| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055210 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Terraces at Los Altos Health Facility | 373 Pine Lane<br>Los Altos, CA 94022 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>32398<br><br>Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the proper agencies per the facility's abuse policy for one of two residents (Resident 23) when Resident 23's abuse allegation was not reported after surveyor notified the administrator (ADM) and executive director (ED). This failure left information relevant to an allegation of abuse unreported to agencies required to be reported to for such allegations.<br><br>Findings:<br><br>Review of Resident 23's clinical information yielded a face sheet that indicated she was admitted with diagnoses which included atrial flutter (a type of abnormal heart rhythm, or arrhythmia), muscle weakness, and osteoarthritis (joint pain and stiffness). Resident 23's Minimum Data Set (MDS, an assessment tool) indicated she had full mental capacity per her brief interview of mental status, dated 2/29/2024, with a score of 15 (on a scale of 0-15, 15 being full capacity).<br><br>During an interview with Resident 23 on 4/02/24 at 8:41 AM, in her room, she stated a nurse on night shift was rough when she was cleaning her. Resident 23 stated she screamed, and the nurse told her to stop screaming. She stated it happened last night and did not know the name of the staff. Resident 23 stated that it happened maybe once a week.<br><br>This surveyor notified the ADM and ED, who were both in the ADM's office, of the allegation made by Resident 23. The ADM and ED both acknowledged the information.<br><br>During an interview with ADM on 4/09/24 at 8:57 AM, she stated the facility did not have any suspicions of abuse with Resident 23, so they did not report the allegation to the Department.<br><br>A review of the facility's policy and procedure titled California LPC-Elder Abuse Prevention, Identification, Response, Reporting, revised 10/2023, indicated, . E. Reporting Abuse, Exploitation, Neglect or Misappropriation. In Life Plan Communities Generally, the timeframe for reporting is to report immediately, but not later than 24 hours after the allegation of alleged violations involving abuse . d. The appropriate community leader makes any required verbal and written report to the local law enforcement and to the Department of Public Health . e. The community leader shall report allegations as dictated by state or local agencies (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. |

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

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

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>50135<br><br>Based on interview and record review, the facility failed to follow a physician's order for one of three sampled residents (Resident 180) when weekly weights were not done as ordered by the physician. This failure of not following a physician's order resulted in the facility to be unaware of Resident 180's weight for over two weeks.<br><br>Findings:<br><br>Review of Resident 180's medical record face sheet (summary of important information) indicated she was admitted with diagnoses including pneumonia (an infection that affects one or both lungs) and muscle weakness. A physician's order, dated 3/13/24, was for weekly weights. The Resident Vital Sign Report indicated no documentation of weights since 3/18/24.<br><br>During interview and concurrent record review with the admissions nurse on 4/9/24 at 2:02 p.m., she stated Resident 180 had no weights taken between 3/18/24 and 4/4/24.<br><br>Review of the facility's policy titled, Weight Assessment and Intervention, revised 3/2022, indicated, Residents are weighed upon admission and at intervals established by the interdisciplinary team. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623<br><br>Based on interview and record review, the facility failed to prevent a pressure ulcer (damage to the skin caused by prolonged pressure) from developing for one of two residents (Resident 12) when a medical device was not placed properly. This failure resulted in a facility-acquired pressure ulcer for Resident 12.<br><br>Findings:<br><br>Review of Resident 12's medical record indicated he was admitted to the facility on [DATE] with a fractured left foot.<br><br>Review of Resident 12's physician order, dated 2/28/24, indicated to keep left boot on at all times.<br><br>Review of Resident 12's wound assessment, dated 3/9/24, indicated a facility acquired presssure injury to the left heel was identified on 3/9/24.<br><br>Review of Resident 12's skin note, dated 3/12/24, indicated the resident was evaluated by the wound specialist on 3/12/24 for medical equipment related wound on his left heel.<br><br>During an interview on 4/2/24 at 12:09 p.m., registered nurse D (RN D) stated Resident 12 developed a big blister on his heel from his boot about three weeks ago. She stated someone put Resident 12's boot on wrong and it resulted in the blister.<br><br>During an interview on 4/2/24 at 12:25 p.m., RN D stated she saw Resident 12's boot placed on Resident 12's foot incorrectly. She stated someone removed the liner from the inside of his boot, so the plastic part of the boot was against his skin. RN D stated when she removed the boot, she saw the blister on Resident 12's heel. She stated his skin rubbing against the plastic boot caused the blister.<br><br>Review of Resident 12's Care Plan Report indicated a skin integrity care plan, starting on 2/28/24 with a goal, Risk of skin integrity will be minimized . throughout their stay at the [facility]. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>32398<br><br>Based on observation, interview, and record review, the facility failed to offer and/or attempt alternatives, explain risks and benefits, or obtain informed consent prior to the use of side rails in accordance with their bed rails (side rails, safety rails, and grab/assist bars) policy for 25 of 25 residents (137, 80, 16, 23, 179, 180, 181, 182, 14, 4, 138, 10, 18, 130, 11, 2, 12, 7, 6, 129, 131, 133, 136, 132, 30). These failures had the potential to place the residents at risk of entrapment and serious injury. For Resident 30, it resulted in the resident's left hand getting caught between the mattress and quarter [one-fourth, one part of a whole divided into four equal parts] side bed rail.<br><br>Findings:<br><br>During an observation in Resident 137's room on 4/2/24 at 8:29 a.m., Resident 137 was in bed with bilateral side rails.<br><br>Review of Resident 137's physician order, dated 3/14/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 137's Side Rail Evaluation, dated 3/14/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 80's room on 4/2/24 at 8:37 a.m., Resident 80 was in bed with bilateral side rails.<br><br>Review of Resident 80's physician order, dated 3/26/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 80's Side Rail Evaluation, dated 3/26/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 16's room on 4/2/24 at 8:41 a.m., Resident 16 was in bed with bilateral side rails.<br><br>Review of Resident 16's physician order, dated 8/30/23, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 16's Side Rail Evaluation, dated 8/30/23, indicated quarter side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation in Resident 23's room on 4/2/24 at 8:41 a.m., Resident 23 was in bed with bilateral side rails.<br><br>Review of Resident 23's physician order, dated 2/25/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 23's Side Rail Evaluation, dated 2/25/24, indicated bilateral half rails were recommended, instead of the quarter side rails ordered. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 179's room on 4/2/24 at 9:09 a.m., Resident 179 was sitting up in bed with bilateral side rails.<br><br>Review of Resident 179's physician order, dated 3/15/24, indicated an order for Side Rails: Quarter.<br><br>Review of Resident 179's Side Rail Evaluation, dated 3/15/24, indicated there was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained an informed consent prior to the use of side rails.<br><br>During an observation in Resident 180's room on 4/2/24, at 9:16 a.m., Resident 180<br><br>was sitting up in bed with bilateral side rails.<br><br>Review of Resident 180's physician order, dated 3/13/24, indicated an order for Side Rails: Quarter.<br><br>Review of Resident 180's Side Rail Evaluation, dated 3/14/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained an informed consent prior to the use of side rails.<br><br>During an observation in Resident 181's room on 4/2/24 at 9:20 a.m., Resident 181 was sitting up in wheelchair. Resident 181's bed had bilateral side rails.<br><br>Review of Resident 181's physician order, dated 3/16/24, indicated she had an order for Side Rails: Quarter.<br><br>Review of Resident 181's Side Rail Evaluation, dated 3/16/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 182's room on 4/2/24, at 9:30 a.m., Resident 182 was sitting up in bed with bilateral side rails intact.<br><br>Review of Resident 182's physician order, dated 4/1/24, indicated an order for Side Rails: Quarter.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of Resident 182's Side Rail Evaluation, dated 4/2/24, indicated area left blank for recommendation of side rails. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 14's room on 4/2/24 at 11:13 a.m., Resident 14 was not in bed, and her bed had bilateral side rails.<br><br>Review of Resident 14's physician order, dated 4/28/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 14's Side Rail Evaluation, dated 4/28/24, indicated bilateral half rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 4's room on 4/2/24 at 11:13 a.m., Resident 4 was in bed with bilateral side rails.<br><br>Review of Resident 4's physician order, dated 12/20/23, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 4's Side Rail Evaluation, dated 9/11/22, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 138's room on 4/2/24, at 11:30 a.m., Resident 138 was sitting in chair, and his bed had bilateral side rails.<br><br>Review of Resident 138's physician order, dated 3/21/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 138's Side Rail Evaluation, dated 3/21/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 10's room on 4/2/24 at 11:38 a.m., Resident 10 was in bed with bilateral side rails.<br><br>Review of Resident 10's physician order, dated 12/16/23, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 10's Side Rail Evaluation, dated 12/16/23, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 18's room on 4/2/24 at 11:40 a.m., Resident 18 was in bed with bilateral side rails.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of Resident 18's physician order, dated 3/4/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 18's Side Rail Evaluation, dated 3/4/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 130's room on 4/2/24 at 11:42 a.m., Resident 130 was in bed with bilateral side rails.<br><br>Review of Resident 130's physician order, dated 3/29/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 130's Side Rail Evaluation, dated 3/29/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 11's room on 4/2/24 at 11:57 a.m., Resident 11 was in bed with bilateral side rails.<br><br>Review of Resident 11's physician order, dated 5/10/23, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 11's Side Rail Evaluation, dated 5/9/23, indicated bilateral quarter rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 2's room on 4/2/24 at 12:02 p.m., Resident 2 was not in room, and his bed had bilateral side rails.<br><br>Review of Resident 2's physician order, dated 10/8/23, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 2's Side Rail Evaluation, dated 9/27/23, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 12's room on 4/2/24 at 12:09 p.m., Resident 12 was in bed with bilateral side rails.<br><br>Review of Resident 12's physician order, dated 2/27/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 12's Side Rail Evaluation, dated 2/28/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation in Resident 7's room on 4/2/24 at 12:18 p.m., Resident 7 was in bed with bilateral side rails.<br><br>Review of Resident 7's physician order, dated 4/8/24, and indicated it was a verbal order which was read back by the director of nursing (DON), indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 7's Side Rail Evaluation, dated 4/8/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 6's room on 4/2/24 at 12:22 p.m., Resident 6 was not in the room , and the bed had bilateral side rails.<br><br>Review of Resident 6's physician order, dated 3/7/24, and indicated it was a verbal order which was read back by the DON, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 6's Side Rail Evaluation, dated 3/7/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation on 4/2/24 at 3:37 p.m. in the rooms of Resident 129, Resident 131, Resident 133, and Resident 136, all four residents' beds had side rails.<br><br>Review of Resident 129's physician order, dated 3/30/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 129's Side Rail Evaluation, dated 3/30/24, indicated there was no documentation that the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>Review of Resident 131's physician order, dated 4/1/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 131's Side Rail Evaluation, dated 3/31/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>Review of Resident 133's physician order, dated 3/27/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 133's Side Rail Evaluation, dated 3/27/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>Review of Resident 136's physician order, dated 3/24/24, indicated she had an order for Side Rails: Quarter.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of Resident 136's Side Rail Evaluation, dated 3/24/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>During an observation in Resident 132's room on 4/3/24 at 10:39 a.m., Resident 132's bed had bilateral side rails.<br><br>Review of Resident 132's physician order, dated 4/1/24, indicated he had an order for Side Rails: Quarter.<br><br>Review of Resident 132's Side Rail Evaluation, dated 4/6/24, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>Review of Resident 30's Side Rail Evaluation, dated 12/26/23, indicated bilateral side rails were recommended. There was no documentation that indicated the facility offered and/or attempted alternatives, explained risks and benefits, or obtained informed consent prior to the use of side rails.<br><br>Review of Resident 30's progress note, dated 1/10/24 indicated Resident 30's left hand was caught between the bedside rails and when asked what happened [Resident 30 stated] he slipped his hands unknowingly in between the rail that he felt the pain. The note also indicated Resident 30 had a small mark of redness with mild numbness on his left hand.<br><br>Review of Resident 30's Interdisciplinary Team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents) note, dated 1/12/24 indicated, certified nursing assistant A (CNA A) was assigned to Resident 30 and [CNA A] stated she heard the resident yelling . and ran to the resident's room. She received [Resident 30] lying in bed, but with both feet on the ground and his left hand caught between the mattress and left bedside rail, palm facing the door. His palm could be seen from the bottom of the bedrail, the bedrail was raised. [CNA A] called for the charge nurse immediately and they were unable to get the resident's hand out. The charge nurse called 911 and [CNA A] stayed with the resident. [Certified nursing assistant B (CNA B)] came and assisted [CNA A] to pull the mattress down and back. CNAs cued [Resident 30] to move his hand up, slowly, until his hand was out from between the mattress and bedside rail.<br><br>During an interview on 4/4/24 at 3:23 p.m., the director of nursing (DON) stated the interdisciplinary team discussed what happened to Resident 30's hand in an IDT meeting. The DON stated she could not see what the facility put in place as an intervention.<br><br>During an interview on 4/4/24 at 3:32 p.m. with the director of staff development (DSD) and the DON, the DSD stated she does not know if the facility put anything in place after Resident 30's hand was caught between the mattress and the side rail. The DON stated all the residents in the facility have quarter side rails. When asked if alternatives are attempted prior to using bed rails, the DON stated nothing else is attached to the beds and the facility can ask the resident if they want them or do not want them. The DON stated informed consent is not obtained for the use of side rails because they are not considered a restraint. The DON also stated she did not see that the risks and benefits of side rail use are documented on the facility's side rail evaluation form.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with the DON in her office, on 4/5/24 at 2:16 p.m., she stated she had called the facility's nurse consultant about the bed rails. The DON did not see anything in the side rail evaluation about risks versus benefits. She also stated the facility did not have consents for side rails for all the residents. The DON stated there were no alternatives for side rails use for any of the residents, since the facility did not consider them restraints.<br><br>Review of the facility's policy, Bed Rails, dated 11/16, indicated, the facility will consider appropriate alternatives prior to installing or using a bed rail . a licensed nurse will review the risks and benefits of bed rails with the resident and/or the authorized representative and obtain written, informed consent from the resident or authorized representative prior to installation and/or use. |

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|---|---|---|---|
| | 055210 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Terraces at Los Altos Health Facility | 373 Pine Lane<br>Los Altos, CA 94022 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>32398<br><br>Based on observation, interview, and record review the facility failed to 1. administer all physician ordered medications to one of three residents (Resident 2) when his Miconazole nitrate 2% topical cream (antifungal cream) was not administered during medication administration, and 2. ensure proper accounting of the controlled medication oxycodone (a semi-synthetic narcotic analgesic drug to relieve pain) in one of two medication carts (med cart 1) when the count of the oxycodone whole tablet (tab) and half tab were not correct. These failures had actual (for Resident 2) and potential implications for residents to not receive their prescribed medication(s) correctly.<br><br>Findings:<br><br>1. Resident 2 was admitted with diagnoses which included psoriasis (a chronic (long-lasting) disease in which the immune system becomes overactive, causing skin cells to multiply too quickly. Patches of skin become scaly and inflamed).<br><br>During an observation of a medication administration on 4/04/24 at 8:23 AM by licensed vocational nurse C (LVN C) for Resident 2, his Miconazole nitrate 2% topical cream was not observed administered.<br><br>A review of Resident 2's physician orders, in his electronic record, indicated an order dated 3/18/24 for miconazole nitrate 2% topical cream topical, twice a day at 9 am and 9 pm.<br><br>During an interview with LVN C on 4/04/24 at 10:40 AM, she stated she did not see the Miconazole in the MAR (medication administration record), but she sees it in the orders. LVN C stated she did not give the miconazole nitrate 2% cream.<br><br>2. During an observation of medications in med cart 1 and subsequent interview with the director of nursing (DON) on 4/04/24 at 11:25 AM, the controlled substance binder indicated Resident 133 had 13 half tablets of 2.5 mg (milligrams, a unit of dose measure) of Oxycodone 5 mg, while the pill pack of the half tablets of Oxycodone 5 mg was observed to have 12 half tablets. The controlled substance binder indicated Resident 133 had nine (9) whole tablets of Oxycodone 5 mg, while the pill pack was observed to contain 10 whole tabs. The DON stated it looked like someone gave a 1/2 tab and signed off for a whole tab.<br><br>During an interview with registered nurse D (RN D) on 4/04/24 at 11:38 AM, she stated she had given a 1/2 tab, and signed off on the whole tab sheet.<br><br>A review of the State Operations Manual (SOM) indicated in Section 483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>36623<br><br>Based on interview and record review, the facility failed to ensure two of five residents (Residents 130 and 131) were free from unnecessary psychotropic (drug that affects brain activities associated with mental processes and behavior) medications.<br><br>1. For Resident 130, there was no side effect monitoring and behavior monitoring for the use of trazodone (medication used to treat depression or help with sleep problems);<br><br>2. For Resident 131, there was no side effect monitoring and behavior monitoring for the use of trazodone.<br><br>These failures had the potential to result in lack of adequate monitoring and for the residents to receive unnecessary medications.<br><br>Findings:<br><br>1. Review of Resident 130's medical record indicated he was admitted to the facility with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and mental functions) and hypertension (high blood pressure).<br><br>Review of Resident 130's physician orders indicated he had an order, dated 3/29/24 for trazodone 50 milligrams (mg, unit of measurement) every bedtime for insomnia (sleep disorder). There was no monitoring for hours of sleep and no monitoring for side effects related to trazodone for Resident 130.<br><br>During an interview and concurrent record review on 4/5/24 at 11:40 a.m., the DON stated Resident 130 was receiving trazodone for insomnia. She confirmed Resident 130 was missing monitoring for hours of sleep and monitoring for side effects related to trazodone.<br><br>2. Review of Resident 131's medical record indicated he was admitted to the facility with diagnoses including acute respiratory failure (a lung condition that can cause shortness of breath) and atrial fibrillation (an irregular heart rhythm which can lead to blood clots and stroke).<br><br>Review of Resident 131's physician orders indicated he had an order for trazodone 50 mg at bedtime for sleep. There was no monitoring for hours of sleep and no monitoring for side effects related to trazodone for Resident 131.<br><br>During an interview and concurrent record review on 4/5/24 at 11:46 a.m., the DON confirmed Resident 131 was missing monitoring for hours of sleep and monitoring for side effects related to trazodone.<br><br>Review of the facility's policy, Psychotropic Medication Use, dated 7/2022, indicated psychotropic medication management includes adequate monitoring for efficacy and adverse consequences. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>36623<br><br>Based on observation, interview, and record review, the facilty failed to ensure sanitary conditions were maintained in the kitchen when:<br><br>1. Kitchen staff did not wear hair restraints while in the kitchen;<br><br>2. A red bucket was stored on the floor<br><br>3. A dietary aide picked up an item from floor and did not perform proper hand hygiene<br><br>4. Three of three ice machines had white residue or scale (the buildup of a white, chalk-like substance that forms where water collects or where water is dispensed) .<br><br>These failures had the potential to cause food contamination and spread food-borne illness to residents who received their food from the kitchen.<br><br>Findings:<br><br>1. During an kitchen observation on 4/2/24 at 8:27 a.m., the dishwasher did not have a hair restraint over his hair.<br><br>During an observation on 4/3/24 at 3:07 p.m., a staff member walked through the kitchen with no hair restraint.<br><br>During a concurrent observation and interview in the kitchen with the director of dining services (DDS) and nutritional care manager (NCM) on 4/3/24 at 3:18 p.m., the DDS was not wearing a hair restraint. The NCM confirmed the DDS had no hair restraint and stated everyone in the kitchen needs hair restraints.<br><br>Review of the facility's policy, Uniform Dress Code, revised 1/2024 indicated, Wear the approved hair restraint when on duty regardless of length or presence of hair.<br><br>Review of the Food and Drug Administration's (FDA) Food Code 2022, indicated food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, linens, and unwrapped single service and single-use articles.<br><br>2. During a kitchen observation and concurrent interview on 4/2/24 at 8:30 a.m., a red bucket was on the ground by the dishwasher. The NCM stated the red bucket was not supposed to be on the ground.<br><br>Review of the facility's policy, Sanitizing Food Contact Surfaces, revised 1/2023 indicated, Red buckets should be placed on a lower shelf of the station .<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. During a dining observation on 4/3/24 at 12:27 p.m. in the kitchenette, dietary aide E (DA E) was providing residents their lunch trays. DA E picked up an item off the ground with her right hand. After opening the refrigerator, DA E removed the glove on her right hand, discarded it with her left hand, and put on a new glove. DA E did not wash or sanitize her hands, nor did she change the glove on her left hand.<br><br>During an interview with DA E on 4/3/24 at 12:44 p.m., she confirmed she only changed one glove after picking up trash from the ground. When asked if she should have washed or sanitized her hands, DA E stated, I guess I should have.<br><br>Review of the facility's policy, Food Handling Guidelines, revised 1/2024 indicated, Gloves are changed between tasks . Hands are washed after gloves are removed.<br><br>4. During a concurrent observation and interview with the director of building and grounds (DBG) on 4/4/24 at 8:40 a.m. , the ice machine in Kitchen 1 had white substances along the edges of the panel that opens to the ice maker. The DBG stated the ice machine needed some more cleaning and it was part of the facility's preventative maintenance.<br><br>During a concurrent observation and interview on 4/4/24 at 9:01 a.m., the ice machine in Kitchen 2 had white substances along the edges of the panel that opens to the ice maker. The DBG stated it was not okay and should be cleaned.<br><br>During a concurrent observation and interview on 4/4/24 at 9:05 a.m., the ice machine in the nourishment room had white substances on the ice chute where the ice is dispensed. The DBG stated it was scaling and he will have it cleaned. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>36623<br><br>Based on observation, interview, and record review, the facility failed to implement infection prevention strategies when:<br><br>1. A nurse did not change gloves and perform hand hygiene during one of two dressing changes.<br><br>2. One of three urinary catheter bags was on the ground.<br><br>These failures had the potential to spread infectious organisms to the residents.<br><br>Findings:<br><br>During a wound dressing change observation on 4/2/24 at 12:09 p.m., registered nurse D (RN D) prepared Resident 12's wound supplies and put on gloves. RN D removed Resident 12's boot and removed the dressing on his heel. Using the same gloves, RN D cleaned the wound with saline and put on a new dressing. Using the same gloves, RN D cleaned the other wounds on top of Resident 12's foot. RN D did not change gloves or wash or sanitize hands after removing the wound dressing, before cleaning the wound, and before cleaning another wound.<br><br>During an interview on 4/2/24 at 12:25 p.m., RN D confirmed she only used one pair of gloves throughout Resident 12's wound dressing change.<br><br>During an interview with the director of staff development (DSD) on 4/8/24 at 10:37 a.m., she stated removing gloves and hand hygiene should be done after removing a soiled dressing and moving to the next wound.<br><br>Review of the facility's policy, Dressings, Dry/Clean, revised 9/2013, indicated to wash and dry your hands thoroughly after removing the soiled dressing and discarding the dressing.<br><br>2. During an observation in Resident 130's room on 4/2/24 at 11:42 a.m., Resident 130 was in bed and his urinary catheter bag was on the floor.<br><br>During an interview with RN D on 4/2/24 at 11:55 a.m., she stated, It is not okay that his bag is on the floor.<br><br>Review of the facility's policy, Catheter Care, Urinary, revised 8/2022, indicated, Be sure the catheter/tubing and drainage bag are kept off of the floor. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135<br><br>Based on interview and record review, the facility failed to ensure one of five residents (Resident 7) was offered and/or received influenza (a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs) and pneumococcal (common bacteria that can affect different parts of the body) vaccinations. This failure increased the potential to for residents to have inadequate immunity to influenza and pneumococcal infections.<br><br>Findings:<br><br>Review of Resident 7's clinical record indicated she was 85-years-old and was admitted to the facility on [DATE].<br><br>Review of Resident 7's Immunizations Report, dated 4/9/24, indicated she received an influenza vaccination on 11/13/21. There was no documentation that Resident 7 was offered and/or received an influenza vaccination in 2023 or 2024. There was no documentation that Resident 7 was offered and/or received a pneumococcal vaccination.<br><br>During an interview on 4/9/24 at 11:25 a.m., the director of staff development (DSD) confirmed Resident 7 had not had an influenza vaccination since 2021. The DSD also stated Resident 7 had no record of a pneumococcal vaccination.<br><br>During an interview on 4/9/24 at 12:01 p.m., the DSD stated she could not find any documentation that Resident 7 was offered an influenza vaccination or a pneumococcal vaccination in 2023 or 2024.<br><br>Review of the facility's policy, Pneumococcal Vaccine, dated 3/2022 indicated, Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. The policy also indicated, Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.<br><br>Review of the CDC's Pneumococcal Vaccine Recommendations, dated 9/21/23, indicated the CDC recommends pneumococcal vaccination for adults [AGE] years or older.<br><br>Review of the CDC's National Center for Immunization and Respiratory Diseases, dated 3/20/24, indicated, Everyone [six] months and older should get an annual flu vaccine. |