 a.m. with Resident 267, Resident 267 stated she did not receive some of her medications when she was admitted in the facility. Resident 267 also stated it was upsetting for her to wait that long for her medications. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 267's MAR was reviewed. LN 6 confirmed the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were not given. LN 6 stated there was a risk for Resident 267 to develop gastric acidity when the pantoprazole was not given and a risk to develop difficulty breathing when the fluticasone-salmeterol inhalation was not given. During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 60's medication orders were reviewed. PPT stated they only received Resident 267's medication orders for fluticasone-salmeterol inhalation and pantoprazole on 3/5/25 at 12:35 p.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 267's fluticasone-salmeterol inhalation and pantoprazole indicated the medications were received by the facility on 3/5/25 at 3:20 p.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	2. A review of Resident 264's clinical record indicated Resident 264 was admitted February of 2025 and had diagnoses that included osteoarthritis (OA- a deteriorating disease that causes pain, stiffness, and swelling where two or more bones meet), pain in right hip, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), neuropathy (a nerve condition that can cause pain, numbness, tingling, or weakness in the body), chronic pain syndrome (condition that involves persistent pain that lasts for weeks to years), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 264's MDS Cognitive Patterns, dated 2/26/25, indicated Resident 264 had a BIMS score of 15 out of 15 which indicated Resident 264 had an intact cognition. A review of Resident 264's MDS Health Conditions, dated 2/26/25, indicated Resident 264 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, frequently limited her participation in rehabilitation therapy sessions, and frequently limited her day-to-day activities. A review of Resident 264's physician's order, dated 2/19/25 at 3:06 p.m., indicated, Pregabalin [a drug used to treat nerve and muscle pain] Oral Capsule 150 MG . Give 1 capsule by mouth two times a day related to PAIN IN RIGHT HIP . A review of Resident 264's MAR, for the month of February 2025, indicated Resident 264's pregabalin was scheduled to be administered every 9 a.m. and 5 p.m., with the first dose on 2/19/25 at 5 p.m. A further review of the MAR indicated that Resident 264's dose of pregabalin on 2/19/25 at 5 p.m., 2/20/25 at 9 a.m. and 5 p.m., and 2/21/25 at 9 a.m. were all marked with a chart code 5, which indicated the medication was held and not given to the resident. A review of Resident 264's physician's order, dated 2/20/25 at 7:48 p.m., indicated, metFORMIN HCl [a medication used to treat high blood sugar levels] Oral Tablet 500 MG . Give 1 tablet by mouth two times a day for DM. A review of Resident 264's MAR, for the month of February 2025, indicated Resident 264's metformin was scheduled to be administered starting 2/21/25 every 9 a.m. and 5 p.m. A further review of the MAR indicated the metformin 9 a.m. dose on 2/21/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident. A review of Resident 264's care plan, initiated 2/19/25, indicated, At risk for alteration in comfort/pain related to recent fall with right hip pain, chronic back pain .DM . A review of Resident 264's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD ordered . A review of Resident 264's progress notes, dated 2/20/25 at 2:19 p.m., indicated, Followed up with [name of facility pharmacy] about Pregabalin; no response from doctor for authorization. Additional message was left for doctor by pharmacy staff. During an interview on 3/10/25 at 9:48 a.m. with Resident 264, Resident 264 stated she did not get all her medications on the first few days when she was admitted in the facility, including her pain medication. Resident 264 also stated her pain level was so bad which she rated at 10 (severe pain). Resident 265 further stated, I was hurting .I cannot move or do anything .so I just stayed here in the room on those days .I was just in bed because I can't do anything .I was not comfortable, I was in a lot of pain .I was so upset to wait that long for it [pain medication] . (continued on next page)

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	055189	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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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 - Actual harm Residents Affected - Some	During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 264's MAR for February 2025 was reviewed. LN 6 confirmed that Resident 264's pregabalin was held and not given on 2/19/25 at 5 p.m., 2/20/25 at 9 a.m. and 5 p.m., and 2/21/25 at 9 a.m. LN 6 stated there was a risk for Resident 264 to have her pain not relieved when the pregabalin was not given for four times. LN 6 also confirmed that Resident 264's metformin was held and not given on 2/21/25 at 9 a.m. LN 6 further stated there was a risk for Resident 264 to have high blood sugar when the metformin was not given. During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with PPT, Resident 264's medication orders were reviewed. PPT stated they only received Resident 264's valid prescription order for pregabalin from the doctor on 2/21/25 at 7:32 a.m. and had filled and sent it on the next scheduled delivery time. PPT also stated they only received Resident 264's medication order for metformin on 2/21/25 at 8:06 a. m. and had filled and sent it on the next scheduled delivery time. During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the AC, Resident 264's medication records were reviewed. The AC stated Resident 264 came from a local hospital that sends medication order to their pharmacy electronically in which they're having problems with. The AC also stated that their nurse would then need to call their facility doctor to get the actual prescription order and fax it the pharmacy. The AC then confirmed that there was no valid prescription order for Resident 264's pregabalin that was faxed to the pharmacy. A review of the Shipping Manifest for Resident 264's pregabalin and metformin indicated the facility received the medication on 2/21/25 at 1:45 p.m. 3. A review of Resident 266's clinical record indicated Resident 266 was admitted March of 2025 and had diagnoses that included neuralgia and neuritis, osteoarthritis, chronic pain, respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his/her own) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). A review of Resident 266's admission History and Physical, dated 3/6/25, indicated Resident 266 was oriented to person, place and time, Has the capacity to understand and make medical decisions, and was a high risk for fall and Activities of Daily Living (ADL- normal daily functions required to meet basic needs) decline. A review of Resident 266's progress notes, dated 3/4/25, indicated Resident 266 arrived at the facility at around 11:30 a.m. A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Buprenorphine [a strong medication used to treat moderate to severe pain] HCl Sublingual [below the tongue] Tablet Sublingual 8 MG . Give 1 tablet sublingually two times a day for Chronic pain. A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Pregabalin Oral Capsule 25 MG . Give 1 capsule by mouth two times a day related to NEURALGIA AN NEURITIS . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Dulera [a prescription medicine used to control symptoms such as difficulty breathing] Inhalation Aerosol 200-5 MCG/ACT [micrograms/puff] .2 puff inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE . A review of Resident 266's MAR for the month of March 2025, indicated Resident 266's buprenorphine, pregabalin, and dulera inhalation were scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 3/4/25 at 5 p.m. A further review of the MAR indicated the 5 p.m. dose of buprenorphine on 3/4/25, the pregabalin 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25, and the dulera inhalation 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25 were all marked with chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 266's care plan, initiated 3/4/25, indicated, At risk for pain or discomfort related to: .> NEURALGIA AND NEURITIS .> OA. >Chronic Pain. A review of Resident 266's care plan intervention, initiated 3/4/25, indicated, Administer pain meds as MD ordered .Buprenorphine HCl .Pregabalin Oral Capsule . A review of Resident 266's progress notes, dated 3/5/25 at 12:58 a.m., indicated, .some of the medication still to be delivered from pharmacy . A review of Resident 266's Weights and Vitals Summary, indicated Resident 266 had pain levels as follows: 3/5/25 at 12:39 a.m.- 5 (moderate pain), 3/5/25 at 9:40 a.m.- 5 (moderate pain), 3/5/25 at 4:40 a.m.- 7 (moderate pain). During an interview on 3/10/25 at 10:04 a.m. with Resident 266, Resident 266 stated she did not get all her medications when she was admitted , including her pain medications. Resident 266 also stated she had pain on the days she did not receive her pain medications which she rated at a level of 9 out of 10 (severe pain). Resident 266 further stated, I was in so much pain .I tried to rest but I could not sleep at all that night .It's [pain] so bad. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 266's MAR was reviewed. LN 6 confirmed that Resident 266's 5 p.m. dose of buprenorphine on 3/4/25, the pregabalin 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25, and the dulera inhalation dose on 3/4/25 at 5 p.m. and on 3/5/25 at 9 a.m. were not given. LN 6 stated there was a risk for Resident 266 to have uncontrolled pain when the buprenorphine and pregabalin was not administered and there a risk to develop difficulty breathing when the dulera inhalation was not given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 266's medication orders were reviewed. PPT stated they received Resident 266's medication order for buprenorphine from the facility on 3/4/25 at 3:27 p.m., they had to send the order to the doctor for approval and only received the valid prescription order for buprenorphine on 3/4/25 at 5:55 p.m. then they had filled and sent it on the next scheduled delivery time. PPT also stated they received Resident 266's medication order for dulera inhalation on 3/4/25 at 3:27 p.m., they needed additional authorization for high-cost medications from the Director of Nursing (DON) which they received on 3/4/25 at 11:36 p.m. and had filled and sent it on the next scheduled delivery time. During a concurrent phone interview and record review on 3/13/25 at 10:54 a.m. with the PP, Resident 266's medication orders were reviewed. The PP stated they received Resident 266's medication order for pregabalin on 3/4/25 at 3:27 p.m. but the facility only sent discharge paper, which is not a valid prescription order, so they needed to fax it to the doctor on 3/4/25 at 6:57 p.m. for approval and only received the valid prescription order for pregabalin on 3/5/25 at 10:37 a.m. which then they had filled and sent it on the next scheduled delivery time which was 5:30 pm. During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the AC, Resident 266's medication records were reviewed. The AC then confirmed that there was no valid prescription order for Resident 266's buprenorphine and pregabalin that was faxed to the pharmacy. The AC stated they're aware that controlled medications (medications with high potential for abuse or addiction) like buprenorphine and pregabalin needs valid prescription order before the pharmacy dispense the medication. A review of the Shipping Manifest for Resident 266's buprenorphine indicated the facility received the medication on 3/5/25 at 1 a.m. A review of the Shipping Manifest for Resident 266's dulera inhalation indicated the facility received the medication on 3/5/25 at 1:20 p.m. A review of the Shipping Manifest for Resident 266's pregabalin indicated the facility received the medication on 3/5/25 at 7:10 p.m. 4. A review of Resident 160's clinical record indicated Resident 160 was admitted March of 2025 and had diagnoses that included migraine (a neurological condition characterized by recurring headaches, often with throbbing pain, sensitivity to light and sound, and sometimes nausea or vomiting), DM with neuropathy, muscle spasm (an involuntary and sudden contraction of a muscle), irritable bowel syndrome (IBS- a gastrointestinal disorder characterized by chronic abdominal pain, bloating, and changes in bowel habits), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of Resident 160's admission History and Physical, dated 3/5/25, indicated Resident 160 Has the capacity to understand and make medical decisions and was a high risk for falls and ADL decline. A review of Resident 160's physician's order, dated 3/3/25 at 12:46 p.m., indicated, Qulipta [a medication used to prevent episodic and chronic migraine headaches] Oral Tablet 60 MG . Give 1 tablet by mouth one time a day for migraine. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 160's physician's order, dated 3/3/25 at 1:27 p.m., indicated, LinaCLOtide [a drug used to treat IBS] Oral Capsule 72 MCG [micrograms- unit of measurement] .Give 1 capsule by mouth one time a day for gastrointestinal agent. A review of Resident 160's physician's order, dated 3/3/25 at 2:36 p.m., indicated, Biotin [vitamin B7 supplement] Oral Tablet 10000 MCG .Give 1 tablet by mouth one time a day for supplement. A review of Resident 160's MAR for the month of March 2025, indicated Resident 160's Qulipta, linaclotide, and biotin were scheduled to be administered starting 3/4/25 every 9 a.m. A further review of the MAR indicated the qulipta, linaclotide, and biotin 9 a.m. doses on 3/4/25 was marked with a chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 160's care plan, initiated 3/4/25, indicated, At risk for pain or discomfort related to: . >migraine .>muscle spasm .>DM w/ neuropathy. A review of Resident 160's care plan intervention, initiated 3/4/25, indicated, Administer pain meds as MD ordered .Qulipta Oral Tablet .for migraine. A review of Resident 160's progress notes, dated 3/4/25 at 2:33 p.m., indicated, .following meds [medications were] not available to be given on time: linaclotide 75mg [sic], Biotin 1000mg, Qulipta 60 mg tabs. Pharmacy contacted and will [be] delivered ASAP [as soon as possible]. A review of Resident 160's Weights and Vitals Summary, indicated Resident 160 had pain levels as follows: 3/3/25 at 8:10 p.m.- 8 (severe pain), 3/3/25 at 10:05 p.m.- 8 (severe pain), 3/4/25 at 7:38 a.m.- 4 (moderate pain), 3/4/25 at 8:45 a.m.- 9 (severe pain), 3/4/25 at 3:47 p.m.- 8 (severe pain), 3/4/25 at 4:36 p.m.- 6 (moderate pain), 3/5/25 at 12:25 a.m.- 4 (moderate pain), 3/5/25 at 12:47 a.m.- 8 (severe pain), 3/5/25 at 5:22 a.m.- 8 (severe pain). During an interview on 3/11/25 at 2:17 p.m. with Resident 160, Resident 160 stated she needed to wait two days to get some of her medications when she was admitted , including her medication for migraines. Resident 160 also stated she had a migraine on those days and was very uncomfortable. Resident 160 further stated, I felt really bad not getting some of it .well, It's upsetting but what can I do .It [missing migraine medication] was not comfortable of course. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 160's MAR was reviewed. LN 6 confirmed that Resident 160's qulipta, linaclotide, and biotin were not given on 3/4/25 at 9 a. m. LN 6 stated there was a risk for Resident 160 to experience unrelieved migraine or pain when the qulipta was not given. LN 6 also stated there was a risk for Resident 160 to develop constipation when the linaclotide was not given and risk to negatively affect her health when the biotin was not given. During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 160's medication orders were reviewed. PPT stated they received Resident 160's medication order for qulipta and linaclotide on 3/3/25 at 4:39 p.m., they needed additional authorization for high-cost medications from DON which they received on 3/4/25 at 9:30 p.m. and had filled and sent it on the next scheduled delivery time. PPT also stated the pharmacy did not send the biotin medication to the facility because they needed additional authorization for high-cost medications from the DON. A review of the Shipping Manifest for Resident 160's Qulipta indicated the facility received the medication on 3/5/25 at 8:33 a.m. A review of the Shipping Manifest for Resident 160's linaclotide indicated the facility received the medication on 3/5/25 at 10:30 a.m. 5a. A review of Resident 262's clinical record indicated Resident 262 was admitted February of 2025 and had diagnoses that included DM with foot ulcer (open sore or wound) and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection) A review of Resident 262's admission History and Physical, dated 3/2/25, indicated Resident 262 Has the capacity to understand and make medical decisions. A review of Resident 262's progress notes, dated 2/28/25, indicated Resident 262 arrived at the facility at around 11:35 a.m. A review of Resident 262's physician's order, dated 2/26/25 at 3:38 p.m., indicated, Insulin Glargine [a long-acting insulin used to control blood sugar levels] Subcutaneous [under the skin] Solution 100 unit/ML [milliliters- unit of measurement] .Inject 20 unit subcutaneously two times a day for DM. A review of Resident 262's MAR for the month of February 2025, indicated Resident 262's insulin glargine was scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 2/28/25 at 5 p.m. A further review of the MAR indicated the insulin glargine 5 p.m. dose on 2/28/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident. A review of Resident 262's progress notes, dated 2/28/25 at 5:34 p.m., indicated, .At 1630pm [4:30 p.m.] BS [Blood sugar was] 149 .Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine)Inject 20 unit subcutaneously two times a day for DM, not given, per [Nurse Practitioner- an advanced practice registered nurse with advanced clinical training who provides direct patient care, including diagnosing, treating, and managing health conditions, and can prescribe medications] ok to administer when delivered tonight by pharmacy . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/10/25 at 9:13 a.m. with Resident 262, Resident 262 stated he had to wait for 1-2 days to receive all his medications. Resident 262 further stated, I felt not so good, when asked how he was when he did not receive all his medications. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 262's MAR was reviewed. LN 6 confirmed that Resident 262's Insulin Glargine was held and not given on 2/28/25 at 5 p.m. LN 6 stated there was a risk for Resident 262 to have high blood sugar when the insulin glargine was not given. During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 262's medication orders were reviewed. PPT stated they received Resident 262's medication order for insulin glargine on 2/28/25 at 2:16 p.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 262's insulin glargine indicated the facility received the medication on 2/28/25 at 8 p.m. 5b. A review of Resident 263's clinical record indicated Resident 263 was admitted March

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 47197 Based on interview and record review, the facility failed to ensure two out of 31 sampled residents (Resident 264 and Resident 265) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 264 and Resident 265's pain medication order was not followed. These deficient practices negatively affected the residents' physical comfort and psychosocial well-being as evidenced by unnecessary pain and emotional distress which caused sleeplessness and resulted in unmanageable pain levels. Findings: 1a. A review of Resident 264's clinical record indicated Resident 264 was admitted February of 2025 and had diagnoses that included osteoarthritis (OA- a deteriorating disease that causes pain, stiffness, and swelling where two or more bones meet), pain in right hip, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), neuropathy (a nerve condition that can cause pain, numbness, tingling, or weakness in the body), chronic pain syndrome (condition that involves persistent pain that lasts for weeks to years), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 264's MDS Cognitive Patterns, dated 2/26/25, indicated Resident 264 had a BIMS score of 15 out of 15 which indicated Resident 264 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 264's MDS Health Conditions, dated 2/26/25, indicated Resident 264 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, frequently limited her participation in rehabilitation therapy sessions, and frequently limited her day-to-day activities. A review of Resident 264's physician's order, dated 2/21/25, indicated, oxyCODONE HCl [a pain medication used to relieve severe pain] Oral Tablet 5 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 6 hours as needed for Severe Pain [numeric pain scale from 1 to 10; 1-3 is mild pain, 4-7 is moderate pain, 8-10 is severe pain]. A review of Resident 264's physician's order, dated 2/21/25, indicated, HYDROcodone-Acetaminophen [a medication for pain which contains a combination of hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] Oral Tablet 10-325 MG . Give 1 tablet by mouth every 6 hours as needed for Moderate Pain. A review of Resident 264's care plan, initiated 2/19/25, indicated, At risk for alteration in comfort/pain related to: recent fall with right hip pain, chronic back pain .DM . A review of Resident 264's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD [Medical Doctor] ordered . (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/10/25 at 9:48 a.m. with Resident 264, Resident 264 stated she did not get all her medications on the first few days when she was admitted in the facility, including her pain medication. Resident 264 also stated her pain level was so bad which she rated at 10 (severe pain). Resident 265 further stated, I was hurting .I cannot move or do anything .so I just stayed here in the room on those days .I was just in bed because I can't do anything .I was not comfortable, I was in a lot of pain .I was so upset to wait that long for it [pain medication] . A review of Resident 264's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of February 2025 indicated Resident 264 received oxycodone which was indicated for severe pain on the following occasions: 2/22/25 at 11:36 a.m.- pain level was 7 (moderate pain) 2/24/25 at 1:40 p.m.- pain level was 7 (moderate pain) 2/24/25 at 7:38 p.m.- pain level was 7 (moderate pain) 2/27/25 at 6:19 p.m.- pain level was 5 (moderate pain) 2/28/25 at 8:11 p.m.- pain level was 6 (moderate pain) A review of Resident 264's MAR for the month of March 2025 indicated Resident 264 received hydrocodone-acetaminophen which was indicated for moderate pain on the following occasions: 3/7/25 at 1:21 a.m.- pain level was 8 (severe pain) 3/7/25 at 4:55 p.m.- pain level was 8 (severe pain) During a concurrent interview and record review on 3/12/25 at 2:28 p.m. with Licensed Nurse (LN) 6, Resident 264's MAR for February and March 2025 were reviewed. LN 6 confirmed that Resident 264's physician's order for oxycodone and hydrocodone-acetaminophen were not followed. LN 6 stated there was a risk for over-medication or even drug-dependence when Resident 264 was given oxycodone when she had moderate pain. LN 6 further stated there was a risk for under-medication and unrelieved pain when Resident 264 was given hydrocodone-acetaminophen when she had severe pain. 1b. A review of Resident 265's clinical record indicated Resident 265 was admitted February of 2025 and had diagnoses that included fracture (a break in the continuity of a bone) of left humerus (upper arm bone), neuralgia (pain caused by irritation or damage to a nerve) and neuritis (inflammation of a nerve), and need for assistance with personal care. A review of Resident 265's MDS Cognitive Patterns, dated 3/2/25, indicated Resident 2665 had a BIMS score of 10 out of 15 which indicated Resident 265 had a moderately impaired cognition. A review of Resident 265's MDS Health Conditions, dated 3/2/25, indicated Resident 265 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, occasionally limited her participation in rehabilitation therapy sessions, and occasionally limited her day-to-day activities. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 265's physician's order, dated 2/19/25, indicated, HYDROcodone-Acetaminophen Oral Tablet 10-325 MG . Give 1 tablet by mouth every 4 hours as needed for Sever [sic] Pain A review of Resident 265's care plan, initiated 2/19/25, indicated, At risk for pain or discomfort related to left humeral fracture due to ground fall at home. A review of Resident 265's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD ordered .MS Contin Oral Tablet .for Pain management. During an interview on 3/10/25 at 9:42 a.m. with Resident 265, Resident 265 stated she would experience pain, and she was taking pain medications for it. A review of Resident 265's MAR for the month of March 2025 indicated Resident 265 received hydrocodone-acetaminophen which was indicated for severe pain on the following occasions: 3/1/25 at 5:42 a.m.- pain level was 7 (moderate pain) 3/2/25 at 2:48 a.m.- pain level was 7 (moderate pain) 3/2/25 at 1:50 p.m.- pain level was 6 (moderate pain) 3/3/25 at 5:30 a.m.- pain level was 7 (moderate pain) 3/3/25 at 10:14 a.m.- pain level was 7 (moderate pain) 3/3/25 at 8 p.m.- pain level was 7 (moderate pain) 3/4/25 at 9:05 p.m.- pain level was 7 (moderate pain) 3/5/25 at 5:30 a.m.- pain level was 7 (moderate pain) 3/6/25 at 10:15 a.m.- pain level was 6 (moderate pain) 3/6/25 at 9:15 p.m.- pain level was 5 (moderate pain) 3/7/25 at 11:23 a.m.- pain level was 7 (moderate pain) 3/8/25 at 1:35 p.m.- pain level was 7 (moderate pain) 3/9/25 at 11:35 a.m.- pain level was 7 (moderate pain) 3/10/25 at 11:37 p.m.- pain level was 7 (moderate pain) 3/11/25 at 5:45 p.m.- pain level was 6 (moderate pain) 3/12/25 at 1:13 p.m.- pain level was 7 (moderate pain) (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/12/25 at 2:28 p.m. with LN 6, Resident 265's MAR for March 2025 was reviewed. LN 6 confirmed that Resident 265's physician's order for hydrocodone-acetaminophen was not followed. LN 6 stated there was a risk for over-medication or drug-dependence when Resident 265 was given hydrocodone-acetaminophen when she had moderate pain. LN 6 further stated Resident 265 should only be given hydrocodone-acetaminophen when she's experiencing severe pain. During an interview on 3/13/25 at 9:41 a.m. with the Director of Nursing (DON), the DON stated that staff should follow doctor's order when administering medication. A review of the facility's P&P titled, Pain Management, revised 1/2025, indicated, To provide guidelines for consistent .management .of pain, in order to provide the maximum level of comfort and enhanced quality of life for residents having pain or at risk of having pain .2. The physician may order appropriate .medication intervention s to address the resident's pain. A review of the facility's P&P titled, Administering Medications, revised 1/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47197 Based on observation, interview, and record review the facility failed meet the needs of each resident and ensure safe pharmaceutical services for a census of 60 residents when: 1. Resident 264, 262, 263, 160, 266, 60, 267, 28 and 140 did not received prescribed medications in a timely manner in accordance with the physician's order; 2. Medication delivery manifest or receipts from provider pharmacy were not signed by two licensed staff for accountability; and, 3. Facility's policies and procedures (P&P) were not followed for destruction of a controlled medication (medications with high potential for abuse or addiction). These failed practices contributed to unsafe and not timely medication use, and had the risk of drug diversion. Findings: 1a. A review of Resident 264's clinical record indicated Resident 264 was admitted February of 2025 and had diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and need for assistance with personal care. A review of Resident 264's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/26/25, indicated Resident 264 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 264 had an intact cognition status (mental process of acquiring knowledge and understanding). A review of Resident 264's physician's order, dated 2/20/25 at 7:48 p.m., indicated, metFORMIN HCl [a medication used to treat high blood sugar levels] Oral Tablet 500 MG [milligrams- unit of measurement] .Give 1 tablet by mouth two times a day for DM. A review of Resident 264's Medication Administration Record (MAR- a legal document used to record medications given to the residents), for the month of February 2025, indicated Resident 264's metformin was scheduled to be administered starting 2/21/25 every 9 a.m. and 5 p.m. A further review of the MAR indicated the metformin 9 a.m. dose on 2/21/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident. During an interview on 3/10/25 at 9:48 a.m. with Resident 264, Resident 264 stated she did not get all her medications on time on the first few days when she was admitted which was disappointing. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with Licensed Nurse (LN) 6, Resident 264's MAR was reviewed. LN 6 confirmed that Resident 264's metformin was held and not given on 2/21/25 at 9 a.m. LN 6 stated there was a risk for Resident 264 to have high blood sugar when the metformin was not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the Pharmacy Technician from the Facility's Pharmacy (PPT), Resident 264's medication orders were reviewed. PPT stated they only received Resident 264's medication order for metformin on 2/21/25 at 8:06 a.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest (receipt) for Resident 264's metformin indicated the medication was received by the facility on 2/21/25 at 1:45 p.m. 1b. A review of Resident 262's clinical record indicated Resident 262 was admitted February of 2025 and had diagnoses that included DM with foot ulcer (open sore or wound) and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection) A review of Resident 262's admission History and Physical, dated 3/2/25, indicated Resident 262 Has the capacity to understand and make medical decisions. A review of Resident 262's progress notes, dated 2/28/25, indicated Resident 262 arrived at the facility at around 11:35 a.m. A review of Resident 262's physician's order, dated 2/26/25 at 3:38 p.m., indicated, Insulin Glargine [a long-acting insulin used to control blood sugar levels] Subcutaneous [under the skin] Solution 100 unit/ML [milliliters- unit of measurement] .Inject 20 unit subcutaneously two times a day for DM. A review of Resident 262's MAR for the month of February 2025, indicated Resident 262's insulin glargine was scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 2/28/25 at 5 p.m. A further review of the MAR indicated the insulin glargine 5 p.m. dose on 2/28/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident. A review of Resident 262's progress notes, dated 2/28/25 at 5:34 p.m., indicated, .At 1630pm [4:30 p.m.] BS [Blood sugar was] 149 .Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine)Inject 20 unit subcutaneously two times a day for DM, not given, per [Nurse Practitioner- an advanced practice registered nurse with advanced clinical training who provides direct patient care, including diagnosing, treating, and managing health conditions, and can prescribe medications] ok to administer when delivered tonight by pharmacy . During an interview on 3/10/25 at 9:13 a.m. with Resident 262, Resident 262 stated he had to wait for 1-2 days to receive all his medications. Resident 262 further stated, I felt not so good, when asked how he was when he did not receive all his medications. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 262's MAR was reviewed. LN 6 confirmed that Resident 262's Insulin Glargine was held and not given on 2/28/25 at 5 p.m. LN 6 stated there was a risk for Resident 262 to have high blood sugar when the insulin glargine was not given. During a concurrent observation and interview on 3/11/25 at 4:55 p.m. with LN 6, the facility's Emergency Kit (Ekit- a supply of medication used for urgent needs of residents) was checked. LN 6 confirmed that insulin glargine is not part of the facility's Ekit supplies. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 262's medication orders were reviewed. PPT stated they received Resident 262's medication order for insulin glargine on 2/28/25 at 2:16 p.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 262's insulin glargine indicated the medication was received by the facility on 2/28/25 at 8 p.m. 1c. A review of Resident 263's clinical record indicated Resident 263 was admitted March of 2025 and had diagnoses that included DM and cerebral infarction (damage to a part in the brain due to a disrupted blood flow). A review of Resident 263's admission History and Physical, dated 3/2/25, indicated Resident 263 was oriented to person and place, and needed assistance to make medical decisions. A review of Resident 263's progress notes, dated 3/1/25, indicated Resident 263 arrived at the facility at around 12:30 p.m. A review of Resident 263's physician's order, dated 3/1/25 at 12:06 p.m., indicated, Empagliflozin [a medication used to treat DM] Oral Tablet 25 MG . Give 1 tablet by mouth one time a day for lower blood sugar. A review of Resident 263's MAR for the month of March 2025, indicated Resident 263's empagliflozin was scheduled to be administered every 5 p.m., which first dose should be on 3/1/25 at 5 p.m. A further review of the MAR indicated the empagliflozin 5 p.m. dose on 3/1/25 was not given to the resident. A review of Resident 263's progress notes, dated 3/1/25 at 7:19 p.m., indicated, Called Pharmacy at 18:43 [6:43 p.m.] to follow up all medications, as per [name of pharmacy staff] .it's on its way. During an interview on 3/10/25 at 9:28 a.m. with Resident 263, Resident 263 stated he just received his medications the next day when he was admitted . Resident 263 further stated he was not okay with it, but he could not do anything. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 263's MAR was reviewed. LN 6 confirmed that Resident 263's empagliflozin not given on 3/1/25 at 5 p.m. LN 6 stated there was a risk for Resident 263 to have high blood sugar when the empagliflozin was not given. During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 263's medication orders were reviewed. PPT stated they received Resident 262's medication order for empagliflozin on 3/1/25 at 1:41 p.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 263's empagliflozin indicated the medication was received by the facility on 3/1/25 but did not indicate the time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1d. A review of Resident 160's clinical record indicated Resident 160 was admitted March of 2025 and had diagnoses that included DM and irritable bowel syndrome (IBS- a gastrointestinal disorder characterized by chronic abdominal pain, bloating, and changes in bowel habits). A review of Resident 160's admission History and Physical, dated 3/5/25, indicated Resident 160 Has the capacity to understand and make medical decisions. A review of Resident 160's physician's order, dated 3/3/25 at 2:36 p.m., indicated, Biotin [vitamin B7 supplement] Oral Tablet 10000 MCG [micrograms- unit of measurement] .Give 1 tablet by mouth one time a day for supplement. A review of Resident 160's physician's order, dated 3/3/25 at 1:27 p.m., indicated, LinaCLOtide [a drug used to treat IBS] Oral Capsule 72 MCG .Give 1 capsule by mouth one time a day for gastrointestinal agent. A review of Resident 160's MAR for the month of March 2025, indicated Resident 160's biotin and linaclotide were scheduled to be administered starting 3/4/25 every 9 a.m. A further review of the MAR indicated the biotin and linaclotide 9 a.m. doses on 3/4/25 was marked with a chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 160's progress notes, dated 3/4/25 at 2:33 p.m., indicated, .following meds [medications were] not available to be given on time: linaclotide 75mg [sic], Biotin 1000mg . Pharmacy contacted and will [be] delivered ASAP. During an interview on 3/11/25 at 2:17 p.m. with Resident 160, Resident 160 stated she needed to wait two days to get some of her medications when she was admitted . Resident 160 stated she did not feel comfortable not taking some of her medications. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 160's MAR was reviewed. LN 6 confirmed that Resident 160's biotin and linaclotide were not given on 3/4/25 at 9 a.m. LN 6 stated there was a risk for Resident 160 to develop constipation when the empagliflozin was not given and risk to negatively affect her health when the biotin was not given. During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 160's medication orders were reviewed. PPT stated the pharmacy did not send the biotin medication to the facility because they needed additional authorization for high-cost medications from the Director of Nursing (DON). PPT further stated they received Resident 160's medication order for linaclotide on 3/3/25 at 4:39 p.m., they needed additional authorization for high-cost medications from DON which they received on 3/4/25 at 9:30 p. m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 160's linaclotide indicated the medication was received by the facility on 3/5/25 at 10:30 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1e. A review of Resident 266's clinical record indicated Resident 266 was admitted March of 2025 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his/her own) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). A review of Resident 266's admission History and Physical, dated 3/6/25, indicated Resident 266 was oriented to person, place and time, and Has the capacity to understand and make medical decisions. A review of Resident 266's progress notes, dated 3/4/25, indicated Resident 266 arrived at the facility at around 11:30 a.m. A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Dulera [a prescription medicine used to control symptoms such as difficulty breathing] Inhalation Aerosol 200-5 MCG/ACT [micrograms/puff] .2 puff inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE . A review of Resident 266's MAR for the month of March 2025, indicated Resident 266's dulera inhalation was scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 3/4/25 at 5 p.m. A further review of the MAR indicated the dulera inhalation 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 266's progress notes, dated 3/5/25 at 12:58 a.m., indicated, .some of the medication still to be delivered from pharmacy . During an interview on 3/10/25 at 10:04 a.m. with Resident 266, Resident 266 stated she did not get all her medications when she was admitted . Resident 266 further stated she had some trouble breathing because she did not get one of her inhalers. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 266's MAR was reviewed. LN 6 confirmed that Resident 266's dulera inhalation on 3/4/25 at 5 p.m. and on 3/5/25 at 9 a.m. were not given. LN 6 stated there was a risk for Resident 266 to develop difficulty breathing when the dulera inhalation was not given. During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 266's medication orders were reviewed. PPT stated they received Resident 266's medication order for dulera inhalation on 3/4/25 at 3:27 p.m., they needed additional authorization for high-cost medications from DON which they received on 3/4/25 at 11:36 p.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 266's dulera inhalation indicated the medication was received by the facility on 3/5/25 at 1:20 p.m. 1f. A review of Resident 60's clinical record indicated Resident 60 was admitted March of 2025 and had diagnoses that included thrombocytosis (a condition characterized by an abnormally high number of clotting components in the blood) and benign prostatic hyperplasia (BPH- the prostate gland grows larger than normal potentially causing urinary problems). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 60's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, but Does not have the capacity to understand and make medical decisions. A review of Resident 60's progress notes, dated 3/5/25, indicated Resident 60 arrived at the facility on 3/4/25 at 3:05 p.m. A review of Resident 60's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Tamsulosin HCL [a medication used to treat enlarged prostate] Oral Capsule 0.4 MG . Give 1 capsule by mouth at bedtime related to BENIGN PROSTATIC HYPERPLASIA . A review of Resident 60's physician's order, dated 3/4/25 at 4:43 p.m., indicated, Apixaban [a medication used to treat and prevent blood clots and to prevent stroke] Oral Tablet 2.5 MG . Give 1 tablet by mouth two times a day . A review of Resident 60's MAR for the month of March 2025, indicated Resident 60's tamsulosin was scheduled to be administered starting 3/4/25 every 9 p.m. and the apixaban was scheduled every 9 a.m. and 9 p.m., with first dose on 3/4/25 at 9 p.m. A further review of the MAR indicated the 9 p.m. doses for tamsulosin and apixaban on 3/4/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 60's progress notes, dated 3/5/25 at 6:56 a.m., indicated, .f/u [follow up] with pharmacy as medication not delivered.as per pharmacy they did not receive the face sheet and order. Refaxed all the order and face sheet. Requested stat [immediate] delivery of medication. endorsed to next shift . During an interview on 3/11/25 at 4:08 p.m. with Resident 60, Resident 60 stated he could not remember if he got all his medications when he was admitted in the facility. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 60's MAR was reviewed. LN 6 confirmed that 9 p.m. doses of Resident 60's tamsulosin and apixaban on 3/4/25 were not given. LN 6 stated there was a risk for Resident 60 to develop impaired circulation when the apixaban was not given and a risk to negatively affect Resident 60's health when the tamsulosin was not given. During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 60's medication orders were reviewed. PPT stated they only received Resident 60's medication orders for tamsulosin and apixaban on 3/5/25 at 4:18 a.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 60's tamsulosin and apixaban indicated the medications were received by the facility on 3/5/25 at 10:30 a.m. 1g. A review of Resident 267's clinical record indicated Resident 267 was admitted March of 2025 and had diagnoses that included asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe) and gastro-esophageal reflux disease (GERD- a condition where stomach acid flows back up into the esophagus causing symptoms like heartburn and regurgitation). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 267's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, and Has the capacity to understand and make medical decisions. A review of Resident 267's progress notes, dated 3/4/25, indicated Resident 267 arrived at the facility at around at 3 p.m. A review of Resident 267's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Fluticasone-Salmeterol Inhalation [a combination medication used to treat asthma] .500-50 MCG/ACT .1 puff inhale orally one time a day for asthma . A review of Resident 267's physician's order, dated 3/4/25 at 6:29 p.m., indicated, Pantoprazole Sodium [a medication used to treat GERD] Oral Capsule 100 MG . Give 1 capsule by mouth two times a day for GERD . A review of Resident 267's MAR for the month of March 2025, indicated Resident 267's fluticasone-salmeterol inhalation was scheduled to be administered starting 3/5/25 every 9 a.m. and the pantoprazole was scheduled every 6:30 a.m. and 4:30 p.m., with first dose on 3/5/25 at 6:30 a.m. A further review of the MAR indicated the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident. A review of Resident 267's progress notes, dated 3/5/25 at 4:19 p.m., indicated, Fluticasone spray unable to give, waiting for pharmacy delivery . During an interview on 3/10/25 at 11:10 a.m. with Resident 267, Resident 267 stated she did not receive some of her medications when she was admitted in the facility. Resident 267 also stated it was upsetting for her to wait that long for her medications. During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 267's MAR was reviewed. LN 6 confirmed the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were not given. LN 6 stated there was a risk for Resident 267 to develop gastric acidity when the pantoprazole was not given and a risk to develop difficulty breathing when the fluticasone-salmeterol inhalation was not given. During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 60's medication orders were reviewed. PPT stated they only received Resident 267's medication orders for fluticasone-salmeterol inhalation and pantoprazole on 3/5/25 at 12:35 p.m. and had filled and sent it on the next scheduled delivery time. A review of the Shipping Manifest for Resident 267's fluticasone-salmeterol inhalation and pantoprazole indicated the medications were received by the facility on 3/5/25 at 3:20 p.m. During a phone interview on 3/13/25 at 9:15 a.m. with the Pharmacy Consultant (PC), the PC stated he would expect the facility would be able to provide all prescribed medications to newly admitted residents in a timely manner. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/25 at 9:28 a.m. with the Admissions Coordinator (AC), the AC stated the facility was having issues with faxing medication orders to their pharmacy. The AC further stated whenever they would follow-up with the pharmacy, the pharmacy would say they did not receive the faxed orders. During an interview on 3/13/25 at 9:41 a.m. with the DON, the DON stated she would expect staff to fax medication orders to pharmacy immediately or at most an hour after the resident arrived in the facility so the pharmacy could send the medications right away. The DON further stated that she would expect that all medications for newly admitted residents are provided timely and in accordance with the physician's order. A review of the facility's P&P titled, Administering Medications, revised 1/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame. A review of the facility's P&P titled, Admission Assessment, revised 1/2025, indicated, It is the policy of the facility to admit and retain only residents it can adequately meet the needs and provide services to. A review of the facility's P&P titled, Obtaining, Accepting and Delivery of Medications, revised 3/2025, indicated, 6. Orders from New Admissions will be verified with the Attending Physician for reconciliation and will be transcribed as ordered. 7. A copy of the transcribed orders will be faxed to the Pharmacy and the Nurse will call Pharmacy to verify if the faxed orders were received. A review of the facility's P&P titled, Pharmacy Services, revised 1/2025, indicated, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications .4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 17069 1h. During a review of Resident 28's Progress Note dated 1/31/25 at 3:35 p.m. indicated she was admitted to the facility on [DATE] around 12:30 p.m. During a review of Resident 28's Order Summary Report for January 2025 contained a physician's order dated 1/31/25 for Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated (to treat difficulty breathing and reduce swelling in the airways) one puff inhale two times a day. Review of Resident 28's January 2025 MAR indicated the Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated was to be given twice a day at 9 a.m. and 5 p.m. The MAR indicated on 1/31/25 at 5 p.m. the Licensed Nurse (LN) documented 5 in the initial box. Under the section Chart Codes on the MAR indicated 5=Hold/See Nurse Notes. Review of a Progress Note (Type: eMAR Medication Administration Note) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 1/31/25 at 6:26 p.m. indicated Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 500-50 mcg (micrograms)/act (actuation) 1 puff inhale orally two times a day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (lung disease that blocks airflow and makes it difficult to breathe) .New admit, wait for delivery. Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated was delivered to the facility on [DATE] at 7:30 p.m. During an interview on 3/11/25 at 10:32 a.m. with the Director of Nursing (DON), she stated 5 documented in the initial box on the MAR indicated a progress note was written by the LN. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m. During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 28's clinical record was reviewed. The DON confirmed Resident 28's Fluticasone-Salmeterol Inhaler was not given as ordered once the facility had received the medication from the pharmacy. During a review of Resident 28's Order Summary Report for January 2025 contained a physician's order dated 1/31/25 for Pantoprazole Sodium Oral Suspension (used to treat heartburn and acid reflux) 10 ml (milliliters) via Peg-Tube (a tube inserted in the stomach used to administer nutrition and medications) two times a day. Review of Resident 28's January 2025 MAR indicated the Pantoprazole Sodium was to be given twice a day at 9 a.m. and 5 p.m. The MAR indicated on 1/31/25 at 5 p.m. the LN documented 5 in the initial box. Review of a Progress Note (Type: eMAR Medication Administration Note) dated 1/31/25 at 6:26 p.m. indicated, Pantoprazole Sodium Oral Suspension 4 mg/ml give 10 ml via Peg-Tube two times a day related to Gastrointestinal Hemorrhage .New admit, wait for delivery. Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Pantoprazole Sodium was delivered to the facility on [DATE] at midnight. During an interview on 3/11/25 at 10:32 a.m. with the DON, she stated 5 documented in the initial box on the MAR indicated a progress note was written by the LN. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m. During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 28's clinical record was reviewed. The DON confirmed Resident 28's Pantoprazole Sodium Oral Suspension was not given as ordered due to the medication was not delivered by the pharmacy until 2/1/25 at midnight. During a review of Resident 28's Order Summary Report for January 2025 contained a physician's order dated 1/31/25 for Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated (relaxes and opens the air passages in the lungs) one puff one time a day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's February 2025 MAR indicated the Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated was to be given every day at 9 a.m. The MAR indicated on 2/1/25 and 2/2/25 at 9 a.m. the LN documented 5 in the initial box. Review of a Progress Note (Type: eMAR Medication Administration Note) dated 2/1/25 at 8:56 a.m. indicated, Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated 62.5 MCG/ACT 1 puff inhale orally one time a day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation .Follow up with pharmacy. Review of a Progress Note (Type: eMAR Medication Administration Note) dated 2/2/25 at 8:38 a.m. indicated, Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated 62.5 MCG/ACT 1 puff inhale orally one time a day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation .Follow up with pharmacy, according to pharmacy staff ., it will be delivered today. Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Umeclidinium Bromide Inhalation Aerosol Powder was delivered to the facility on [DATE] at 1:25 p.m. During an interview on 3/11/25 at 10:32 a.m. with the DON, she stated 5 documented in the initial box on the MAR indicated a progress note was written by the LN. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m. During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 28's clinical record was reviewed. The DON confirmed Resident 28's Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated was not given as ordered due to it was not delivered by the pharmacy until 2/2/25 at 1:25 p.m. 1i. During a review of Resident 410's Progress Notes dated 2/13/25 at 6:08 p.m. indicated he was admitted to the facility on [DATE] around 4:08 p.m. During a review of Resident 410's Order Summary Report for February 2025 contained a MD order dated 2/13/25 for Carbidopa-Levodopa Oral Tablet Disintegrating 25-250 mg two tablets four times a day. Review of Resident 410's February 2025 MAR indicated the Carbidopa-Levodopa was to be given at 9 a.m., 1 p.m., 5 p.m., and 9 p.m. The MAR indicated on 2/13/25 at 9 p.m. and 2/14/25 at 9 a.m. and 1 p.m. the LN documented 5 in the initial box. Review of Resident 410's Progress Note (Type: eMAR Medication Administration Note) dated 2/13/25 at 9:48 p.m. indicated Carbidopa-Levodopa Oral Table-c Disintegrating 25-250 mg Give 2 tablet by mouth four times a day related to Parkinsonism .Take 1 to 2 tabs extra tabs (tablet) daily than previously taken. Max 6 tablets per day Pending from pharmacy Review of Resident 410's Progress Note (Type: eMAR Medication Administration Note) dated 2/14/25 at 10:49 a.m. indicated Carbidopa-Levodopa Oral Table-c Disintegrating 25-250 mg Give 2 tablet by mouth four times a day related to Parkinsonism .Take 1 to 2 tabs extra tabs (tablet) daily than previously taken. Max 6 tablets per day waiting for pharmacy delivery. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 410's Progress Note (Type: eMAR Medication Administration Note) dated 2/14/25 at 2:48 p.m. indicated Carbidopa-Levodopa Oral Table-c Disintegrating 25-250 mg Give 2 tablet by mouth four times a day related to Parkinsonism .Take 1 to 2 tabs extra tabs (tablet) daily than previously taken. Mac 6 tablets per day will be given when available. Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Carbidopa-Levodopa was delivered to the facility on [DATE] at 8:30 p.m. During an interview on 3/11/25 at 10:32 a.m. with the DON, she stated 5 documented in the initial box on the MAR indicated a progress note was written. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m. During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 410's clinical record was reviewed. The DON confirmed Resident 410's Carbidopa-Levodopa was not given as ordered on 2/13/25 and 2/14/25. The DON stated the medication had not been delivered by the pharmacy. A review of the facility's P&P titled, Administering Medications, revised 1/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame. A review of the facility's P&P titled, Admission Assessment, revised 1/2025, indicated, It is the policy of the facility to admit and retain only residents it can adequately meet the needs and provide services to. A review of the facility's P&P titled, Obtaining, Accepting and Delivery of Medications, revised 3/2025, indicated, 6. Orders from New Admissions will be verified with the Attending Physician for reconciliation and will be transcribed as ordered. 7. A copy of the transcribed orders will be faxed to the Pharmacy and the Nurse will call Pharmacy to verify if the faxed orders were received. A review of the facility's P&P titled, Pharmacy Services, revised 1/2025, indicated, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications .4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 43238 2.On 3/10/25, a review of facility documents [TRUNCATED]

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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. 43238 Based on observation, interview and record review, the facility failed to ensure safe medication administration practices when the facility's medication error rate was less than 5% for a facility census of 60. The facility had a total of 3 errors out of 30 opportunities, which resulted in a facility wide medication error rate of 10%. These failures had the potential to negatively affect the health of Resident 48 and Resident 16. Findings: During a medication administration observation on 3/10/25, that started at 12:14 p.m., Licensed Nurse 2 (LN 2) added less than half of a 5 -ounce cup of water to 17 grams (unit of measure) of Polyethylene Glycol powder (medication used for bowel regularity) for Resident 48. During a medication administration observation on 3/11/25, that started at 8:10 a.m., LN 3 added less than half of a 5-ounce cup of water to 17 grams of Polyethylene Glycol powder for Resident 16. A review of the manufacturer's Directions for Polyethylene Glycol powder indicated the powder is to be dissolved in any 4 to 8 ounces of beverage. During an interview on 3/12/25 at 9:41 a.m., the Director of Nursing (DON) stated To my knowledge, Polyethylene Glycol powder should be reconstituted with six -eight ounces of water, otherwise it could produce a different problem than we use the medication for. During a medication administration observation on 3/10/25, that started at 12:14 p.m., LN 2 administered 4 medications via the gastrostomy tube (G Tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach. Common for people with swallowing problems) to Resident 48. No water flushes were given in between medication boluses (given all at once, rather than over time) or after the final medication was administered. During an interview on 3/12/25 at 9:41 a.m., the DON stated I think the G tube is supposed to be flushed with 5 milliliters (ml- a unit of volume) after each medication. It is the expectation that the G tube be flushed after every medication to ensure medication delivery. During an interview on 3/12/25 at 2:30 p.m., the Director of Staff Development (DSD) stated, Evidence based practice indicates that the G tube should be flushed with 10-30 ml of water in between each medication administration. All medications should be dissolved in different cups, administered, followed by a flush. During a document review of, The National Institute of Health's, Library of Medicine's Open Resources for Nursing, dated 2021, indicated, .during enteral tube medication administration .between each medication, the tube is flushed with 15 ml of water .after the final medication is administered, the tube is flushed with 15 ml of water.

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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** 43238 Based on observation, interview and record review, the facility failed to safely store medications when, unused medications from a discharged resident (Resident 41) were stored in the bottom drawer of the Medication Cart C (Med Cart C) and an expired narcotic for Resident 15 found in the bottom drawer of Med Cart C. These failures had the potential to contribute to unsafe medication use and storage, and potential for diversion. Findings: During a concurrent observation and interview on [DATE] at 3:24 p.m., Licensed Nurse 4 (LN 4) opened Med Cart C for inspection. The following medications were observed stored in the bottom drawer: Pantoprazole (used to treat acid reflux and heartburn) 40 mg (milligrams, a unit of measure) tablets. Nifedipine (used to treat high blood pressure and chest pain) 30 mg tablets. Morphine Sulfate Oral Solution (used to treat moderate to severe pain) - Solution expired [DATE]. The LN 4 stated These [medications] should not be in here. I will remove them right now. During an interview on [DATE], at 9:41 a.m., the Director of Nursing (DON) stated The expectation is [for LNs] to check expiration dates when doing counts. Any expired medication or medications from discharged residents should be removed from the cart. Two LNs should destroy non- narcotics, all narcotics should be surrendered to me to be placed in the lockbox. During a record review of the facility's policy titled Labeling and Storing Medications, dated ,d+[DATE], indicated Medications no longer in use or medication which have expired will be disposed of in accordance with Federal and State Laws.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51387 Based on interview and record review, the facility failed to ensure a full-time Dietary Manager / Supervisor position was filled, when a kitchen staff member, lacking the training and qualifications for the Dietary Manager / Supervisor role, was placed in the position to cover for the Dietary Manager during a leave over the past 4 months. This failure had the potential for providing inadequate nutritional needs for a census of 60 residents. Findings: During an interview on 3/10/25, at 8:51 a.m., with facility full-time [NAME] 1 (CK 1), CK 1 stated that the full-time Dietary Manager went out on a medical leave approximately mid-November in 2024. CK 1 stated she and the facility staff do not know when or if the Dietary Manager will be returning. CK 1 stated she is covering for the Dietary Manager, and reports to the facility Administrator, (ADM). CK 1 acknowledged she does not have the regulatory training and certification required for the Dietary Manager / Supervisor position. CK 1 stated the facility does have a part-time Registered Dietician (RD) with whom she communicates with on occasion, to get approval for dietary substitutions for recipe ingredients. CK 1 stated the RD is part-time and comes to work at the facility on Tuesdays. During an interview on 3/11/25, at 2:29 p.m., with the facility part-time / consultant RD, RD stated that the facility Dietary Manager is on a leave, and neither she nor the facility knows when or if the Dietary Manager would be returning from her medical leave. The RD stated that she works part-time more on a consultant basis with her company for the facility, as well as for other facilities in the area. The RD acknowledged that CK 1 is serving in the role of the Dietary Manager / Supervisor position to cover this position for the facility, and that CK 1 did not have the regulatory required training and credentials for the position of Dietary Manager / Supervisor but is doing the best that she can. The RD acknowledged the risk associated with not having either a full-time Dietary Manager / Supervisor with the proper regulatory training and credentials or a full-time RD employed at this facility, could potentially put the facility residents at risk for inadequate nutritional status. During an interview on 3/13/25, at 9:24 a.m., with the facility Administrator (ADM), the ADM stated that the Dietary Manager had been out of the facility on a medical leave since mid-November of 2024, and that he did not know when she would be returning. ADM acknowledged the facility job descriptions reflecting the differences in roles, qualifications, and reporting structure between the two roles discussed here, for the CK 1 and the Dietary Manager / Supervisor. The ADM stated that the facility does employ an RD and acknowledged that the RD works part-time for the facility (less than 40 hours a week), and she also works at other facilities in the area. The ADM stated CK 1 has been working in the role / position of the Dietary Manager / Supervisor, covering for her while she is out on medical leave. ADM acknowledged that CK 1 did not have the required regulatory training and credentials for this role and that the associated risk of having CK 1 covering the Dietary Manager / Supervisor without the required regulatory training and credentials, is potentially putting the facility residents at risk for inadequate nutritional status. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility document revised on 2/18 and titled, Dietary Supervisor Job Description JOB DESCRIPTION AND PERFORMANCE STANDARDS Position Title Dietary/Food Service Supervisor indicated the following: The purpose of this position is to implement and maintain effective, efficient systems to operate the dietary department and provide food service to residents in a cost-effective, efficient manner to safely meet residents' needs in compliance with federal, state and local requirements Qualifications: Either a Certified Dietary Manager or Certified Food Protection Professional, and further stated that the Dietary Services Supervisor reports to the Administrator. During a review of facility document undated and titled JOB DESCRIPTION AND PERFORMANCE STANDARDS Position Title [NAME] indicated the following: The purpose of this position is to prepare and provide food service to residents in a cost-effective, efficient manner to safely meet residents' needs in compliance with federal, state, and local requirements Qualifications 1. Experience desirable, but not a requirement. 2. Mentally alert. 3. Ability to accurately measure food ingredients and portions, including the ability to learn. 4. Knowledge of basic principles of quantity food cooking and equipment use, preferred Authority is delegated to the individual in this position to: * Prepare residents' diets in accordance with diet orders and daily menus. * Assist the food service supervisor to determine the amount and type of food necessary to prepare the daily menus. * Monitor use of food to eliminate waste. * Follow posted menus for food preparation. * Stock food in compliance with dietary policies and procedures. The document had a blank spot immediately after the verbiage This position reports to: indicating on this facility job description that there is no stated person or position for the [NAME] to report to.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51387 Based on observation, interview, and record review, the facility failed to prepare and store food in a sanitary manner for 54 residents who received food from the kitchen out of a census of 60 residents when: 1. Sanitizing solution was found to be under the minimum effective concentration, 2. Dietary Aide 1 (DA 1) did not cover his facial hair/beard while working in the kitchen, 3. Foods found in containers that were not sealed or closed tightly, 4. Foods found without labels indicating their use by date (expiration date), 5. Expired food found in food storage area, 6. Dishware found in ready to use areas in unsanitary condition. These failures had the potential to result in foodborne illness for all facility residents receiving food from the kitchen. Findings: 1. During a concurrent observation and interview, on [DATE] beginning at 8:53 a.m., [NAME] 1 (CK 1, who is the acting Dietary Manger), confirmed the presence of a red plastic bucket, stored on the counter of the dishwashing sink, which contained Quaternary Ammonia sanitizing solution (Quat, a disinfectant solution containing chemicals and water). CK 1 stated testing determines the correct concentration of sanitizer solution and then performed the test. CK 1 confirmed the test result indicated that the sanitizing concentration was less than 200 parts per million (ppm, a unit of measure) which was under the manufacturer's minimum requirement for effectiveness. CK 1 acknowledged, a new Quat solution needed to be made and using Quat below 200 ppm on kitchen surfaces would be a risk for foodborne illness for the residents. During an interview on [DATE] at 2:29 p.m. with the facility's Registered Dietician (RD), the RD stated using Quat solution below the minimum effective concentration should not happen and acknowledged it could negatively affect the sanitary conditions of the kitchen. A review of the facility's policy and procedure (P&P) titled, Quaternary Ammonia Log Policy, undated, indicated, .The quaternary solution, used for sanitizing clean work surfaces in the kitchen, will be made according to the instructions on the product container or dispensing device set up for the specific quat product. The Food & Nutrition services worker will place the solution in the appropriate bucket labeled for its contents and will test* the concentration of the sanitation solution. The concentration will be tested at least every shift or when the solution is cloudy. The solution will be replaced when the reading is below 200 ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview, on [DATE] beginning at 8:55 a.m., CK 1 confirmed Dietary Aide (DA 1), had uncovered facial hair-beard, while he was mopping the kitchen floor. CK 1 stated DA 1 should be wearing a beard cover. During an interview on [DATE] at 2:29 p.m. the RD stated kitchen personnel with facial hair and/or beards, need to wear a beard cover and acknowledged this finding could negatively affect the sanitary conditions of the kitchen. A review of facility policy and procedure (P&P), titled Personnel Adherence to Sanitary Procedures, revised , d+[DATE], indicated .It is the policy of this facility that the food services personnel shall follow appropriate sanitary procedures . Hair nets . covering all of the hair, must be worn at all times, while on duty . 3. During a concurrent observation and interview on [DATE] at 8:58 a.m. with CK 1, the refrigerator was inspected. CK 1 confirmed the presence of a clear plastic bin containing a facility prepared food labeled Jello was stored with a lid that was not completely closed or sealed. During an observation and concurrent interview on [DATE] beginning at 9:15 a.m., with CK 1, the dry food storage area was inspected. CK 1 confirmed the presence of an opened box of pancake mix with an unsealed inner paper bag containing the mix. During an interview on [DATE] at 2:29 p.m., the RD stated, We should be following [our] policy, and acknowledged foods stored unsealed could negatively affect the sanitary conditions of the kitchen. A review of the facility P&P titled, Food Storage, dated 2023, indicated, .Prepared food stored in the refrigerator until service shall be .be tightly sealed with plastic wrap, foil or a lid . A review of the facility policy and procedure (P&P) dated 2023 and titled LABELING AND DATING OF FOODS, indicated .DRY GOODS STORAGE GUIDELINES . FOOD ITEM: Pancake and Pie Crust Mix* . *These items are not to be refrigerated after opening. Keep them dry and tightly covered . 4. During a concurrent observation and interview on [DATE] at 8:58 a.m. with CK 1, the refrigerator was inspected. CK 1 confirmed the presence of a clear plastic bin containing a facility prepared food labeled Jello with a preparation date of [DATE], but the use by date space was left blank. CK 1 stated the facility does not fill out the use by date for facility prepared foods in the refrigerator. During an observation and concurrent interview on [DATE] beginning at 9:15 a.m., with CK 1, the dry food storage area was inspected. CK 1 confirmed the presence of an opened box of pancake mix labeled open [DATE]. The Use by date on the label was blank. CK 1 stated, we only write the opened date, not the use by date. CK 1 confirmed the presence of a partial loaf of sliced bread labeled only R. [received] [DATE] and no use by date labeled. During an interview on [DATE] at 2:29 p.m., the RD stated, We should be following [our] policy, and acknowledged prepared and opened foods not labeled with a use by date could negatively affect the sanitary conditions of the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of P&P titled, LABELING AND DATING OF FOODS, dated 2023, indicated, .All food items in the storeroom, refrigerator, and freezer need to be labeled and dated .Food delivered to facility needs to be marked with a received date .Newly opened food items will need to be closed and labeled with an open date and used by date that follows the various storage guidelines within this section .All prepared foods need to be covered, labeled and dated .DRY GOODS STORAGE GUIDELINES . Pancake and Pie Crust Mix* UNOPENED ON SHELF: 9 months OPENED ON SHELF: N/A .*These items . Any opened shelf life is included in the unopened shelf life . Refrigerated Storage Guidelines . Gelatin prepared plain or with fruit Maximum Refrigeration Time . 5 days . 5. During a concurrent observation and interview on [DATE] beginning at 9:15 a.m., with CK 1, the dry foods storage area was inspected. CK 1 confirmed the presence of a bag containing a partial loaf of sliced bread labeled, R. [DATE] and nothing else written on the bag. CK 1 indicated the bread was expired and needs to be thrown out. During an interview on [DATE] at 2:29 p.m., the RD stated, Expired food needs to be thrown out and acknowledged this finding could negatively affect the sanitary conditions of the kitchen. A review of the facility P&P titled, LABELING AND DATING OF FOODS, dated 2023, indicated, .All food items in the storeroom, refrigerator, and freezer need to be labeled and dated Food delivered to facility needs to be marked with a received date Newly opened food items will need to be closed and labeled with an open date and used by date that follows the various storage guidelines within this section specifically the Dry Goods Storage Guidelines . DRY GOODS STORAGE GUIDELINES FOOD ITEM: Bread . UNOPENED ON SHELF: ,d+[DATE] days . OPENED ON SHELF: ,d+[DATE] days . 6. During a concurrent observation and interview, on [DATE] beginning at 9:01 a.m., CK 1 confirmed the presence of food preparation and storage bins which were stored wet and stacked within each other in a storage area for clean/ready to use dishware. CK 1 stated storing the bins wet and stacked without the ability to air dry presents a risk for growth of bacteria in the containers and acknowledged they could also cause foodborne illness for the residents. During a concurrent observation and interview in the kitchen on [DATE] at 9:21 a.m. with CK 1, confirmed the presence of cooking and baking pans with large areas of blackened debris on their cooking surfaces. CK 1 stated the expectation was to replace cookware when they have burnt on debris, which cannot be removed after washing them. CK 1 acknowledged the dishware was in unsanitary condition. During an interview on [DATE] at 2:29 p.m., the RD stated regarding the dishware stacked wet, [kitchen staff] need to separate and dry the bins before storing. The RD added, regarding cookware that was no longer able to be cleaned, if we can't get the grit off them, then we need to replace them. The RD acknowledged these findings negatively affect the sanitary conditions of the kitchen.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 51387 Based on observation, interview and record review the facility failed to ensure garbage was in a closed dumpster for a census of 60 residents when a dumpster was observed overflowing, and the lid was unable to be closed. This failure had the potential to attract insects and pests that could affect the health and safety of a highly vulnerable population of 60 residents, and could lead to the spread of infection among staff, and visitors. Findings: During an observation and concurrent interview, on 3/11/25, at 10:09 a.m. with [NAME] 1 (CK 1), the facility's kitchen and garbage dumpster area was inspected. CK 1 acknowledged the dumpster was overflowing and the lid could not close. CK 1 added, to fix this issue the facility could schedule an extra dumpster pick up. During an interview on 3/11/25 at 2:29 p.m. with the facility's Registered Dietitian (RD), the RD stated dumpster lids should be closed to prevent attracting pests. A review of facility policy and procedure titled, Food Related Garbage and Rubbish Disposal, revised 01/25, indicated It is the policy of this facility that the food related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters . All garbage and food waste shall be kept in containers . Garbage and rubbish containing food wastes will be stored in a manner that is inaccessible to vermin .Outside dumpsters provided by garbage pick up services will be kept closed.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Some	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 46872 Based on interview, the facility failed to ensure there was a written transfer agreement with a local General Acute Care Hospital (GACH) when the facility failed to provide a copy of a current transfer agreement upon request. This failure could potentially place residents at risk for inadequate continuity of care and treatment. Findings: During an interview on 3/12/25, at 11:35 a.m., with the Director of Nursing (DON), a request for a copy of the facility's transfer agreement with a local hospital was made. During a follow up interview on 3/12/25, at 2:06 p.m., with the DON, the DON was not able to provide a copy of a transfer agreement with a local hospital and stated she would ask the facility's consultants for assistance. During a follow up interview on 3/12/25, at 4:26 p.m., with the DON, the DON stated she was still looking for the transfer agreement. The DON confirmed she was aware that having a transfer agreement with a local hospital was required per federal regulations. During a follow up interview on 3/13/25, at 9:10 a.m., with the DON, the DON confirmed she was not able to provide a copy of a transfer agreement with a local hospital.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46872 Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 60 when: 1. Facility staff did not wear required personal protection equipment (PPE) while providing wound care to Resident 13 who was on enhanced barrier precautions (EBP-also known as enhanced standard precautions, infection control intervention designed to reduce transmission of multidrug-resistant organisms that employes targeted gown and glove use); 2. A caregiver did not wear required PPE while providing care for Resident 17, who was on EBP; 3. Facility staff did not wear required PPE while providing direct care for Resident 53, who was on EBP; 4. Facility staff did not perform hand hygiene prior to and after medication administration; and, 5. Licensed nurse did not properly disinfect the glucometer (device for measuring the concentration of glucose [main type of sugar in the blood and is the major source of energy for the body's cells] in the blood). These failures resulted in an increased risk of cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of Resident 13, Resident 17, and Resident 53 to germs, and may cause infection among vulnerable residents, staff, and visitors. Findings: 1. Resident 13 was originally admitted to the facility in October 2014 with multiple diagnosis which included infection and inflammatory reaction due to indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). A review of Resident 13's Minimum Data Set (MDS, an assessment tool), dated 1/7/25, indicated Resident 13 had intact cognition. During a review of Resident 13's Order Summary Report, with order date 3/4/25, indicated, Resident on Enhanced Barrier Precautions related to the use of indwelling catheter. During a concurrent observation and interview on 3/11/25, at 10:40 a.m., the DSD (Staff Development Director) was observed providing wound care to Resident 13 without wearing a gown. The DSD confirmed Resident 13 was on Enhanced Barrier Precautions and he should have been wearing a gown while performing wound care. The DSD stated wearing a gown was needed for extra protection of staff and to prevent spreading of germs from one resident to another. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/25, at 9:40 a.m., with the IP (Infection Preventionist), the IP confirmed it was the expectation for all staff to wear gowns, masks, and gloves, when providing direct patient care for residents on EBP. The IP stated wearing proper PPE while providing direct care to residents on EBP was needed to prevent the spread of infection. During a review of Resident 13's Order Summary Report, with order date 3/5/25, indicated, Treatment for Lt [left] medial [toward the center] shin: Cleanse with NSS [normal saline solution], pat dry, apply + Silver alginate and cover with foam dressing. Everyday and PRN [as needed]. every day shift for Wound healing. During a review of Resident 13's care plan, initiated on 2/28/25, the care plan indicated, Mr. [NAME] is on Enhanced Barrier Precautions r/t [related to]: Indwelling Catheter and Wound on Left Knee .Use of gown and gloves during high contact resident care activities such as .wound care. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, revised 1/2025, the P&P indicated, .It is the policy of this facility that Enhanced Barrier Precautions .will be implemented during high-contact resident care activities when care for residents that have an increased risk . high-contact resident care activities include .dressing .bathing/showering .personal protective equipment is required .to include .gown and gloves .communication and education will be provided to resident representative, family, and/or visitors . 49950 2. During a review of Resident 17's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated, Resident 17 was admitted to the facility June 2020 with multiple diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting left side. During a review of Resident 17's Order Summary Report, dated 3/4/25, the Order Summary Report indicated, .Resident on Enhanced Barrier Precautions related to he has a Gastric Tube [GT a flexible, hollow tube inserted through the abdominal wall and into the stomach] . During a review of Resident 17's Care Plan Report, initiated 2/28/25, the Care Plan Report indicated, . Precautions r/t Gastric Tube .Infection Prevention practices to be observed include .donning [putting on] .of PPE .monitor adherence to infection prevention and control practices .use of gown and gloves during high contact resident care activities such as: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting needs . During a concurrent observation and interview on 3/10/25 at 11:23 a.m. with Resident 17's wife in Resident 17's room, Resident 17's wife was dressing Resident 17 while he was lying in bed. Resident 17's wife stated Resident 17 had just gotten done taking a shower. Resident 17's wife further stated she assisted with providing care to Resident 17, which included showering and dressing Resident 17. Resident 17's wife further stated she did not wear a gown or gloves when providing care to Resident 17. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/25 at 9:35 a.m., with the IP, the IP stated facility staff and caregivers, including Resident 17's wife, should have worn PPE when providing direct care to Resident 17. IP further stated facility staff should have been supervising care provided to Resident 17. IP further stated Resident 17's wife should have been instructed to wear PPE when providing care. IP further stated there was a risk for spread of infection when PPE was not worn as indicated. During an interview on 3/12/25 at 10:31 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she supervised Resident 17's shower on 3/10/25. CNA 1 confirmed Resident 17's wife did not wear PPE during the shower. CNA 1 further stated Resident 17's wife was not educated on PPE when direct care was provided to Resident 17. 39489 3. A review of Resident 53's Admission Record, indicated, Resident 53 was admitted to the facility on [DATE] with diagnosis that included Severe Sepsis (serious infection condition), Dysphagia (difficulty swallowing), and Gastrostomy tube (GT). During a concurrent observation and interview in Resident 53's room on 3/10/25 at 9:25 a.m., signage for EBP was posted at the entrance to Resident 53's room that indicated, providers and staff must wear a gown and gloves for residents with urinary catheters and feeding tubes during high -contact care. CNA 5 and Restorative Nursing Assistant (RNA 1) were observed to prop up and repositioned Resident 53 on her bed. CNA 5 and RNA 1 confirmed they did not wear the required Personal Protective Equipment when they repositioned Resident 53. CNA 5 stated he did not check the signage before he entered Resident 53's room. RNA 1 stated she should have worn a gown to promote infection control. A review of Resident 53's Order Summary Report, dated 2/11/25, indicated, Resident 53 had indwelling catheter (foley catheter, thin flexible tube that drains urine from your bladder into a bag outside) inserted as ordered by the primary physician. A review of Resident 53's Order Summary Report, dated 2/12/25, indicated, Enteral [tube feeding] Feed Order for dysphagia following Cerebral infarction [blood supply to the brain was blocked]. During an interview with the IP, on 3/11/25 at 2:35 p.m., the IP stated, residents on EBP are identified as residents with GTs, and foley catheters. Staff should wear a gown and gloves when repositioning residents on EBP to promote infection control. During an interview with the Director of Nursing (DON), on 3/12/25 at 10:55 a.m., the DON stated, the staff are supposed to wear the required PPE when repositioning residents with EBP to prevent cross contamination. EBP residents are residents with medical devices such as urinary catheters or feeding tubes. A review of the facility's policy and procedure titled, Enhanced Barrier Precaution, revised 1/25, indicated, .It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO, [bacteria that resist treatment with more than one antibiotic]) such as resident with wounds, indwelling medical devices ., Enhanced Barrier Precautions require gown and glove use ., High-Contact Resident Care Activities include: . Device care or use: urinary catheter, feeding tube . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43238 4.During an observation on 3/10/25, at 11:58a.m., LN 2 failed to perform hand hygiene prior to and after performing a blood sugar check on Resident 49. During an observation on 3/11/25, at 8:10 a.m., LN 3 failed to perform hand hygiene prior to and after administration of medications to Resident 16. During an observation on 3/11/25, at 8:22 a.m., LN 5 failed to perform hand hygiene prior to and after administration of medications to Resident 25. During an observation on 3/11/25 at 12:53 p.m., LN 3 failed to perform hand hygiene prior to and after administration of an insulin injection to Resident 261. During a concurrent observation and interview on 3/11/25 at 1:26 p.m., LN 3 failed to perform hand hygiene prior to and after administration of pain medication to Resident 160. LN 3 stated Hand washing was the best practice to prevent the spread of disease and infection. During an observation on 3/11/25 at 3:59 p.m., LN 10 failed to perform hand hygiene prior to and after administration of pain medication to Resident 55. During an interview on 3/12/25, at 9:41 a.m., the DON stated, The expectation is [for licensed nurses] to perform hand hygiene before and after each med pass and in between if needed. During an interview on 3/12/25, at 10:35 a.m., the IP stated Hand hygiene is vital in preventing infections. Whenever they [facility staff] enter, they gel in. Prior to rendering care, they gel in. When they leave, they gel out. It prevents infection. This includes med pass. During a record review of the facility's policy titled Handwashing/Hand Hygiene, dated 05/24, indicated This facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections . all personnel are expected to adhere to hand hygiene .practices to help prevent the spread of infections . hand hygiene is indicated immediately before touching a resident .after touching a resident .after touching the resident's environment . 5.During an observation on 3/10/25, at 11:23 a.m., LN 2 removed two glucometers (G1 and G2) from the top drawer of the medication cart, wiped the sides and top of both glucometers with a germicidal disposable wipe (from the container with a purple top). The wipe was disposed of and G2 was left on top of the medication cart with a facial tissue wrapped around it. LN 2 immediately proceeded to perform a blood sugar check on Resident 266 using G1. LN 2 wiped each side and top of G1 with a purple top wipe and placed it on a facial tissue on the medication cart. During an observation on 3/10/25, at 11:58 a.m., LN 2 used G2 to perform a blood sugar check on Resident 49. After use, LN 2 wiped each side and top of G2 and returned to facial tissue on top of medication cart. During an interview on 3/10/25, at 12:04 p.m., LN 2 stated what dwell time was, LN 2 was not sure what dwell time (the specified amount of time the disinfectant needs to remain visibly wet on a surface to effectively kill germs) was or what it meant. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/25, at 10:35 a.m., the IP stated Cleaning of the glucometer should be before and after each use, usually in between each resident. The IP stated she was unaware of what dwell time was and how it affected efficacy of the disinfecting process. IP further stated, I will check into this, and perform an in-service for the nursing staff. During a document review of the instruction manual titled FOR A G20, Blood Glucose Monitoring System, undated, indicated in chapter titled Cleaning and Disinfection procedures . Disinfect the meter between each patient to prevent infection .keep meter wet with disinfection solution contained in the wipe for a minimum of 2 minutes.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46872 Based on observation, interview, and record review, the facility failed to ensure call light system was accessible for three out of 31 sampled residents (Resident 13, Resident 48, and Resident 263), when call light buttons were observed not within reach. This failure had the potential to result in residents' needs not being met and preventing communication for assistance when needed. Findings: 1. Resident 13 was originally admitted to the facility in October 2014 with multiple diagnosis which included multiple sclerosis (disease where nerve damage disrupts communication between the brain and the body which can result in muscle weakness, numbness and impaired coordination) and generalized muscle weakness. A review of Resident 13's Minimum Data Set (MDS, an assessment tool), dated 1/7/25, indicated Resident 13 had intact cognition. During a concurrent observation and interview on 3/10/25, at 10:27 a.m., with Resident 13, Resident 13 was observed lying in bed with his right hand bent and contracted. The call light button was on the right side of Resident 13's body hanging on the bed's side rail. Resident 13 confirmed he was unable to reach the call light button and stated, Can't reach it [call light button], if it was closer can reach it. During a concurrent observation and interview on 3/10/25, at 10:36 a.m., with Licensed Nurse (LN) 4, LN 4 confirmed Resident 13's call light button was not within his reach and stated the call light button needed to be closer to Resident 13. LN 4 stated the expectation was for the call light button to always be within reach of the resident and accessible depending on the resident's physical limitations. During an interview on 3/12/25, at 11:35 a.m., with the Director of Nursing (DON), the DON confirmed the expectations were for call light buttons to always be within reach of the resident and always working. The DON stated if call light buttons were not within reach of residents, potentially the resident would not be able to call for help when needed. A review of Resident 13's care plans initiated on 5/15/23, indicated, Keep call light within easy reach and answer promptly. 39489 2. A review of Resident 48's Admission Record, indicated, Resident 48 was admitted to the facility on [DATE] with diagnosis that included Hemiplegia (paralysis on one side of the body), Epilepsy (brain disorder characterized by recurring seizures) and Dysphagia (difficulty swallowing). (continued on next page)

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	055189	A. Building B. Wing	03/13/2025

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Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with a family member (FM) of Resident 48 on 3/10/25 at 12:30 p.m., the FM stated, Resident 48's right upper arm and right lower leg are contracted and he's unable to move them. The FM was frustrated with the staff when she visited Resident 48 and found his call light on his right side of the bed. The FM further stated, Resident 48 should always have the call light within his reach, on his left side, so he can call for help anytime. During a concurrent observation and interview inside Resident 48's room with LN 2 on 3/10/25 at 2:50 p.m., Resident 48 was lying down on a Geri chair (reclining chair), away from his bed, and no call light was seen within his reach. LN 2 confirmed that Resident 48 had been laying down on the Geri chair from 11 a.m., to 2:55 p.m., today, and his call light was not near him, as it was tied to his bed's side rail. LN 2 stated, Resident 48 was Hemiplegic on his right side, and should have his call light within his reach at all times. LN 2 left Resident 48's room without placing his call light near him. During an interview with Certified Nursing Assistant 6 (CNA 6) on 3/10/25 at 3 p.m., CNA 6 confirmed Resident 48 was lying down on a Geri chair and should have his call light within his reach and not tied to his bed's side rail. CNA 6 stated, Resident 48's call light should be easily accessible so he can call for help as needed. During an interview with the DON on 3/12/25 at 10:55 a.m., the DON stated, call lights are the lifeline of all residents, and they are supposed to be within their reach so they can get help right away. During a review of the facility's policy and procedure (P&P) titled, Call Light/Bell, revised 1/2025, the P&P indicated, Call light only to be out of reach during care to prevent injury and during the time when residents are out of bed .immediately be within reach .when resident is back to bed . It is the policy of this facility to provide the resident a means of communication with nursing staff . 6. Leave the resident comfortable. Place the call device within reach . 47197 3. A review of Resident 263's clinical record indicated Resident 263 was admitted March of 2025 and had diagnoses that included cerebral infarction (damage to a part in the brain due to a disrupted blood flow), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and atherosclerosis of native arteries (hardening of arteries from plaque building up gradually causing slowed or blocked blood flow). A review of Resident 263's admission History and Physical, dated 3/2/25, indicated Resident 263 was oriented to person and place, and needed assistance to make medical decisions. A further review of the document indicated Resident 263 had weakness on both legs and inability to walk and was at high risk for falls and activities of daily living decline. A review of Resident 263's care plan intervention, dated 3/1/25, indicated, Keep call light within easy reach and answer promptly. During an observation on 3/10/25 at 9:28 a.m. in Resident 263's room, Resident 263 was observed lying on bed, awake, and his call light button on the floor, below his bed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/10/25 at 10:40 p.m. with CNA 4, in Resident 20's room, CNA 4 confirmed that Resident 263's call light button was on the floor, below his bed. CNA 4 stated the call light button should be within the reach of the resident so he could use it whenever he needs help. During an interview on 3/13/25 at 9:41 a.m. with the DON, the DON stated that she expects that all call light button should be within reach of the resident so they could use it when they need assistance. During a review of the facility's policy and procedure (P&P) titled, Call Light/Bell, revised 1/2025, the P&P indicated, Call light only to be out of reach during care to prevent injury and during the time when residents are out of bed .immediately be within reach .when resident is back to bed . It is the policy of this facility to provide the resident a means of communication with nursing staff . 6. Leave the resident comfortable. Place the call device within reach .

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on interview and record review, the facility failed to ensure that Effective Communications in-services were done as a mandatory training for direct care staff for a census of 60. This failure had the potential to result in staff with poor communication skills and may negatively affect the residents' quality of care. Findings: During a concurrent interview and record review on 03/12/25 10:41 a.m. with the Director of Staff Development (DSD), the DSD's 2024/2025 In Service Calendar [NAME] Care Center of Fairfield was reviewed. The DSD confirmed there was no communication in-service listed on the in-service calendar and confirmed he had not conducted any communication training in 2024 or 2025. During a review of the facility's policy and procedure titled, In-Service Training Program, revised 01/25 indicated, It is the policy of this facility to develop an effective in-service training program . Our in-service training program (staff development) is planned and conducted for the development and improvement of skills of all our personnel. In-service training programs are on-going and classes are scheduled by the in-service coordinator.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on interview and record review, the facility failed to ensure that in-direct staff members (staff that do not provide direct resident care) were educated on the rights of the residents and the responsibilities of a facility to properly care for its residents, for a census of 60. This had the potential for residents to not recieve care according to their rights. Findings: During a concurrent interview and record review on 03/12/25 10:41 a.m. with the Director of Staff Development (DSD), the DSD's 2024/2025 In Service Calendar [NAME] Care Center of Fairfield was reviewed. The DSD confirmed training on the rights of the resident and the responsibilities of a facility to properly care for its residents was not conducted for indirect staff members. During a review of the facility's policy and procedure titled, In-Service Training Program, revised 01/25 indicated, It is the policy of this facility to develop an effective in-service training program . Our in-service training program (staff development) is planned and conducted for the development and improvement of skills of all our personnel. In-service training programs are on-going and classes are scheduled by the in-service coordinator.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on interview and record review, the facility failed to conduct mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI (Quality Assurance and Performance Improvement a systematic and interdisciplinary approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical problem solving)) for a census of 60. This deficient practice had the potential to result in poor communication among staff, lack of awareness of facility updates, lack of collaborative work, and compromised resident care. Findings: During a concurrent interview and record review on 03/12/25 10:41 a.m. with the Director of Staff Development (DSD), the DSD's 2024/2025 In Service Calendar [NAME] Care Center of Fairfield was reviewed. The DSD confirmed there was no QAPI listed on the in-service calendar and confirmed he had not conducted any training that outlines and informs staff of the elements and goals of the facility's QAPI program in 2024 or 2025. During a review of the facility's policy and procedure titled, In-Service Training Program, revised 01/25 indicated, It is the policy of this facility to develop an effective in-service training program . Our in-service training program (staff development) is planned and conducted for the development and improvement of skills of all our personnel. In-service training programs are on-going and classes are scheduled by the in-service coordinator.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on interview and record review, the facility failed to conduct staff training on behavioral health for a census of 60. This had the potential for staff to not have the knowledge to care for residents with behavioral health issues and needs. Findings: During a concurrent interview and record review on 03/12/25 10:41 a.m. with the Director of Staff Development (DSD), the DSD's 2024/2025 In Service Calendar [NAME] Care Center of Fairfield was reviewed. The DSD confirmed there was supposed to in-service conducted on Problems and needs of the aged, chronically ill acutely ill and disabled patients in April. The DSD confirmed he had not conducted this in-service in 2024. During a review of the facility's policy and procedure titled, In-Service Training Program, revised 01/25 indicated, It is the policy of this facility to develop an effective in-service training program . Our in-service training program (staff development) is planned and conducted for the development and improvement of skills of all our personnel. In-service training programs are on-going and classes are scheduled by the in-service coordinator.