STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055211	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idylwood Care Center	1002 W. Fremont Avenue Sunnyvale, CA 94087

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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 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** 36623 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained dignity and respect for two of 32 residents when: 1. Maintenance staff intervened while staff attempted to de-escalate Resident 62's angry outburst. 2. Resident 88's urinal was on his bedside table next to food items. These failures had the potential to affect the emotional well-being of the residents. Findings: 1. During an observation on 4/7/25 at 1:31 p.m., there were two maintenance staff working on a handrail in the hallway, close to the nurse's station. Resident 62 was in his wheelchair banging on the door to the nurse's station. One of the maintenance workers, maintenance staff M (MS M) was repeatedly telling Resident 62 to stop banging on the door. MS M stood up from his position fixing the handrail, walked to Resident 62 at the nurse's station, and stood behind Resident 62's wheelchair. MS M continued to tell Resident 62 to stop banging on the door. MS M then grabbed Resident 62's wheelchair and pulled the resident backward. Resident 62 swung his right arm behind him and hit MS M in the face. Review of Resident 62's face sheet indicated he was admitted to the facility with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making). Review of Resident 62's care plan indicated he has repetitive anxious concerns/complaints, demands juice, burritos, popsicles, and does not allow ample time for staff to accommodate requests. The care plan also indicated Resident 62 bangs on office and nurse's station doors. The care plan interventions included to explain all procedures to the resident before starting and allow the resident time to adjust to changes. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the report sent to the Department on 4/11/25 indicated the following: On 4/7/2025, at approximately [1:30 p.m.], staff observed Resident 62 repeatedly banging on the . nursing station window. While CNA [certified nursing assistant] was assisting Resident 62, one maintenance staff intervened and loudly verbalized to [Resident 62] to stop banging on the window. Maintenance staff attempted to redirect [Resident 62] by pulling [Resident 62]'s wheelchair backward towards [his] room. Maintenance staff was behind [Resident 62]'s wheelchair. [Resident 62] responded to maintenance staff by suddenly punching staff using his [Resident 62] right fist to hit the staff member's right eye. Two nurses remained with Resident 62 until he [calmed] down . During an interview on 4/7/25 at 1:45 p.m. licensed vocational nurse N (LVN N) stated he saw the incident with Resident 62. LVN N stated Resident 62 is constantly banging on the window. He stated he saw MS M try to take the resident back to his room and Resident 62 hit MS M on the right side of his face. During an interview on 4/10/25 at 1:43 p.m., the maintenance supervisor O (MS O) stated he heard about the incident with Resident 62 and MS M. The MS O stated he supervises four staff members. He stated he expects maintenance staff to be considerate to residents. The MS O stated if there was a situation related to nursing, he would expect maintenance staff to find someone appropriate to help. When asked about whether maintenance staff should be involved in a resident's disruptive behavior, the MS O stated maintenance staff do not get involved in those types of interactions. When asked what he thought about MS M pulling backwards on Resident 62's wheelchair from behind, the MS O stated, I don't feel that that was the best approach. During an interview on 4/11/25 at 3:38 p.m. with the administrator (ADM) and director of nursing (DON), the DON stated Resident 62 has a behavior of banging on the door of the nursing station. She stated staff is aware how to handle Resident 62. The DON stated staff does not have to go close to Resident 62 to redirect him because he can get aggressive. She stated MS M attempted to redirect Resident 62 and pulled his wheelchair backwards. The DON stated Resident 62's reaction to his wheelchair being moved was to swing and Resident 62 hit MS M's right eye. Both the DON and ADM stated MS M should not have been involved in that type of situation. Review of the facility's policy and procedure, Adequate Staffing/Workplace Composition, revised 8/2023 indicated, Staff will participate in de-escalation training. Review of Crisis Prevention Institute's Nonviolent Crisis Intervention Training Participant Workbook, (training the facility provides) indicated, Always respond with respect, empathy, and compassion. The workbook also indicated, Interpret distress behaviors and address the cause of the behavior to de-escalate the situation and Manage your own emotional responses to distress behavior. 38087 2. Review of Resident 88's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including depression, anxiety, and need for assistance with personal care. Review of Resident 88's minimum data set (MDS, an assessment tool), dated 3/20/25, indicated his cognition was moderately impaired and he needed partial/moderate assistance for toileting hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/7/25 at 9:47 a.m., Resident 88's bedside table had several drink items on the table including a glass of milk, a cup of coffee, and a glass with a pink liquid. Next to the drinks, on Resident 88's bedside table, was a plastic urinal that contained a yellow liquid. When Resident 88 was asked about the items on his bedside table he stated, That's the remnants of my breakfast I am finishing. Resident 88 further stated he does not like the urinal next to his food but stated, I can't do anything about it. During an observation on 4/7/25 at 9:50 a.m., the activities director (AD) was removing Resident 88's urinal from his bedside table. During a concurrent interview with the AD, he stated, It should not be on the bedside table next to the food. The AD removed the urinal and returned with a plastic urinal holder which he placed on the left side of Resident 88's bedframe. During an interview with the director of nursing (DON) on 4/10/25 at 7:30 a.m., she stated a urinal should not be placed on the bedside table during the meal service or when any food items are on the bedside table. The DON further stated staff should empty urinals after each use and then store in holders on the side of the resident's bed. Review of the facility's policy titled, Use of Bedpans and Urinals indicated, Avoid storing on any surface used for eating, such as the rolling bedside table.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on observation, interview, and record review, the facility failed to perform interdisciplinary team (IDT, staff from different departments who coordinate the residents care) assessment and obtain a physician order for self-administration of medication for one out of 32 sampled residents (Resident 78) when Resident 78 had over-the-counter medication (OTC, can be purchased without a prescription from medical doctor) bottle of expired Vicks VapoRub (used to treat to relieve coughs, congestion and minor pains) on the bedside tray table. This failure had the potential for unsafe and improper administration of OTC medication. Findings: Review of Resident 78's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 78 was admitted to facility on [DATE]. Resident 78's FS also indicated diagnoses included congestive heart failure (a condition when heart is unable to pump blood efficiently), chronic obstructive pulmonary disease (a progressive lung disease characterized by airflow limitation and lung tissue destruction), and depression (a condition of persistent feeling of sadness, and loss of interest or pleasure in daily activities). Review of Resident 78's minimum data set (MDS, clinical and functional assessment tool) dated [DATE] indicated Resident 78's brief interview for mental status (BIMS, a tool used to assess cognition) score of 15 (score of 0 to 7- severe cognitive impairment, 8 to 12-moderate cognitive impairment, and 13 to 15 - intact cognition). Review of Resident 78's clinical documentation indicated there was no documented evidence of the IDT's assessment for self-administration of medication. Review of Resident 78's physician orders indicated there was no order for OTC Vicks VapoRub for self-administration. During an observation in Resident 78's room on [DATE] at 9:11 a.m., a bottle of OTC medication Vicks VapoRub was on the tray table next to Resident 78's bed. This bottle had about one-fourth of the medication left and was labeled with an expiration date ,d+[DATE]. During a concurrent interview, Resident 78 stated he used this medication himself most of the days for his nose and was not aware of the expiration date. Resident 78 also stated his son gave this bottle long ago and nursing staff was aware of him using this medication often. During an interview with licensed vocational nurse B (LVN B) on [DATE] at 12:42 p.m., LVN B confirmed the bottle of Vicks VapoRub OTC medication was left on Resident 78's tray table and was expired. LVN B also stated there was no physician order for this medication for self-use for Resident 78. LVN B stated this medication should not have been left in the room for Resident 78. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with facility's director of nursing (DON) on [DATE] at 10:55 a.m., the DON stated she was not aware of Resident 78 self-administering OTC medication. The DON also stated the IDT should have assessed Resident 78 for safely self-administering the medication and nursing staff should have obtained a physician order for Vicks VapoRub for self-administration for Resident 78. Review of facility's policy and procedure (P&P) titled, Self Administration of Medications, last revised dated [DATE], the P&P indicated, Facility, in conjunction with the Interdisciplinary Care Team, should assess and determine, with respect to each resident, whether Self-Administration of medications is safe and appropriate. Facility should ensure that orders for Self-Administration list the specific medication(s) the resident may Self-Administer.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46552 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for advance directive (AD, written instructions, such as a living will or durable power of attorney [a document that authorizes to act on behalf of resident] for healthcare when the individual is incapacitated) and physician orders for life-sustaining treatment (POLST, a document that specifies the medical treatments the resident wants to receive during serious illness) form for three of six sampled residents (Resident 17, 10, and 117). These failures could lead to the delivery of unnecessary or inappropriate medical services against a resident's goals and wishes. Findings: Review of Resident 17's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 17 was admitted to facility on 8/13/2019. Review of Resident 17's POLST form date prepared on 2/3/2025 indicated section D for AD was incomplete and left blank. Review of Resident 17's clinical record indicated there was no documented evidence the facility verified, offered, or assisted Resident 17 to execute an AD. Review of Resident 10's FS indicated Resident 10 was admitted to facility on 1/31/2002. Review of Resident 10's POLST form prepared undated indicated section D for AD incomplete, left blank. Review of Resident 10's clinical record indicated there was no documented evidence the facility verified, offered, or assisted Resident 10 to execute an AD. Review of Resident 117's FS indicated Resident 117 was admitted to facility on 9/15/2021. Review of Resident 117's POLST form prepared date 7/13/2021, section D for AD indicated, No Advance Directive. Review of Resident 117's clinical record indicated there was no documented evidence the facility offered or assisted Resident 117 to execute an AD. During an interview with the facility's social service director (SSD) on 4/9/2025 at 2:05 p.m., the SSD confirmed above findings. The SSD stated facility should have completed POLST form for section D for AD for Residents 17 and 10. The SSD also stated social service staff should have verified, discussed, offered, and assisted to execute AD for Residents 17, 10, and 117. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the director of nursing (DON) on 4/11/2025 at 10;29 a.m., the DON stated nursing staff should have verified and completed all sections of POLST form for residents. The DON also stated social service staff should have verified, offered, and assisted Residents 17, 10, and 117 to execute an AD. Review of facility's P&P titled, Advance Directives, revised 9/1/2013, the P&P indicated, When admitted , the resident/client is asked if he or she has executed an Advance Directive. If the answer is Yes, a copy of the Advance Directive is obtained and placed in the clinical record. Social Services may provide information on preparing an Advance Directive and contacts the local Ombudsman (independent advocate acts as a point of contact between the resident and nursing facility, ensuring fair solutions related to care, safety, and services) for assistance. Review of facility's P&P titled, POLST (Physician Orders for Life Sustaining Treatment), revised 9/1/2013, the P&P indicated, The admitting nurse will note the existence of the POLST form on admission and review the form for completeness .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50855 Based on observation, interview, and facility's document review, the facility failed to maintain resident's rights to privacy and confidentiality for one of five sampled residents (Resident 34) when Resident 34's personal information and care instructions were posted in the room visible to roommate and visitors. This failure had the potential to compromise resident's rights. Finding: During an observation on 4/7/2025 at 10:52 a.m., inside Resident 34's room, Resident 34 was sharing a room with one other resident. Resident 34 was awake and there were two care instructions posted at the wall above Resident 34's head of bed (HOB). One care instruction indicated, SPLINT INSTRUCTION, type of splint: Resting hand splint, The purpose of your splint: Maintain skin integrity and joint ROM (range of motion), When to wear your splint: 4-6 hours daily 5x [times]/week, how to wear splint: apply splint . The second care instruction indicated, Feeding Safely 1. Slow rate of feeding, 2. [Resident 34] need cues to chew thoroughly! 3. Every 3 bites of food - sip of liquid, 4. Check mouth for pocketing. During a concurrent observation and interview with Registered Nurse J (RN J) on 4/7/25 at 3:25 p.m., inside Resident 34's room, the care instructions were still posted. RN J confirmed the above observation and stated the facility put the care instruction for communication. RN J further stated Resident 34's care instruction should have been covered for privacy. During an interview on 4/9/25 at 3:31 p.m., with the Director of Nursing (DON), the DON stated care instructions should have been covered for resident privacy and confidentiality. During a review of facility's policy and procedure (P&P) titled RESIDENT RIGHTS revised date 1/15/07, indicated, .RESIDENT RIGHTS UNDER FEDERAL REGULATIONS . 30. The Resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of the family and Resident groups .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50855 Based on observation, interview, and record review, the facility failed to ensure oxygen (O2) was administered per physician's order for one of three sampled residents (Resident 79) when Resident 79 was receiving 5 liters per minute (LPM) of oxygen. This failure had the potential to affect Resident 79's respiratory health. Finding: During an observation on 4/7/25 at 10:47 a.m., Resident 79 was lying in bed with oxygen concentrator (a device which concentrates the oxygen from ambient air) in used at 5 LPM via nasal cannula (NC, device placed in the nostril used to deliver oxygen). During a review of Resident 79's physician's order indicated an order, dated 5/28/24, Administer oxygen at 3LPM/NC continuously to maintain oxygen saturation [the percentage of oxygen in the blood] > [greater than] 92%. every shift. During an observation on 4/7/25 at 1:54 p.m., inside Resident 79's room. Resident 79 was sleeping with a NC and the O2 concentrator on and set at 5 LPM. During a concurrent observation and interview on 4/7/25 at 3:22 p.m., with Registered Nurse J (RN J), inside Resident 79's room, RN J checked Resident 79's oxygen concentrator and she confirmed it was set at 5 LPM. RN J stated the order is 3 LPM and it should not be at 5 LPM. During an interview on 4/9/25 at 3:27 p.m., with the Director of Nursing (DON), the DON stated the nurses should be following the physician's order for oxygen. The DON further stated the resident can affect the breathing if they are getting too much oxygen. During a review of facility's policy and procedure (P&P) titled, Oxygen Management revised date 9/01/13, indicated, It is the policy of this facility to provide oxygen support in a safe manner to prevent accidents, to maintain adequate oxygenation to the resident . During a review of facility's policy and procedure (P&P) titled, Labeling of Oxygen Cannula/Tubing revised date 9/01/13, indicated, 4. Procedure: Before use: Verify the physician's order for oxygen therapy, including the flow rate . During use: . Adjust the flow rate as ordered by the physician . Documentation: Document, including the flow rate, duration and patient's response .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38573 Based on interview and record review the facility failed to provide dialysis services consistent with professional standards for one of one resident (Resident 100) when: 1. Communication with the dialysis facility was not properly coordinated when Resident 100's dialysis communication records (DCR) were not completed; 2. Resident 100's dialysis care plan did not have a person-centered intervention and 3. Staff was not trained on emergency care for residents with renal diseases, dialysis care, and there was no emergency dialysis kit available. These failures may affect the quality of dialysis care being provided to the residents and had the potential to cause resident health complications. Findings: 1. Review of Resident 100's clinical record indicated he was readmitted to the facility on [DATE] with diagnoses including chronic kidney disease stage 5 (CKD, a condition in which the kidney no longer functions normally to filter waste and excess water from the blood as urine) and dependence on renal dialysis (a process of removing waste and excess water from the blood in those whose kidneys have lost normal function) and diabetes mellitus (DM) type 2 (A chronic condition that affects the way the body processes blood sugar). He was scheduled for dialysis every Tuesday, Thursday, and Saturday. During a concurrent interview and record review on 4/9/25 at 11:09 a.m., with the minimum data sheet coordinator (MDSC), he reviewed Resident 100's DCR's records dated 2/11/25, 2/13/25, 2/27/25, 3/1/25, 3/4/25, 3/6/25, 3/11/25, 3/13/25, 3/18/25, 3/22/25, 3/25/25, 3/27/25, and 3/29/25 were not completed by a dialysis center. He stated that facility licensed nurses should have followed up with Resident 100's dialysis center and completed the DCR's post dialysis assessment for Resident 100's continuity of dialysis care. The MDSC further stated that there was no documentation in the nurse's notes indicating that the licensed nurse called the dialysis clinic to inquire about Resident 100's special instructions, pre and post-dialysis weight and condition while at the dialysis clinic. During a concurrent interview and record on 4/9/25 at 11: 32 a.m., with the MDSC, He confirmed that Resident 100's clinical record revealed DCR's dated 2/11/25, 3/4/25, 3/15/25 and 3/29/25 DCR's post dialysis assessment was not completed by the facility. MDSC stated that the facility licensed nurses should have completed the Dialysis Assessment Communication Form prior to Resident 100's dialysis treatment and should have completed the assessment after he returned to the facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure revised 9/1/13, titled, Dialysis, Care for a Resident/Client on indicated, Residents/clients receiving dialysis are cared for in a manner that limits or prevents complications. Exchange of information useful and necessary for the care of the resident/client is documented in the medical record . When dialysis treatments are provided at an outside agency, the agency has direct responsibility for the supervision and care of the resident during the entire treatment process including assessment, access device care, prevention of infections, immediate post-dialysis assessment, administration of treatments and medications etc. while the skilled facility, the facility has direct responsibility for the care of the resident, including customary standard care and the following: Assessment of the resident, including monitoring of vital signs post dialysis, monitoring of shunt site, monitoring for post dialysis complications, providing and monitoring any special diets and etc. Review of the facility's Skilled Nursing Facility (SNF) Dialysis Assessment Communication Form (DACF) indicated, The dialysis unit should complete the dialysis unit section of the Dialysis Communication Form and return the form to the facility and the information shall be shared between the facility and the dialysis unit. Prior to dialysis the SNF Nurse shall complete the Dialysis Communication Form including resident condition, status of the dialysis access site, vital signs, weight diet etc. and send with resident to dialysis for each treatment and complete back of form when resident returns from dialysis. 2. During an observation on 4/8/25 at 9:43 a.m., and 4/9/25 a.m. at 10:28 a.m., Resident 100 had a permacath (long, flexible tube inserted into a vein most commonly in the neck and into the heart to allow dialysis to occur) in place. Review of Resident 100's physician's order, dated 2/7/25, indicated he had a hemodialysis catheter for dialysis via right chest permacath and was scheduled to go to a dialysis facility three times a week. During a concurrent interview and record on 4/9/25 at 3: 13 p.m., with the assistant director of nursing (ADON), She reviewed Resident 100's care plan dated 2/7/25 indicated Resident 100 has right upper chest permacath for dialysis related to diagnosis of Type 2 DM and CKD stage five and one of the interventions was to check for thrill (vibration over an arteriovenous [AV] fistula or graft [types of accesses used for dialysis] and bruit (whooshing sound heard over an AV fistula or graft). ADON stated that the care plan did not have a person-centered intervention because for chest permacath, there would be no monitoring of the thrill and bruit. ADON further stated that she will revise the dialysis care plan to reflect the Resident 100's status. Review of the facility's policy and procedure revised 1/22/20, titled, Care Planning indicated person-centered care plans are prepared by an Interdisciplinary Team with input from the person served, to meet individual needs and preferences . Begin with identifying the person's served strengths, needs, abilities, preferences, considering cultural needs and addressing challenges to care. Problems experienced by the persons served are care planned to use three main care plan components: Problem Statement, Goals, Interventions. 3. During a concurrent observation and interview on 4/9/25 at 10:52 a.m., with registered nurse I (RN I) and licensed vocational nurse S (LVN S) both stated that they don't have a current training about taking care of Resident 100 that was on dialysis care. Both further stated that there was no emergency dialysis kit in the unit, medication room, medication cart, and crash cart.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50855 Based on observation, interview, and record review, the facility failed to follow its policy and procedure when Registered Nurse I (RN I) did not use a pair of gloves while preparing a hazardous drug (medications that pose potential health risks to individuals who handle them). This failure had the potential to expose RN I to hazardous drug. Findings: During the medication administration observation on 4/8/25 at 9:04 a.m., Registered Nurse I (RN I), was observed preparing five medications for Resident 139. One of the medications was finasteride (used to treat symptoms of Benign Prostatic Hyperplasia (BPH, a benign [not cancerous] condition in which the prostate gland [prostate is a gland in the male reproductive system] is larger than normal) 5 mg (milligrams, unit of measurement). The finasteride medication blister pack (packaged doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles.) was labeled with a red sticker stating, Hazardous drug. RN I prepared the finasteride medication without using gloves. During a concurrent interview and record review after the observation on 4/8/25 at 9:26 a.m., RN I confirmed the finasteride medication blister pack red sticker indicated hazardous drug. She stated she did not wear gloves when preparing the medication. She further stated she should have used gloves when preparing finasteride. During an interview on 4/10/25 at 8:35 a.m., with the Director of Nursing (DON), the DON stated when preparing finasteride, the nurse should wear gloves. During an interview on 4/10/25 at 3:35 p.m., with the Facility Pharmacist Consultant (FPC), the FPC stated they [nurse] should wear gloves when preparing finasteride. The FPC further stated finasteride can affect women. During a review of facility's policy and procedure titled, Hazardous Drug/Chemicals and Safety Data Sheets (MSDSs) revised date 1/1/13, indicated, .2. Facility staff preparing, infusing administering or removing a hazardous drug/chemical from its packaged should use protective equipment such as gloves or masks to protect themselves from exposure to aerosolized fluids or particles per Facility Policy. According to Drugs.com Finasteride can be absorbed through the skin. Finasteride can cause birth defects if a woman is exposed to it during pregnancy. The tablets should not be handled by a woman who is pregnant or who may become pregnant.

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	055211	A. Building B. Wing	04/11/2025

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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. 50855 Based on observation, interview, and record review, the facility had a medication error rate of 18.75% when six medication errors occurred out of 32 opportunities during the medication administration for three out of seven residents (Resident 3, Resident 34, and Resident 139). The failures resulted in the nursing staff not following physician's orders and the facility's policy and procedures (P&P), and had the potential for medication complications or residents not receiving full therapeutic effects of the medication. Findings: 1. During the medication administration observation on 4/7/24 at 4:35 p.m., Licensed Vocational Nurse F (LVN F) was observed administering five medications for Resident 3. Included in the medications was eye drops, Brimonidine Tartrate [used to lower pressure in the eyes in patients with glaucoma (high pressure in the eyes that may damage nerves and cause vision loss)]. LVN F asked Resident 3 to open the eyes but did not instruct the resident to look up. LVN F instilled one drop of the medication directly to the inner corner of Resident 3's eye without pulling the lower eyelid down. As soon as the eye drop was instilled to inner corner of Resident 3's eyes, LVN J immediately wiped Resident 3's eyes with a tissue. LVN J did not apply gentle pressure on Resident 3's tear duct after administering the eye drops. During an interview after the medication administration, on 4/7/25 at 4:53 p.m. with LVN F, he confirmed he instilled the drops directly into the inner corner of Resident 3's eyes and did not pull the resident's lower eyelid to make a pocket to instill the medication in during eye drop administration. He further stated he normally administered the eye drop in the center of the eye or pupil [circular black opening in the center of the iris (the colored part of the eye that surrounds the pupil) of the eye]. During a review of Resident 3's physician's order indicated an order, dated 2/26/25 for Brimonidine Tartrate Instill 1 drop in both eyes three times a day for Glaucoma. During an interview on 4/8/25 at 3:13 p.m., with the Director of Nursing (DON), she stated during eye drop administration, the nurses should make a pocket and instill the eye drop in the conjunctival sac (the pocket where eye drops and ointments are typically administered). During phone interview on 4/10/25 at 3:39 p.m., with the Facility Pharmacist Consultant (FPC), the FPC stated for eye drop administration the nurse should wash hands, wear gloves, instruct the patient to look up if the patient cannot follow instruction, they have to hold the eyelid (lower). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to MedlinePlus.gov, a service of the National Library of Medicine (NLM), the world's largest medical library, which is part of the National Institutes of Health (NIH). Indicated the following for Brimonidine Ophthalmic: To instill eye drops, follow these steps: . 5. While tilting your head back, pull down the lower lid of your eye with your index finger to form a pocket . 7. While looking up, gently squeeze the dropper so that a single drop falls into the pocket made by the lower eyelid. Remove your index finger from the lower eyelid . 9. Place a finger on the tear duct and apply gentle pressure [prevent the medication from draining into the nose and reduces the risk of systemic side effects]. 10. Wipe any excess liquid from your face with a tissue . During a review of the facility's P&P titled 6.0 General Dose Preparation and Medication Administration Revised date 1/1/13, indicated, Applicability: This Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to Facility policy regarding medication administration and should comply with Applicable Law and the State Operations Manual when administering medications . 5. During medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: .Provide the resident with any necessary instructions. 5.8 Follow manufacturer medication administration guidelines . 2. During the medication administration observation on 4/8/25 at 8:36 a.m., Registered Nurse E (RN E), was observed preparing five medications, one liquid medication, four tablets of three different medications, and one powdered medication for Resident 34. The four tablets were one tablet of aspirin (treat mild to moderate pain) 81 milligrams (mg, unit of measurement); two tablets of carbamazepine (used to treat seizures, nerve pain) 200 mg; and one tablet of lithium (treat bipolar disorder, a mental condition in which a person has wide or extreme swings in their mood) 300 mg. The resident was receiving medications via gastrostomy tube (G-tube, tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). RN E placed the four tablets of three different medications in one small medication cup, then she put it inside the pill crusher pouch and crushed all the three medications together. She put the three crushed medications in one cup of 4 ounces (oz, unit of measurement) of water, which was mixed with 17 grams of polyethylene glycol powder (treat occasional constipation). On 4/8/25 at 8:45 a.m., RN E was observed administering the medication to Resident 34 via G-tube. RN E flushed the G-tube with water and she administered the four mixed medications in one cup using a 60 ml (milliliter, unit of measurement) syringe (commonly used in a wide range of applications, including medication delivery, fluid injections, blood draws, and laboratory testing), then she flushed the G-tube with water. During an interview shortly after the observation, on 4/8/25 at 8:59 a.m., RN E confirmed she crushed the three medications all together and mixed it with 17 gram of polyethylene powder in the cup, total of four mixed medications was administered to Resident 34's G-tube together. The liquid medication was administered separately. RN E stated the three medications should be crushed separately. She stated she should have flushed 15 ml in between each mediation. RN E also stated the four medications should be administered separately. She further stated the medications has different interactions. During an interview on 4/8/25 3:15 p.m., with the DON, she stated during G-tube medication administration, nurses should crush the medication separately and administer the medications separately with flushing in between. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's physician's order indicated an order, dated 1/25/24 Enteral Feed (also known as tube feeding) Order every shift flush tube with 15 ml of water in between each medication. During a telephone interview on 4/10/25 at 3:37 p.m., with the Facility Pharmacist Consultant (FPC), the FPC stated for G-tube medicaiton administration, the nurse should administer the medication in separate cups and flush after each medication. She further stated it is a precaution because some drugs might have an interaction. During a review of the facility's P&P titled, ENTERAL THERAPY (Tube Management, Feeding, Medications) Revised date 9/1/13, indicated, . III MEDICATION AND ADMINISTRATION VIA ENTERAL TUBE A. Procedure for Administering Medication: . 4. Administer each medication one at a time, with water flushes prior to administration, due to risk for physical and chemical incompatibilities, potential for tube obstruction, and potential for altered therapeutic drug response . 3. During the medication administration observation on 4/8/25 at 9:04 a.m., Registered Nurse I (RN I), was observed preparing five medications for Resident 139. Included in the medications was tamsulosin (used in men to treat the symptoms of an enlarged prostate [prostate is a gland in the male reproductive system]) 0.4 mg 2 capsules. The medication was not in the cart and RN I stated she will check the medication room for tamsulosin. RN I came back without the tamsulosin and she stated the medication is not available. She further stated she will call the pharmacy. During an interview on 4/8/25 at 1:18 p.m., when RN I was asked whether she was able to give tamsulosin to Resident 139, RN stated it was not given and the pharmacy will deliver the medication later in afternoon. During a review of Resident 139's physician's order indicated an order for Tamsulosin capsule 0.4 mg give 2 capsule by mouth one time a day for BPH (benign prostatic hyperplasia, condition when the prostate gland is larger than normal), dated 5/29/24. During a review of Resident 139's Medication Administration Record (MAR) indicated the 4/8/25 9 a.m. administration for tamsulosin 0.4 mg give 2 capsule was marked 18 meaning medication not available. During an interview of 4/9/25 at 3:36 p.m., with the DON, she stated medication should have been ordered on time and stated medications should be available. She further stated Resident 139 did not receive the medication tamsulosin yesterday. During a review of the facility's P&P titled, MED PASS, MEDICATION ADMINISTRATION ESSENTIALS Revised date 9/1/13, indicated, . 2. The licensed nurse administers medications within one hour before or one hour after the scheduled administration time. E. Medication Rights Licensed nurses are to follow the seven rights of medication: 4. The right time.

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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. 50855 Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when: 1. Opened multi-dose vials/inhalers had no open date; 2. Expired medications were not removed from active stock; 3. A treatment cart was left unlocked and unattended. These failures had the potential for residents to receive medications with reduced efficacy and had the potential for residents to access the unlocked and unattended treatment cart. Findings: 1. During an inspection of a medication cart on 4/7/25 at 3:31 p.m., with Registered Nurse D (RN D), one opened bottle of Pepto Bismol (indication include diarrhea, heartburn, indigestions, nausea, and stomach upset) was identified. The bottle had an expiration of 3/2025. RN D confirmed Pepto Bismol was expired on 3/2025. She further stated it should not be in the cart and should not be used. During an interview on 4/8/25 at 3:27 p.m., with the Director on Nursing (DON), the DON stated any expired medication should not be in the cart because the efficacy of the medication is not the same. 2. During an inspection of another medication cart on 4/7/25 at 3:46 p.m., with Registered Nurse E (RN E), RN E confirmed the following findings: a. One opened multi-dose vial of insulin did not have an open date. A review of the manufacturer's label on the insulin vial indicated it must be discarded 28 days after opening. RN E stated insulin should have an open date and discard 28 days after opening. b. A Wixela (medication to treat breathing problems such as asthma) inhaler had an open date of 3/5/25. A review of manufacturer's label indicated to discard one month after opening. RN E stated it should be discarded. c. A Breyna (medication to treat breathing problems such as asthma) inhaler was undated with the open date. A review of manufacturer's label with RN E indicated, to discard three months after opening. RN E stated Breyna should have an open date and be discarded in three months. During an interview on 4/8/25 at 3:33 p.m. with the Director of Nursing (DON), the DON stated the expired Wixela inhaler should not be in the medication cart, the Breyna inhaler should have an open date, and the multi-dose vial of insulin should have an open date to know when it should be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure titled, Storage and Expiration of Medications, Biologicals, Syringes and Needles revised date 6/30/17, indicated, . 4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommendation by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or return to the supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the dated opened on the medication container when the medication has as shortened expiration once opened. 38087 3. During a wound treatment observation, on 4/9/25 at 8:15 a.m., the treatment nurse (TXN) prepared supplies to perform a wound treatment for Resident 98. The TXN left the treatment cart unlocked, entered Resident 98's room, and closed the door. The treatment cart was left unlocked in the hallway, outside of Resident 98's room. During an interview, on 4/9/25 at 8:22 a.m., the TXN confirmed he left the treatment cart unlocked and stated it should be locked. During an interview with the director of nursing (DON) on 4/10/25 at 7:30 a.m., she confirmed the treatment cart should be locked when not in use. The DON further added the treatment cart should always be within view of the user when unlocked. The facility's policy, General Dose Preparation and Medication Administration, revised 1/1/13 indicated, Facility should ensure that medication carts are always locked when out of sight or unattended.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 46552 Based on observation, interview and record review, the facility failed to ensure to provide adaptive equipment (a device specifically designed to assist with drinking/eating) with meals to one of two sampled residents (Resident 10). This failure had the potential to affect the swallowing ability, fluid intake, health, and well-being of Resident 10. Findings: Review of Resident 10's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 10 was admitted to facility on 1/31/2002 with diagnoses including dysphagia (difficulty swallowing). Review of Resident 10's physician orders indicated, Nosey cup TID (three times per day) with meals for adaptive equipment . dated 11/5/2021. Review of Resident 10's meal tray card for lunch on 4/8/2025 indicated, Nosey Cup (an adaptive drinking cup with a U-shaped cut out on one side, designed to maintain proper head and neck position when drinking for safe swallowing liquids) highlighted in yellow color. During lunch meal observation and interview with certified nursing assistant K (CNA K) in Resident 10's room on 4/8/2025 at 12:30 p.m., there was a regular plastic cup provided with Resident 10's meal tray. There was no nosey cup on Resident 10's tray. CNA K confirmed there was no nosey cup with Resident 10's meal tray. Resident 10 drank a strawberry health shake (supplemental nutritional liquid filled with nutrients) by herself from the regular plastic drinking cup and it spilled out of Resident 10's mouth. During this observation other liquid supplements also spilled out of Resident 10's mouth while drinking with the plastic cup. CNA K stated Resident 10 drinks liquids comfortably with a nosey cup and liquids will not spill out of her mouth. CNA K also stated Resident 10 frequently did not receive a nosey cup with her meal tray. During an interview with assistant dietary supervisor (ADS) on 4/8/2025 at 3:07 p.m., ADS stated dietary staff should have read the lunch tray card and provided a nosey cup with each meal tray for Resident 10. During an interview with registered dietitian 1 (RD 1) and RD 2 together on 4/8/2025 at 3:11 p.m., RD 1 stated kitchen staff should have provided a nosey cup with lunch meal tray on 4/8/2025 for Resident 10. RD 1 also stated kitchen staff will receive education for extra attention for tray cards with adaptive equipment. During a second observation of a lunch meal on 4/9/2025 at 12:45 p.m., Resident 10 was able to drink liquids from nosey cup without spilling and there were no swallow concerns. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a third observation along with CNA L during breakfast meal on 4/10/2025 at 7:45 a.m., Resident 10 was able to drink liquids from nosey cup with no concerns. CNA L stated nosey cup helps to drink liquids for Resident 10. CNA L stated the kitchen was not sending a nosey cup with meal trays once in a while for Resident 10. During an interview with the assistant director of nursing (ADON) on 4/10/2025 at 10:03 a.m., the ADON stated kitchen staff should have provided a nosey cup for Resident 10 with each meal. During an interview with occupational therapist (OT) on 4/10/2025 at 10:37 a.m., OT stated nosey cup facilitates drinking liquids for residents. During an interview with speech therapist (ST) on 4/10/2025 at 10:51 a.m., ST stated nosey cup facilitates drinking, helps with swallowing liquids, prevents spilling out of the mouth, and helps to increase fluid intake for Resident 10. During an interview with director of nursing (DON) on 4/11/2025 at 10:48 a.m., DON stated kitchen staff should have provided nosey cup for Resident 10 with each meal. Review of facility's undated policy and procedure (P&P) titled, Self-Feeding Devices, the P&P indicated, Devices commonly used, such as divider plates and feeding cups, will be kept in stock. The Food & Nutrition Services Department will store self-feeding devices. Residents needing devices will receive them with each meal or snack, on their meal trays.

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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. 38573 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen when: 1. A table mounted can opener had brownish colored substances; 2. Six food trays had black substances inside the corners of the trays; and 3. The back and side of a food cart parked inside the kitchen had whitish substances outside food cart surfaces. These failures had the potential to cause foodborne illnesses for residents. Findings: 1. During an initial tour in the kitchen on 4/7/25 at 8:44 a.m., with Registered Dietitian 2 (RD 2), a table mounted can opener had brownish colored substances on the top and sides. RD 2 confirmed the observation and stated the can opener needed to be cleaned and free from rust. 2. During a concurrent observation and interview on 4/7/25 at 8:52 a.m., with RD 2, she confirmed two trays with three loaves of bread were stored in each tray. One tray with 15 bowls, one tray with 27 bowls, and two empty trays were stored together inside a cart. There were black substances inside the corners of each tray. RD 2 stated they will clean the trays now. 3. During a concurrent observation and interview on 4/7/25 at 8:59 a.m., with RD 1 and RD 2, there was a food cart parked inside the kitchen and had whitish substances outside the back and side surface. RD 1 and RD 2 acknowledged the above observation and stated they will clean the food cart now. According to the FDA Food Code 2017, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Review of the facility's undated policy and procedure, titled, Pot and Pan Washing indicated pots and pans will be properly sanitized. The preferred method is to run all pots and pans through the dish machine.