STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055239	A. Building B. Wing	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Bay Post-Acute	20259 Lake Chabot Road Castro Valley, CA 94546

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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. 36087 Based on observation, interview, and record review, for one of 30 sampled residents (Resident 32), the facility failed to provide the resident with an appropriate facility gown to wear according to her size and preference. This failure resulted in Resident 32 wearing tight clothing, feeling uncomfortable, and restricted to both her upper arms and chest area. Findings: Review of Resident 32's Admission Record, printed 1/10/24, indicated resident was admitted to the facility in 2019 with diagnoses of multiple sclerosis (a disabling disease that impacts the central nervous system which controls everything a person does) and morbid obesity (excessive body fat). A review of Resident 32's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 12/9/23, indicated Resident 32 was able to understand others and be understood. The MDS indicated Resident 32 required substantial/maximal assistance (helper does more than half the effort) for personal hygiene including dressing. During a concurrent observation and interview on 1/8/24, at 10:42 a.m., in Resident 32's room, Resident 32 wore a green-colored facility gown, with snaps on both sleeves. Resident 32 stated it was very important for her to choose what clothes she wore. Resident 32 stated the green gown was constricted on the chest area, tight on the upper arm with sleeves snapped together, and made her feel restricted and uncomfortable. Resident 32 stated Certified Nursing Assistants (CNAs) had told her the yellow-colored gowns, which were bigger-sized gowns had not been available for a week. During a concurrent observation and interview on 1/9/24, at 1:47 p.m., with the Housekeeping/Central Supply staff(HSKG/CS), Clean Laundry Supply Storage and Linen Storage Closets were viewed. The shared Linen Supply Storage for Station 2 & 3 Closet and Clean Laundry Room Storage did not have any available beige-leaf (bigger-sized, yellow-colored) gowns. Station 1 Closet had five remaining beige-leaf gowns. HSKG/CS stated Clean Linen Storages were replenished regularly for each shift's (day, evening, and night work schedule) use. HSKG/CS also stated the facility used Outside Laundry Services to wash soiled linens and provide clean linen supplies. HSKG/CS stated each order was delivered every two days and since HSKG/CS placed orders daily, deliveries also came in daily. (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	During an interview on 1/09/24, at 2:11 p.m., with CNA 1, CNA 1 stated Resident 32 liked to wear a facility gown and preferred the yellow-colored gown (a bigger size) over the green-colored gown (a smaller size). Resident 32 currently used a green gown because yellow gowns were not available. CNA 1 stated Resident 32 would usually let CNA know which gown she preferred to use. During a concurrent interview and facility record review on 1/10/24, at 3:00 p.m., with HSKG/CS, Laundry Delivery Invoice Forms were reviewed. HSKG/CS stated Delivery Invoice Form, dated 12/19/23, indicated facility's last ordered and received yellow gowns were 20 pieces of Gown .10x, Beige Leaf, Plastic Snaps. HSKG/CS stated soiled yellow gowns were sent to laundry for washing with no more replacements ordered until yesterday, 1/9/24. Laundry Delivery Invoice Form dated 1/10/24, indicated 30 pieces Gown .10x, Beige Leaf, Plastic Snaps were delivered. A review of the facility's policy and procedure (P&P) titled, Dignity, revised date February 2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction in life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Individual needs and preferences of the resident are identified through the assessment process .When assisting with care, residents are supported in exercising their rights. For example, residents are a. groomed as they wish to be groomed .

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 36087 Based on interview and record review, the facility failed to ensure the Annual (comprehensive) Minimum Data Sets (MDS, an assessment tool used to guide resident care) were completed within the required time frames for four of 30 sampled residents (Resident 31, Resident 50, Resident 47, and Resident 53). Resident 31, Resident 50, Resident 47, and Resident 53's annual MDS' were not completed within 14 days of the Assessment Reference Date (ARD, a date set to establish a uniform look-back period for all the responses to MDS coding items). These deficient practices had the potential for Resident 31, Resident 50, Resident 47, and Resident 53 to not receive the appropriate care and services needed based on these residents' current health status. Findings: A review of Resident 31's Admission Record, printed 1/10/24, indicated Resident 31 was admitted to the facility in 2018 with diagnosis of quadriplegia (a form of paralysis that affects all person's limbs and body from the neck down). A review of Resident 50's Admission Record, printed 1/10/24, indicated Resident 50 was admitted to the facility in 2021 with diagnosis of Diabetes Mellitus (high blood sugar). A review of Resident 47's Admission Record, printed 1/10/24, indicated Resident 47 was admitted to the facility in 2021 with diagnosis of metabolic encephalopathy (a change in how the brain functions). A review of Resident 53's Admission Record, printed 1/10/24, indicated Resident 53 was admitted to the facility in 2020 with diagnosis of hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body). During a concurrent interview and record review on 1/10/24, at 2:35 p.m., with the Minimum Data Set Coordinator 1 (MDSC 1), Resident 31, Resident 50, Resident 47, and Resident 53's MDS Assessments were reviewed. Resident 31's Annual ARD was 11/7/23. Resident 50's Annual ARD was 11/3/23. Resident 47's Annual ARD was 11/11/23. Resident 53's Annual ARD was 11/11/23. MDSC 1 stated Resident 31, Resident 50, Resident 47, and Resident 53's comprehensive MDS's should have been completed and submitted no later than 14 days from the ARD. MDSC 1 further stated resident assessments should be completed and submitted in a timely fashion to effectively provide appropriate resident care. A review of the facility record titled, Final Validation Report, submission date 1/11/24, indicated, Resident 31's Care Plan was completed late and is more than 14 days after ARD, Resident 50's Care Plan was completed late and is more than 14 days after ARD, Resident 47's Care Plan was completed late and is more than 14 days after ARD, and Resident 53's Care Plan was completed late and is more than 14 days after ARD. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MDS Manual, Centers of Medicare and Medicaid Services (CMS) Chapter 2: Assessments for the Resident Assessment Instrument (RAI), dated October 2023, indicated, For Annual Assessment (Comprehensive), the MDS Completion Date may be no later than 14 days from the ARD .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 36087 Based on interview and record review, the facility failed to ensure the quarterly Minimum Data Sets (MDS, an assessment tool used to guide resident care) were completed within the required timeframes for four of 30 sampled residents (Resident 67, Resident 51, Resident 13, and Resident 30). Resident 67, Resident 51, Resident 13, and Resident 30's quarterly MDS' were not completed within 14 days of the Assessment Reference Date (ARD, a date set to establish a uniform look-back period for all the responses to MDS coding items). These deficient practices had the potential for Resident 67, Resident 51, Resident 13, and Resident 30 to not receive the appropriate care and services needed based on their current health status. Findings: A review of Resident 67's Admission Record, printed 1/10/24, indicated Resident 67 was admitted to the facility in 2023 with diagnosis of Diabetes Mellitus (high blood sugar). A review of Resident 51's Admission Record, printed 1/10/24, indicated Resident 51 was admitted to the facility in 2021 with diagnosis of cerebral infarction (a stroke or lack of blood flow to the brain). A review of Resident 13's Admission Record, printed 1/10/24, indicated Resident 13 was admitted to the facility in 2022 with diagnosis of end stage renal disease (kidney failure). A review of Resident 30's Admission Record, printed 1/10/24, indicated Resident 30 was admitted to the facility in 2020 with diagnosis of Alzheimer's Disease (memory loss). During a concurrent interview and record review on 1/10/24, at 2:35 p.m., with the Minimum Data Set Coordinator 1 (MDSC 1), Resident 67, Resident 51, Resident 13, and Resident 30's MDS Assessments were reviewed. Resident 67's quarterly MDS Assessment indicated an ARD of 11/23/23 and was 34 days overdue. Resident 51's quarterly MDS Assessment indicated an ARD of 11/28/23 and was 46 days overdue. Resident 13's quarterly MDS Assessment indicated an ARD of 11/24/23 and was 32 days overdue. Resident 30's quarterly MDS Assessment indicated an ARD of 11/17/23 and was 40 days overdue. The MDS Coordinator stated a quarterly MDS should have been completed no later than 14 days from the ARD and submitted no later than 14 days from the completion of the MDS Assessment. MDS Coordinator stated Resident 67, Resident 51, Resident 13, and Resident 30 had delayed completion and submission of quarterly MDS Assessments. MDSC 1 further stated resident assessments should be completed and submitted in a timely fashion to effectively provide appropriate resident care. A review of the MDS Manual, Centers of Medicare and Medicaid Services (CMS) Chapter 2: Assessments for the Resident Assessment Instrument (RAI), dated October 2023, indicated, For Quarterly Assessment (Non-Comprehensive), the MDS Completion Date must be no later than 14 days from the ARD .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 36087 Based on interview and record review, the facility failed to ensure the Minimum Data Sets (MDS, an assessment tool used to guide resident care) were completed and submitted to the Centers for Medicare and Medicaid Services (CMS) within the required time frames determined by the Assessment Reference Date (ARD, a date set to establish a uniform look-back period for all the responses to MDS coding items) when: 1. For four of 30 sampled residents (Resident 31, Resident 50, Resident 47, and Resident 53), Annual MDS' were not completed and transmitted within 14 days of the ARD. 2. For four of 30 sampled residents (Resident 67, Resident 51, Resident 13, and Resident 30), Quarterly MDS' were not completed and transmitted within 14 days of the ARD. These deficient practices had the potential for Resident 31, Resident 50, Resident 47, Resident 53, Resident 67, Resident 51, Resident 13, and Resident 30 to not receive the appropriate care and services needed based on these residents' current health status. Findings: 1. A review of Resident 31's Admission Record, printed 1/10/24, indicated Resident 31 was admitted to the facility in 2018 with diagnosis of quadriplegia (a form of paralysis that affects all person's limbs and body from the neck down). A review of Resident 50's Admission Record, printed 1/10/24, indicated Resident 50 was admitted to the facility in 2021 with diagnosis of Diabetes Mellitus (high blood sugar). A review of Resident 47's Admission Record, printed 1/10/24, indicated Resident 47 was admitted to the facility in 2021 with diagnosis of metabolic encephalopathy (a change in how the brain functions). A review of Resident 53's Admission Record, printed 1/10/24, indicated Resident 53 was admitted to the facility in 2020 with diagnosis of hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body). During a concurrent interview and record review on 1/10/24, at 2:35 p.m., with the Minimum Data Set Coordinator 1 (MDSC 1), Resident 31, Resident 50, Resident 47, and Resident 53's MDS Assessments were reviewed. Resident 31's Annual ARD was 11/7/23. Resident 50's Annual ARD was 11/3/23. Resident 47's Annual ARD was 11/11/23. Resident 53's Annual ARD was 11/11/23. MDSC 1 stated Resident 31, Resident 50, Resident 47, and Resident 53 had delayed completion and submission of annual MDS Assessments. MDSC 1 further stated comprehensive MDS' should have been completed no later than 14 days from the ARD and submitted no later than 14 days from the Care Plan Completion Date. 2. A review of Resident 67's Admission Record, printed 1/10/24, indicated Resident 67 was admitted to the facility in 2023 with diagnosis of Diabetes Mellitus (high blood sugar). (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 51's Admission Record, printed 1/10/24, indicated Resident 51 was admitted to the facility in 2021 with diagnosis of cerebral infarction (a stroke or lack of blood flow to the brain). A review of Resident 13's Admission Record, printed 1/10/24, indicated Resident 13 was admitted to the facility in 2022 with diagnosis of end stage renal disease (kidney failure). A review of Resident 30's Admission Record, printed 1/10/24, indicated Resident 30 was admitted to the facility in 2020 with diagnosis of Alzheimer's Disease (memory loss). During a concurrent interview and record review on 1/10/24, at 2:35 p.m., with the Minimum Data Set Coordinator 1 (MDSC 1), Resident 67, Resident 51, Resident 13, and Resident 30's MDS Assessments were reviewed. Resident 67's quarterly MDS Assessment indicated an ARD of 11/23/23 and was 34 days overdue. Resident 51's quarterly MDS Assessment indicated an ARD of 11/28/23 and was 46 days overdue. Resident 13's quarterly MDS Assessment indicated an ARD of 11/24/23 and was 32 days overdue. Resident 30's quarterly MDS Assessment indicated an ARD of 11/17/23 and was 40 days overdue. The MDS Coordinator stated a quarterly MDS should have been completed no later than 14 days from the ARD and submitted no later than 14 days from the completion of the MDS Assessment. MDS Coordinator stated Resident 67, Resident 51, Resident 13, and Resident 30 had delayed completion and submission of quarterly MDS Assessments. MDSC 1 further stated resident assessments should be completed and submitted in a timely fashion to effectively provide appropriate resident care. A review of the facility record titled, Final Validation Report, submission date 1/11/24, indicated, Resident 31's Care Plan was completed late and is more than 14 days after ARD, Resident 50's Care Plan was completed late and is more than 14 days after ARD, Resident 47's Care Plan was completed late and is more than 14 days after ARD, and Resident 53's Care Plan was completed late and is more than 14 days after ARD. Further review of the Final Validation Report indicated, Resident 67's assessment was completed late and was more than 14 days after ARD, Resident 51's assessment was completed late and was more than 14 days after ARD, Resident 13's assessment was completed late and was more than 14 days after ARD, and Resident 30's assessment was completed late and was more than 14 days after ARD. A review of the MDS Manual, Centers of Medicare and Medicaid Services (CMS) Chapter 2: Assessments for the Resident Assessment Instrument (RAI), dated October 2023, indicated, For Annual Assessment (Comprehensive), the MDS Completion Date may be no later than 14 days from the ARD and the Transmission Date (submission of assessment electronically) no later than 14 days from the Care Plan Completion Date .For Quarterly Assessment (Non-Comprehensive), the MDS Completion Date must be no later than 14 days from the ARD and the Transmission Date (submission of assessment electronically) no later than 14 days from the MDS Completion Date .

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Deficiency Text Not Available

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49983 Based on observation, interview, and record review, the facility failed to provide fingernail care to one of 30 sampled residents (Resident 13) when Resident 13's fingernails on both hands were long. This failure resulted in Resident 13 feeling bothered by the long fingernails and placed him at risk for scratching himself. Findings: A review of Resident 13's Admission Record, printed on 01/10/24, indicated Resident 13 was originally admitted to the facility on [DATE]. During a review of Resident 13's Minimum Data Set (MDS, an assessment tool used to guide care) dated 8/25/2023, indicated Resident 13 required limited assistance with personal hygiene. The MDS assessment also indicated Resident 13 was able to understand others and was able to make himself understood. During a concurrent observation and interview on 01/08/24, at 1:39 p.m., Resident 13's fingernails on both hands were long. Resident 13 stated the length of his nails bothered him. During a concurrent interview and record review on 1/10/24, at 1:12 p.m., with the Director of Staff Development (DSD), Resident 13's Electronic Health Record for Nail Care, dated from 12/28/23 to 01/10/24, was reviewed. The record indicated Resident 13 received nail care on 01/08/24, 01/09/24 and 01/10/24. The DSD stated that nail care includes shortening/trimming and cleaning of nails and the Certified Nursing Assistants (CNAs) were responsible for this task. During a concurrent observation and interview on 01/10/24, at 1:30 p.m., Resident 13's fingernails were still long and not trimmed. Resident 13 stated that he preferred his nails shorter. During a concurrent observation and interview on 1/10/24, at 1:33 p.m., with the DSD, DSD stated that Resident 13's fingernails were about 1/8 of an inch long. During an interview on 1/10/24, at 2:33 p.m., with CNA 3, CNA 3 stated she was the assigned CNA for Resident 13 that day and she trimmed Resident 13's fingernails that morning. CNA3 stated she did not know why Resident 13's nails appeared to be the same length as they were on 1/8/24. During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, dated February 2018, the P&P indicated, trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. During a review of the facility's P&P titled, Dignity, dated February 2021, the policy indicated, when assisting with care, residents are supported in exercising their rights. For example, residents are: groomed as they wish to be groomed (hair style, nails, facial hair, etc).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 34975 Based on observation, interview, and document review, the facility failed to ensure care provided to a resident (Resident 27) was in accordance with professional standards of practice when a staff who was not a nursing staff provided resident care by helping the resident sit up in bed, and serving her lunch tray. This failure had the potential for one resident to receive food not appropriate for her diet resulting in a negative outcome such as an allergy reaction. Findings: Review of the tray card on Resident 27's tray for lunch on 1/9/24 showed Resident 27 was on a Consistent Carbohydrate (a diet typically prescribed to a person to help regulate blood sugar), No Added Salt therapeutic diet. The tray card also showed she had gluten (a protein found in grains such as wheat, barley, and rye) and iodine (a mineral found in some foods) allergies. In the notes section of the tray card, it showed Resident 27 received small portions of starch foods and she disliked wheat bread. An observation on 1/9/24 at 12:37 p.m., showed a food tray delivery cart holding resident lunch trays parked in the hallway by resident rooms. Maintenance Staff 1 (MS1) removed a resident lunch tray from the cart and carried it into the room where Resident 27 was in her bed. MS1 placed the lunch tray on Resident 27's bedside table and raised her bed to prepare her for her lunch. Nursing staff was not in the resident's room at the time. In an interview on 1/10/24 at 11:45 a.m., MS1 confirmed he served residents their food trays because he thought serving food to residents was a way to get to know them. In an interview on 1/12/24 at 9:56 a.m., the Administrator (Admin) stated MS1 should not enter a resident room to pass a food tray directly to the resident. Admin stated if MS1 wanted to help with passing a tray, MS1 could carry it to the resident's door and hand it to a Certified Nursing Assistant (CNA), who would provide the resident with the tray of food. According to the Board of Registered Nursing document titled Unlicensed Assistive Personnel dated 11/94, showed the term unlicensed assistive personnel refers to those health care workers who are not licensed to perform nursing tasks; it also refers to those health care workers who may be trained and certified, but are not licensed. Examples of unlicensed personnel certified nursing assistants, home health aides, and patient care technicians. Registered Nurses (RNs) may assign assistive personnel activities which unlicensed assistive personnel have traditionally performed in the delivery of patient care. These activities of daily living include basic health and hygiene tasks such as those a certified nursing assistant or home health aid is trained to perform. Unlicensed assistive personnel may not reassign an assigned task. To reiterate, it is the direct care RN who ultimately decides the appropriateness of assignment of tasks. The registered nurse must be knowledgeable regarding the unlicensed assistive personnel's education and training, and must have opportunity to periodically verify the individual's ability to perform the specific tasks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Health and Safety Code Section 1338.5(a)(2)(A) requires any individual who is not licensed or certified and has direct resident care duties must be hired-full-time, enrolled in a nurse aide training program and successfully complete the training and competency testing within 4 months of employment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34975 Based on observation, interview, and record review, the facility failed to ensure a timely evaluation of one resident's (Resident 72) severe weight loss. This failure had the potential to result in further unintentional and/or undesirable weight loss for one resident. Findings: Review of the undated Policy and Procedure titled Weight Assessment and Intervention, Residents are weighed upon admission and at intervals established by the interdisciplinary team. Weights are recorded. Unless notified of a significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant, greater than 5% is sever. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is sever. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. A record review for Resident 72 showed she was [AGE] years, old initially admitted on [DATE]. Resident 72's documented weight history showed the following: 11/2/23 207.8 pounds (lbs) 11/10/23 195.4 lbs (6% weight loss in 9 days compared to 11/2/23 207.8 lbs) 11/13/23 192.2 lbs 11/30/23 187.2 lbs 12/1/23 187.2 lbs 12/12/23 184.2 lbs 12/27/23 178.8 lbs (8.4% weight loss in 48 days compared to 11/10/23 195.4 lbs) A record review for Resident 72 showed a dietary progress note written on 12/27/23. In the progress note, 72's weight history was listed, and the note read . (11/2) 207.8 # [pound] (Initial weight may be inaccurate). Wt [weight] Change: 8.4# (4.5%) weight loss x 26 days (not significant). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Registered Dietitian (RD) on 1/11/24 at 12:50 p.m., RD reviewed resident 72's electronic medical record and confirmed she did not do any assessments or progress notes for Resident 72 between her initial assessment on 11/2/23 and a re-admission assessment on 12/26/23. RD stated she reviewed residents' documented weights monthly as well as weekly if she had time. RD said it was not until Resident 72 was readmitted from the hospital on 12/26/23 when she noticed Resident 72 had weight loss. When asked if the Resident had a severe weight of loss of 6% between 11/2/23 (207.8 lbs) to 11/10/23 (195. 4 lbs), RD stated she suspected Resident 72's initial weight (of 207.8 lbs) was inaccurate, and she documented this in her 12/27/23 progress note initial weight may be inaccurate. RD stated if she suspected there was an inaccurate weight, she sent a note to the person who weighed residents or to the Director of Nursing (DON), to reweigh the resident. She stated she did not have documentation to show she requested the resident to be reweighed in order to verify the accuracy of the resident's initial weight. RD stated reweighs were done almost immediately, within one day. RD confirmed a reweigh of Resident 72's initial weight was not done. She stated she did not ensure reweighs were done after she requested a resident to be reweighed. RD also confirmed she documented Resident 72 did not have a significant weight loss in her 12/27/23 progress note. RD confirmed resident 72 did have an 8.5 percent significant weight loss on 12/27/23 when her weight was documented as 178.8 pounds and compared to her documented weight of 195.3 pounds on 11/10/23. RD stated she did not catch the resident's significant weight loss because she only did one month weight comparisons.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49498 Based on observation, interview, and record review, the facility failed to ensure its nursing staff was competent and knowledgeable about the proper disinfection of shared glucometers (medical equipment used to measure and display the amount of sugar [glucose] in the blood) according to the manufacturer's instructions and accepted professional standards of practice when: 1. Two out of three nurses observed during medication administration did not use appropriate disinfectant to clean and disinfect shared glucometers for two out of three sampled residents (Residents 24 and 52). 2. Record review for two out of two registry nurses (an individual licensed or certified by a regulatory agency who receives compensation from a third party agency to work at a nursing care institution) personnel training files did not have evidence of training or competency related to blood glucometer cleaning and disinfection from the agency or from facility. These failures had the potential for widespread transmission of bloodborne diseases (such as Hepatitis B [a serious liver infection caused by the hepatitis B virus that is most commonly spread by exposure to infected body fluids], Hepatitis C, HIV [human immunodeficiency virus, is a virus that attacks the body's immune system]) among residents. Findings: 1. During the medication administration observation on 01/08/24, at 12:22 p.m., LVN 1 was observed wiping down the shared glucometer (medical equipment used to measure and display the amount of sugar in the blood) with an alcohol prep pad (an antiseptic wipe saturated with 70% isopropyl alcohol) prior to checking Resident 24's blood sugar. She stated the glucometer is being shared among residents receiving blood sugar checks. Shortly after the medication administration for Resident 24, on 01/08/24 at 12:27 p.m., LVN 1 was observed wiping down the shared glucometer with an alcohol prep pad after checking Resident 24's blood sugar. During an interview on 01/08/24, at 12:33 p.m., LVN 1 stated she has been using alcohol prep pad since morning to disinfect the shared glucometer. LVN 1 acknowledged she should have used the Micro-kill Germicidal (to kill germs) wipes to disinfect the glucometer, and that alcohol does not kill all bacteria or viruses. LVN 1 stated she did not receive orientation or training from the facility of what disinfecting wipes to use and has been using alcohol prep pad based on experience. During a concurrent medication administration observation and interview on 01/09/24, at 09:08 a.m., LVN 6 was observed wiping down the shared glucometer with an alcohol prep pad after checking Resident 52's blood sugar. LVN 6 stated she was not oriented as to what type of disinfectant wipe to use for shared glucometer, and there were no germicidal wipes available in the medication cart. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/24, at 09:37 a.m., the Director of Nursing (DON) and the DSD/IP stated the alcohol prep pad was not acceptable for cleaning/disinfecting shared glucometers, and the staff should use the disinfecting wipes based on the manufacturer's guidelines. A review of glucometer manufacturer's guidelines indicated the list of validated products for disinfecting the device, and alcohol prep pad was not included in the list. A review of facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised in September 2022, it indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Center for Disease Control and Prevention) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogen (microorganisms such as viruses or bacteria that are carried in blood and can cause disease in people) Standard; 5. Reusable items are cleaned and decontaminated or sterilized between residents. A review of an online publication by the CDC titled Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration, reviewed 3/2/11, indicated, The disinfection solvent should be effective against HIV, Hepatitis C, and Hepatitis B virus . 70% ethanol solutions are not effective against viral bloodborne pathogens . Healthcare personnel should consult the manufacturers of blood glucose meters in use at their facilities to determine what products, meeting the criteria specified by the FDA, are compatible with their meter prior to using any EPA-registered disinfectant for disinfection purposes. (https://www.cdc.gov/injectionsafety/providers/blood-glucose-monitoring_faqs.html; accessed 1/18/24) 2. During an interview on 01/09/24, at 09:37 a.m., the DSD/IP stated the orientation provided to registry nurses are location of the med room, supplies, report of each resident, fax machine, physician's contact information and access to EHR (Electronic Health Record). The DSD/IP acknowledged the orientation did not include glucometer disinfection. A review of facility's undated checklist, titled Registry Orientation/Training, did not include training on glucometer disinfection. During a concurrent interview and record review on 01/09/24, at 11:52 a.m., with the DSD/IP, when asked how the facility ensure the registry nurses were trained and competent to provide services at the facility, she stated she checked their training in the agency's portal (website to view staff license, background check or trainings). The DSD/IP reviewed the agency's online portal for LVN 1 and LVN 6 and stated both nurses did not have documented records of training or competency on disinfecting glucometer nor clinical training on infection control practices provided by the agency. During an interview on 01/11/24, at 01:31 p.m., the Admin stated the agency providing registry staff did not have a record of staff trainings. The Admin confirmed the facility should have made sure registry staff had adequate training and competency before providing services in the facility. A review of facility's P&P, titled, Staffing, Sufficient and Competent Nursing, revised on August 2022, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 36087 Based on observation, interview, and record review, the facility failed to ensure staffing information was posted and readily available when the daily staffing ratio information was not posted for four consecutive days on 1/8/24 through 1/11/24 and the staffing data was not maintained for five months from August 2023 through the present time January 2024, for a minimum of 18 months. This deficient practice resulted in staffing information not being readily available to residents and visitors at any given time. Findings: During an interview on 1/11/24, at 9:15 a.m., with the Director of Staff Development/Infection Preventionist (DSD/IP), DSD/IP stated Staffing Coordinator (SC) was currently working from home and unable to post Nurse Staffing Information in a designated location in the facility since 1/8/24. During a concurrent observation, interview, and record review on 1/11/24, at 10:58 a.m., with the Operations Manager (OM), OM stated the Nurse Staffing Information was posted daily at the facility entrance, on top of the front desk. OM confirmed the current staffing numbers have not been posted daily since 1/8/24 due to SC's unavailability to work in person. OM further stated the facility was unable to keep a minimum of 18-month records of Nurse Staffing Information. During a telephone interview on 1/11/24, at 11:05 a.m., with the SC, SC confirmed she currently worked from home, and she was directly responsible for staffing and posting daily Nurse Staffing Information in the facility. SC stated she took care of staffing with the help of the OM but had failed to ask OM to post the daily Nurse Staffing Information in the facility since 1/8/24. SC confirmed the facility was unable to provide Nurse Staffing Data from August 2023 thru January 2024 and did not have the complete 18-month records of Nurse Staffing Information. During an interview on 1/11/24, at 12 p.m., with the Director of Nursing 2 (DON 2), DON 2 stated facility was required to keep a minimum of 18-month records of Nurse Staffing Information available upon request. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of the facility document titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, indicated, Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs [Registered Nurses], LPNs [Licensed Practical Nurses], and LVNs [Licensed Vocational Nurses]) and the number of unlicensed nursing personnel (CNAs [Certified Nursing Assistants]) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format .Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator .The previous shift's forms are maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once form is removed, it is forwarded to the office of the Director of Nursing Services (DNS) and filed as a permanent record. Records of staffing information for each shift are kept for a minimum of eighteen (18) months or as required by state law (whichever is greater) .

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F 0755 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46658 Based on observation, interview and record review, the facility failed to follow facility medication administration policy, provide pharmacy services and ensure controlled medication (those with high potential for abuse and addiction) were fully accounted for 11 of 57 sampled residents (Residents 1, 400, 69, 329, 42, 20, 70, 30, 41, 57 and 330) when: 1. Licensed Vocational Nurse 8 (LVN 8) gave Resident 400 and Resident 1 medications without verifying residents' identity and did not name the medications given to the residents. 2. Resident 69 did not take her medications for one hour after LVN 3 left medications on Resident 69's overbed table without watching administration. 3. Resident 329 did not receive scheduled medication for 44 hours because the medications had not been delivered. 4. An as-needed (PRN) controlled medication for Resident 42 was administered but not documented in the E-MAR (Electronic Medication Administration Record) during an inspection in one of two medication carts. 5. Three controlled medications were administered but not documented in the Controlled Substance Accountability Sheet (a.k.a. Count Sheet, an inventory sheet that keeps record of the usage of controlled medications) upon administration for Residents 20 and 70. 6. Thirteen vials of lorazepam for Resident 30 were not counted during shift changes and was not removed from active stock for over a year. 7. Controlled Drugs-Count Record sign-in/sign-out record (records that account for controlled medications) was incomplete for two out of two medication carts (Stations 1 and 2). 8. Controlled medication use audit for Residents 41, 57, and 330 did not reconcile. The medications were signed out of the Count Sheet but was not documented on the E-MAR to indicate they were given to the residents. These failures resulted in: 1. Resident 400's hospitalization for excessive sedation and respiratory failure (inadequate breathing efforts) requiring mechanical ventilation (machine used to provide artificial breathing), a tracheostomy (a surgically created opening through the neck into the trachea, also known as the windpipe), a gastrostomy (a tube surgically inserted through the skin into the stomach for delivery of nutrients and/or medications), and encephalopathy (abnormal deterioration of brain function) from the opioid medications (a group of medications which are federally regulated substances used for pain control with a potential for physical or psychological dependence) overdose. 2. Resident 69 taking her medications one hour late. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	3. Resident 329 had the potential to experience high blood pressure which could result in stroke or heart attack. 4. Inaccurate accountability of controlled medications which had the potential for misuse or diversion (illegal distribution or abuse of prescription drugs or their use for purpose not intended by the prescriber) of controlled medications. Findings: 1. During a review of Resident 400's Admission Record dated 12/22/23, the Admission Record indicated Resident 400 was admitted to the facility in 2008 for stroke (brain tissue death resulting in brain function impairment), hemiplegia (the loss of muscle function on one side of the body), hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body), dysphagia (difficulty swallowing), heart failure and muscle weakness. During a review of Resident 400's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.), dated 11/10/23, the MDS indicated Resident 400 had a score of 13 on the Brief Interview for Mental Status. (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) The MDS indicated Resident 400 was able to be understood and could understand others. The MDS indicated Resident 400 required setup assistance only for eating. The MDS indicated Resident 400 required supervision for oral and personal hygiene such as combing hair, washing hands and face. During a review of Resident 400's, Order Summary Report, Active Orders as of 12/18/23, dated 12/18/23, the Report indicated an order for a regular texture diet. The Report indicated Resident 400 had orders to take medications and food by mouth. The Report indicated Resident 400 had no active orders for baclofen (muscle relaxant medication which can cause drowsiness and shallow breathing), hydrocodone-acetaminophen (an opioid medication), methadone (an opioid medication) or Eliquis (medication to prevent blood clots which can cause stroke or heart attack). During a review of Resident 1's Admission Record dated 12/28/23, the Admission Record indicated Resident 1 was admitted to the facility in 2013 for atrial fibrillation (irregular heart rhythm which can lead to stroke) and chronic pain. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had a BIMS score of 14. The MDS indicated Resident 400 had adequate vision and was able to be understood and could understand others. During a review of Resident 1's Order Summary Report, Active Orders as of 12/28/23, dated 12/28/23, the Report indicated Resident 1 had medication orders for: baclofen 20 mg (milligram, a unit of measurement) oral tablet, three times a day; hydrocodone-acetaminophen 10-325 mg oral tablet, five times a day; Eliquis 5 mg oral tablet, twice a day; and methadone 10 mg oral tablet, four times a day. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 1/2/24, at 4:40 p.m., with LVN 8, LVN 8 stated on 12/16/23, at 9:00 a.m., she was performing a medication pass for Resident 400 and Resident 1, who shared a room. LVN 8 stated she checked the identity of both residents and prepared both of their medications in separate medication cups. LVN 8 stated she took a medication cup to Resident 400's bedside and watched Resident 400 take the medications, and then left the room. LVN 8 stated 30-40 minutes later, Resident 1 told LVN 8 the medications LVN 8 had left on Resident 1's overbed table did not belong to Resident 1. LVN 8 stated she realized she had accidentally switched the medications and had administered Resident 1's medications to Resident 400. LVN 8 stated Resident 400 had not received her morning medications of metformin (a medication to decrease blood sugar) and amlodipine (used to decrease blood pressure), and aspirin (to prevent blood clots), but had received Resident 1's medications which included methadone, hydrocodone-acetaminophen, Eliquis, and baclofen. LVN 8 stated she called the nurse practitioner (NP) and informed the NP that Resident 400 had received Resident 1's medications; the NP told LVN 8 to monitor Resident 400. During a concurrent phone interview and record review on 1/5/24, at 10:40 a.m., with LVN 8, Resident 1's Controlled Substance Accountability Sheet for methadone 10 mg tab and hydrocodone-acetaminophen 10-325 mg tablet, dated December 2023, was reviewed. LVN 8 stated on 12/16/23, Resident 400 had received two doses of methadone 10 mg at 9:00 a.m., and she recorded the two doses on 12/16/23, at 1:00 p.m. under Qty [quantity] destroyed/wasted of the sheet. LVN 8 stated Resident 400 had received two doses of hydrocodone-acetaminophen 10-325 mg at 9:00 a.m., and she recorded the two doses on 12/16/23, at 1:00 p.m. under Qty destroyed/wasted of the sheet. LVN 8 stated Resident 400 had also received the 9:00 a.m. and 1:00 p.m. dose of baclofen during the 9:00 a.m. medication pass. LVN 8 stated the doses were documented under destroyed/wasted because the doses had not been given to Resident 1. LVN 8 stated, at Resident 1's request, LVN 8 left both the 9 a.m. and 1 p.m. doses of hydrocodone-acetaminophen, methadone, and baclofen at Resident 1's bedside for the 1 p.m. doses to be self-administered later in the day. During a concurrent observation and interview on 12/28/23, at 12:06 p.m., with Resident 1, Resident 1 lay in bed with an overbed table across her lap. A palm-sized box with a hinged lid was on the overbed table. Resident 1 stated she had been Resident 400's roommate on the morning of 12/16/23, when LVN 8 came into the room with both Resident 400's and Resident 1's morning medications and placed the medications on the residents' overbed tables. Resident 1 stated LVN 8 left the room before either resident had taken the medications. Resident 1 stated she noticed while sorting the medications left at her bedside, that the medications were not the correct prescribed medications so Resident 1 called for the nurse. Resident 1 stated she told LVN 8 the medications left at her bedside were not her medications when LVN 8 answered the call bell about 30 minutes later. Resident 1 stated her morning medications included baclofen, hydrocodone-acetaminophen, methadone and Eliquis. Resident 1 stated LVN 8 would leave both the 9 a.m. and the 1 p.m. doses of methadone, hydrocodone-acetaminophen, and baclofen during the 9:00 a.m. medication pass at Resident 1's bedside, so Resident 1 would place the 1 p.m. doses in the hinged box on the overbed table for later self-administration. Resident 1 stated LVN 8 had not verified either Resident 400 or Resident 1's identities before leaving the medications at their bedsides or told either resident the names of their medications. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 12/28/23, at 12:39 p.m., with Administrator (Admin) and OM, Resident 400's, Situation, Background, Assessment, Recommendation, Summary, (SBAR, a communication tool to summarize relevant medical information for changes in condition or unusual incidents) by LVN 8, dated 12/16/23, at 10:30 a.m., was reviewed. The SBAR indicated Resident 400 had a change in condition related to a medication error. OM stated the SBAR note indicated at 9:00 a.m., LVN 8 prepared Resident 400 and Resident 1's medications on the medication cart and took Resident 1's medications to Resident 400 and Resident 400 took Resident 1's medications. The SBAR indicated LVN 8 gave Resident 400's medications to Resident 1 but left the room before Resident 1 took the medications. The SBAR indicated after 30 minutes, Resident 1 informed LVN 8 the medications left with Resident 1 were not the correct prescribed medications. OM stated the SBAR indicated the NP was notified of the medication error and LVN 8 was given instructions to monitor Resident 400. During a phone interview on 12/28/23, at 12:23 p.m., with the NP, the NP stated in the morning of 12/16/23, NP received a text message from a facility staff member about Resident 400 receiving the wrong medications. NP stated she instructed the staff member to call the director of nursing (DON) and to monitor Resident 400. NP stated that was the extent of NP's involvement; NP had not done any follow-up or contacted anyone else after giving those instructions. During a concurrent interview and record review on 12/28/23, at 12:31 p.m., with Admin, the Admin presented a phone screenshot of LVN 8's text messages with NP. The text message indicated LVN 8 informed NP that Resident 400 had received baclofen, methadone, acetaminophen and Eliquis; NP responded with instructions to call the DON and monitor Resident 400. During a phone interview on 12/28/23, at 11:49 a.m., with Licensed Vocational Nurse 9 (LVN 9), LVN 9 stated she had worked the 3 p.m. to 11 p.m. shift on 12/16/23. LVN 9 stated that during the change of shift report on 12/16/23, at 3:00 p.m., LVN 8 reported Resident 400 had taken Resident 1's medications in the morning and needed to be monitored. LVN 9 stated Resident 400 was verbally responsive and had stable vital signs from the beginning of the shift until dinner time. LVN 9 stated at dinner time, a certified nursing assistant (CNA) came to LVN 9 and said Resident 400 was unresponsive, so they went to Resident 400's room. LVN 9 stated attempts to awaken Resident 400 were unsuccessful, and upon checking Resident 400's vital signs, Resident 400's oxygen saturation was 78-80%. (Oxygen saturation is a measurement of oxygen in the blood, expressed as a percentage, with 100 percent the maximum amount of oxygen possible, and normal values greater than 90%.) LVN 9 stated Resident 400 was given supplemental oxygen through a non-rebreather mask (an external mask worn over the nose and mouth to provide 100% oxygen), while 9-1-1 was called for emergency transport to the hospital. During a concurrent interview and record review on 12/28/23, at 12:39 p.m., with Admin and OM, Resident 400's nursing progress notes, for 12/16/23 to 12/17/23, were reviewed. A nursing SBAR progress note by LVN 9, dated 12/16/23, at 6:00 p.m., indicated at 5:28 p.m., Resident 400 had a situation of unresponsiveness different than usual with an oxygen saturation of 78-80% and a respiratory rate of seven (number of breaths per minute, normal respiratory rate is 12 to 18 breaths per minute). The SBAR indicated LVN 9 assessed Resident 400's breathing as labored or rapid breathing, with general weakness and altered level of consciousness. A nursing progress note by LVN 9, dated 12/17/23, at 12:45 a.m., indicated, at 5:28 p.m., Resident 400 was unresponsive to multiple attempts to rouse Resident 400. The note indicated Resident 400 had an oxygen saturation of 88% while using the non-rebreather mask. The progress note indicated at 5:46 p.m., the resident was taken to the emergency room . (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 400's hospitalization record, an emergency physician's Provider Note dated 12/16/23, at 7:29 p.m., indicated Resident 400 was transported by ambulance to the emergency room , at 6:02 p.m., and was diagnosed with altered mental status (term used to refer to a change in consciousness), opioid overdose and apnea (cessation of regular breathing). The Provider Note indicated Resident 400 had accidentally received methadone and hydrocodone-acetaminophen. The Provider Note indicated Resident 400 had a Glasgow Coma Scale score of three. (Glasgow Coma Scale is an assessment tool to determine purpose response to stimuli scored on a scale of one to 15 with a score of 15 indicating normal function, and 3-14 indicating abnormal function. A score of three indicates no eye opening, verbal or motor response to stimulus.) The provider note indicated Resident 400 was intubated (a tube is placed into the windpipe through the mouth or nose) and placed on mechanical ventilation (machine used to provide artificial breathing), and the decision was made to admit Resident 400 to the intensive care unit for further evaluation and management. During a record review of Resident 400's hospitalization record, a critical care physician's History and Physical (H&P), dated 12/16/23, at 8:38 p.m., indicated Resident 400 was diagnosed with accidental opiate overdose, acute respiratory failure, and encephalopathy from the opiate drug overdose. The H&P indicated admission to the critical care unit was necessary for further evaluation and management. During a record review of Resident 400's hospitalization record, a critical care Physician Progress Note, dated 1/1/24, indicated Resident 400 had a tracheostomy placed 12/28/23, and required a mechanical ventilator due to apnea. The Progress Note further indicated Resident 400 required a gastrostomy tube, placed 12/28/23, for delivery of medications and nutrition. During a review of facility policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, The individual administering medications verifies the resident's identity before giving the resident his/her medications .and checks the label three times to verify the right resident, right medication, right dosage and right time .before giving the medication medications are administered within one hour of their prescribed time .medication administration times are determined by resident need and benefit, not staff convenience. During a review of facility's P&P titled, Administering Oral Medications, dated 10/2010, the P&P indicated nursing staff were expected to, confirm identity of resident .remain with the resident until all medications have been taken. 2. A review of Resident 69's admission record indicated Resident 69 was admitted to the facility on , d+[DATE] with a diagnosis of sacral pressure ulcer stage 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) and hypertensive heart failure (reduced heart output due to high blood pressure). During a review of Resident 69's MDS, dated [DATE], the MDS indicated Resident 69 had a score of 13 on the Brief Interview for Mental Status. (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) The MDS indicated Resident 69 was able to be understood and could understand others. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 69's physician's orders titled, Order Summary Report, dated 1/10/24, indicated Resident 69 had medication orders for apixaban (medication to prevent blood clots) oral tablet 5mg (milligram, unit of measurement) twice a day, ascorbic acid(vitamin C, an anti-oxidant) tablet 500mg once a day, carvedilol (medication to treat high blood pressure) oral tablet 3.125mg twice a day, cholecalciferol (vitamin D, an essential vitamin) tablet once a day, docusate (medication to soften stool) tablet twice a day, and flaxseed oil (nutritional supplement) 1000mg capsule once a day. During a concurrent observation and interview on 1/8/24, at 10:37 a.m., with Resident 69, Resident 69 was asleep in her bed under her covers. A medication cup containing six medications were on the overbed table positioned over Resident 69's bed. Resident 69 woke up and stated LVN 3 brought her the medications, and she forgot to take them. Resident 69 did not recall when the medications were placed on the overbed table. Resident 69 picked up the medication cup and took some of the medications. Resident 69 placed the medication cup containing two medications back on the overbed table. During a concurrent observation and interview on 1/8/24, at 10:47 a.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 69 was asleep in her bed under her covers. The medication cup containing the remaining two medications were on the overbed table. LVN 3 woke Resident 69 up to instruct Resident 69 to take the two remaining medications. LVN 3 stated she had left Resident 69's medications on the overbed table without observing Resident 69 take the medications. LVN 3 stated she recorded the time she gave Resident 69's medication on Resident 69's medication administration record (MAR). LVN 3 stated she was expected to follow medication administration procedures and observe Resident 69 take her medications before leaving the room. During a record review of Resident 69's Administration History Report, dated 1/11/24, Resident 69's morning medications for 1/8/24 were reviewed. The Report indicated, at 9:22 a.m., LVN 3 gave Resident 69 the following medications: apixaban 5mg tablet, ascorbic acid 500 mg tablet, carvedilol 3.125mg tablet, cholecalciferol tablet, docusate oral tablet, and flaxseed oil 1000mg capsule. During a review of facility policy and procedure titled, Administration of Oral Medications, dated 8/2010, the P&P indicated the nurse who administers medication remain with the resident until all medications have been taken. 3. A review of Resident 329's admission record indicated Resident 329 was admitted to the facility on [DATE] for right knee effusion (fluid buildup in the knee) and hypertensive heart disease (heart disease from high blood pressure). A review of Resident 329's physician order titled, Order Details, dated 1/10/24, indicated, on 12/28/23, Resident 329 had an order for metoprolol 12.5mg tablet twice a day. During an interview on 1/8/23, at 11:37 a.m., with Resident Representative 1, RP 1 stated on 12/28/23 and 12/29/23, Resident 329 did not receive metoprolol 12.5 mg. RP 1 stated at home, Resident 329 had been taking the medication twice a day and the facility told her they did not have the medications for an entire day. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 1/10/24, at 10:30 a.m., with Registered Nurse Supervisor (RNS), Resident 329's medication administration record (MAR), dated 12/2023, was reviewed. RNS stated the MAR indicated on 12/29/23 Resident 329 did not receive metoprolol 12.5 mg for the morning and evening doses. RNS stated nursing staff wrote a progress note about why the medication was not given. During a concurrent interview and record review on 1/10/24, at 10:35 a.m., with RNS, Resident 329's nursing progress note, dated 12/29/23, at 8:20 p.m. was reviewed. The progress note indicated Resident 329 was not given metoprolol 12.5mg because the medication had not been delivered. RNS stated medications were expected to be available when Resident 329 was admitted but did not know why this medication was not available. During a concurrent interview and record review on 1/11/24, at 1:20 p.m., with Operations Manager (OM), a pharmacy packing list titled Reorder Fill History, for Resident 329's metoprolol dated 1/11/24 was reviewed. OM stated the packing list indicated Resident 329's metoprolol 25 mg was received on 12/30/23. 49498 4. During a concurrent observation and interview on 01/08/24, at 03:01 p.m., with Licensed Vocational Nurse (LVN) 3, at Station 1 Medication Cart, two hydromorphone (a controlled medication used to treat moderate to severe pain) 2 milligrams (mg) tablets for Resident 42 were observed inside the locked compartment. LVN 3 stated the Registered Nurse Supervisor (RNS) gave her four tablets of hydromorphone for Resident 42 earlier that morning and she had given two tablets to the resident at 12:30 p.m. When asked to show documentation of the two hydromorphone tablets administered, LVN 3 looked up the E-MAR and stated she had not documented it yet. She acknowledged she should have documented right away after the medication was given. A review on 01/08/24, at 03:43 p.m. of Resident 42's E-MAR indicated the two hydromorphone 2 mg tablet was not documented. During a review of facility's policy and procedure (P&P) titled, Documentation of Medication Administration, revised on November 2022, P&P indicated, 1. A nurse . documents all medications administered to each resident on the resident's medication administration record (MAR) and 2. Administration of medication is documented immediately after it is given. 5. During an inspection of Station 1 Medication Cart on 01/08/24, at 03:01 p.m., with LVN 3, four capsules of pregabalin (a controlled medication to treat nerve and muscle pain) 50 mg and seven tablets of lacosamide (a controlled medication to treat partial seizures) 100 mg were documented in the Count Sheet for Resident 20; however, three capsules of pregabalin 50 mg and six tablets of lacosamide 100 mg were observed in the locked compartment of the medication cart. LVN 3 stated she administered one capsule of pregabalin and one tablet of lacosamide to Resident 20 in the morning but forgot to sign out of the Count Sheet. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Similarly, during an inspection of Station 1 Medication Cart with LVN 3, on 01/08/24, at 03:03 p.m., four tablets of lacosamide 100 mg were documented in the Count Sheet for Resident 70; however, three tablets of lacosamide 100 mg were observed in the locked compartment. LVN 3 stated she administered one tablet of lacosamide to Resident 70 in the morning but forgot to sign out of the Count Sheet. She acknowledged she should have signed out as soon as she administered them to the residents. A review on 01/08/24, at 03:56 p.m., of Resident 20's E-MAR indicated one pregabalin 50 mg and one tablet of lacosamide 100 mg was administered during the morning medication pass. A review on 01/08/24, at 03:58 p.m., of Resident 70's E-MAR indicated one tablet of lacosamide 100 mg was administered on 1/8/24 during the morning medication pass . During an interview on 01/09/24, at 09:58 a.m., the RNS stated controlled medication should be documented in the Count Sheet right after giving it. During a review of facility's undated P&P titled, Narcotics, Controlled Substances, and Preventing Drug Diversion, P&P indicated, 2.b. Each time a resident receives assistance with administration of a narcotic, this is documented and the amount of medication on hand is updated on the Narcotic Count Sheet. 6. During a concurrent observation and interview on 01/08/24, at 11:42 a.m., in the Station 2 and 3 Medication Room, with the Director of Nursing (DON) and LVN 2, an inspection of the medication refrigerator identified thirteen 1-milliliter (ml) injectable vials of lorazepam (a controlled medication used to treat anxiety) 2 mg/ml for Resident 30. The DON and LVN 2 confirmed Resident 30 was already discharged . During an interview and record review on 01/10/24, at 09:39 a.m., the RNS stated the thirteen 1-ml vials of lorazepam was given to her this morning and the Count Sheet was created on 1/8/24 (the day it was identified by the surveyor). During an interview on 01/10/24, at 02:28 PM, the DON stated there was no order found in the EHR (Electronic Health Record) for Resident 30's lorazepam. The DON confirmed the order must have been discontinued over a year and cannot find the Count Sheet for the thirteen vials. The DON stated the RNS called the current and previous pharmacies, and both have no record of sending the lorazepam vials. The DON confirmed there was no Count Sheet for staff to count during shift change and was not able to tell how many the pharmacy sent and how many was used. During a review of facility's P&P titled, Controlled Substance Storage, Revised August 2014, P&P indicated, G. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented; K. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed. 7. On 1/10/24, review of the January 2024 Controlled Drugs-Count Record (a sign-in and sign-out document) for Station 1 Medication Cart indicated it was missing the nurses' signatures eleven times from 1/1 to 1/10/24. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	A review of Station 2's Medication Cart Controlled Drugs-Count Record indicated it was missing the nurses' signatures twenty-two times for December 2023, and fifteen times for January 2024. During a concurrent interview and record review on 01/10/24, at 09:41 a.m., the RNS stated the incoming and outgoing nurses were to sign the Controlled Drugs-Count after they counted the controlled medications together. She acknowledged the Controlled Drugs-Count Record for January 2024 for Station 1 and December 2023 & January 2024 for Station 2 had missing accounting documentation. During a review of facility's undated P&P titled, Narcotics, Controlled Substances, and Preventing Drug Diversion, P&P indicated, 2. A Narcotic Count Sheet will be maintained for all narcotic medications; 2.c. At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications who is starting his/her shift, count all narcotic medications and confirm that the amount on hand matches with what was listed on the Narcotic Count Sheet for each medication. 8. During an interview on 01/10/24, at 2:32 p.m., the RNS stated each time a controlled medication was removed for administration to a resident, the nurse administers the medication to the resident, signs it out of the Count Sheet, and documents the administration on the MAR. 8a. A review of Resident 41's clinical record indicated a physician's order, dated 12/27/23, for oxycodone (a controlled medication to treat moderate to severe pain) 15 mg 1 tablet by mouth every 4 hours as needed for moderate to severe pain. During a concurrent interview and record review on 01/10/24, at 02:36 p.m., with the RNS, a review of the Count Sheet for oxycodone 15 mg and the January 2024 E-MAR for Resident 41 indicated the nursing staff removed one tablet on 1/8/24 at 5:02 a.m., and 1/9/24 at 10:45 a.m.; however, they were not documented on the E-MAR as given to the Resident. The RNS confirmed they were not documented and therefore two oxycodone tablets were unaccounted for. 8b. A review of Resident 330's clinical record indicated a physician's order, dated 1/3/24, for Norco (a controlled medication to treat moderate to severe pain) 10/325 mg 1 tablet by mouth every 6 hours as needed for moderate to severe pain. During a concurrent interview and record review on 01/10/24, at 02:46 p.m., with the RNS, a review of the Count Sheet for Norco and the January 2024 E-MAR for Resident 330 indicated the nursing staff signed out one tablet of Norco 10/325 mg on 1/2/24 at 8:20 p.m. and 1/9/24 at 9:21 a.m. but did not document the administration on the E-MAR. The RNS confirmed they were not documented and acknowledged two Norco tablets were unaccounted for. 8c. A review of Resident 57's clinical record indicated a physician's order, dated 9/10/23, for tramadol (a controlled medication to treat moderate to severe pain) 50 mg 1 tablet by mouth every 6 hours as needed for pain. During a concurrent interview and record review on 01/10/24, at 02:57 p.m., with the RNS, a review of Resident 57's Count Sheet for tramadol 50 mg and the January EMAR indicated one tablet of tramadol 50 mg was signed out for Resident 57 on 1/6/24 at 1:40 a.m. but not documented on the E-MAR. The RNS confirmed they were not documented and acknowledged one tramadol tablet was unaccounted for. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During a review of facility's policy and procedure titled, Documentation of Medication Administration, revised on November 2022, P&P indicated, 1.A nurse . documents all medications administered to each resident on the resident's medication administration record (MAR) and 2. Administration of medication is documented immediately after it is given.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49498 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 43) was free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental process and behaviors). Resident 43 received aripiprazole (an antipsychotic medication, used to manage conditions such as psychosis) and sertraline (medication used to treat depression) without side effects and behavior monitoring. Resident 43's care plan did not have the correct side effect monitoring for the aripiprazole use. These failures resulted in inadequate monitoring for effectiveness and adverse effects of psychotropic medications. Findings: 1. A review of clinical record indicated Resident 43 was admitted to the facility with diagnoses including Schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) and Depression. A review of Resident 43's physician's orders included the following: -Aripiprazole 2 mg (milligrams) 1 tablet by mouth at bedtime for Schizoaffective disorder manifested by verbal abuse (threatening, screaming, cursing at others), dated 10/24/23. -Sertraline 25 mg 1 tablet by mouth at bedtime for Depression manifested by episode of crying, dated 7/13/22. -Monitor Episodes of Depression AEB (as expressed by): episodes of crying every shift, dated 7/13/22. -Monitor Episodes of Verbal Abuse AEB: Threatening, Screaming, Cursing at others every shift, dated 7/13/22. -Monitor for side effects of Abilify (aripiprazole): Anticholinergic effects (dry mouth, constipation, blurred vision, drowsiness, dizziness, increased heart rate, urinary retention, delirium), increase in total cholesterol and triglycerides, akathisia (inability to remain still), parkinsonism (brain conditions that cause slowed movements, rigidity/stiffness and tremors), neuroleptic malignant syndrome (characterized by high fever, stiffness of the muscles, altered mental status and autonomic dysfunction that may result in death), blood sugar elevation, orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down), falls, weight change, tardive dyskinesia (abnormal, recurrent, involuntary movements that may be irreversible and typically present as lateral movements of the tongue or jaw, tongue thrusting, chewing, frequent blinking, brow arching, grimacing, and lip smacking, although the trunk or other parts of the body may also be affected), lethargy/sedation every shift, dated 7/13/22. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor side effects of Zoloft (sertraline) . every shift, dated 7/13/22. During a concurrent interview and record review on 01/11/24, at 10:01 a.m., the Medical Record/Operations Manager (MR/OM) stated the side effect and behavior monitoring for Resident 43's aripiprazole and sertraline were ordered but somehow did not link with the E-MAR (Electronic Medication Administration Record). The MR/OM acknowledged that without documentation the monitoring was not done. During a concurrent interview and record review on 01/11/24, at 10:07 a.m., the Registered Nurse Supervisor (RNS) stated the side effect and behavioral monitoring are documented in the E-MAR. The RNS looked through Resident 43's December 2023 and January 2024 E-MARs and Psychotropic tab and stated she could not find evidence of staff monitoring for side effects and behaviors related to the use of aripiprazole and sertraline. RNS stated I am not sure why the orders did not go over to the E-MAR. On 1/11/24, a review of Resident 43's E-MARs from August 2022 to January 2024 indicated the entries for side effect and behavior monitoring were all blank. 2. On 1/10/24, a review of Resident 43's Anti-psychotic dx (diagnosis) care plan, revised on 07/27/23, indicated one of the interventions for the use of antipsychotic medication was to observe and report signs of Blurred vision, Dizziness, Muscle spasms of neck/back, Shuffling walk, Sexual dysfunction, Diarrhea, Constipation, Drowsiness, Nasal congestion, Nausea, Vomiting, Dry mouth, Skin rashes, Loss of appetite, Increased confusion, Seizure, Tachycardia (rapid heartbeat), Orthostatic hypotension, Photosensitivity. During a concurrent interview and record review on 01/11/24, at 10:07 a.m., the RNS confirmed the aripiprazole side effects on the care plan did not match the side effect profile written on the physician's order (as stated above). During a review of the facility's policy and procedure titled, Psychotropic Medication Use, dated March 2018, P&P indicated, 8. Psychotropic medication management for resident will involve the facility's interdisciplinary team's consideration of the following . adequate monitoring for efficacy and adverse consequences and 12. Monitoring of a resident receiving Psychotropic medication will include an evaluation of effectiveness of the medication, as well as an assessment for possible adverse consequences. Behavior symptoms are reevaluated periodically to determine the potential for reducing or discontinuing the drug based on therapeutic goals, and any adverse effects or possible functional impairment.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49498 Based on observation, interview and record review, the facility had a 7.41% error rate when two medication errors out of 27 opportunities were observed during the medication pass for two of six sampled residents (Residents 28 and 52). Resident 28 did not receive carvedilol (medication used to treat high blood pressure) as ordered and Resident 52 received a wrong calcium product. These failures resulted in medication not given in accordance with the prescriber's orders, which may negatively affect the resident's health.) Findings: 1. During medication administration observation on 01/08/2024, at 10:01 a.m., in Station 1, LVN (Licensed Vocational Nurse) 3 was observed preparing and administering 7 medications to Resident 28. These medications included 1 tablet of allopurinol (medication used to treat gout) , 1 capsule of docusate sodium (medication used to treat constipation), 1 tablet of duloxetine (medication used to treat depression), 1 tablet of finasteride (medication to treat symptoms of an enlarged prostate), one fluticasone inhaler (medication used to treat asthma), 1 tablet of memantine (medication used to treat dementia in patients with Alzheimer's disease) and 1 tablet of valsartan (medication used to treat high blood pressure). A review on 01/08/2024 of Resident 28's Physician's order, dated 12/22/23, and the January 2024 E-MAR (Electronic Medication Administration Record) indicated that carvedilol 3.125mg was scheduled to be given two times a day at 9:00 a.m. and 5:00 p.m. for Resident 28. During a concurrent observation and interview on 01/08/2024, at 02:29 p.m., LVN 3 checked the medication cart drawer and found the 9:00 a.m. and 5:00 p.m. pouches containing carvedilol 3.125 mg (milligrams) for Resident 28. LVN 3 stated she missed giving the carvedilol to Resident 28 during the morning medication pass and will notify the doctor that the dose was missed. 2. During medication administration observation on 01/09/2024, at 08:40 a.m., in Station 2, LVN 6 was observed preparing and administering 8 medications to Resident 52. One of the administered medications was a tablet of calcium 600 mg plus vitamin D 400 IU (international unit). A review on 01/09/2024, the Physician's order dated 07/17/2022 and the January 2024 E-MAR indicated that calcium 600 mg + vitamin D 800 unit was ordered for Resident 52. During a concurrent observation and interview on 01/09/2024, at 01:41 p.m., LVN 6 checked the bottle of calcium 600 mg plus vitamin D 400 IU and compared with the E-MAR. The E-MAR indicated calcium 600 mg + vitamin D 800 unit was ordered for Resident 52. LVN 6 stated the medication cart did not have calcium 600mg with vitamin D 800 unit supply and will clarify the order with the doctor. LVN 6 confirmed the medication given was not the same with the doctor's order. During a review of facility's policy and procedure titled, Administering Medications, dated April 2019, P&P indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49498 Based on observation, interview and record review the facility failed to ensure proper medication storage and labeling of medication for one of one sample medication room and two of two medication carts when: 1. A non-licensed staff had access to the main medication room; and 2. Multiple expired, unlabeled, and undated multi-dose vials, eye drops, and inhalers were identified. These failures had the potential for loss or diversion of medications; and residents to receive medication with unsafe and reduced potency from being used past their discard date. Findings: 1. During a concurrent observation and interview on [DATE], at 11:41 a.m., in Station ,d+[DATE] with the presence of the Director of Nursing (DON) and Licensed Vocational Nurse (LVN) 2, the Housekeeping/Central Supply (HSKG/CS) staff stated she had the key to the medication room and replenished medication and treatment supplies whenever a nurse is available. The DON and LVN 2 acknowledged HSKG/CS staff should not have access to the medication room. HSKG/CS staff was observed giving the medication room key to LVN 2. During a review of facility's policy and procedure (P&P) titled, Storage of Medications, revised ,d+[DATE], P&P indicated, B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, cart, and medication supplies are locked when not attended by persons with authorized access. 2a. During medication administration observation on [DATE], at 10:52 a.m., LVN 1 was observed administering a dose of 0.5 milliliter (ml) of lorazepam (a controlled medication used to treat anxiety) concentrate 2 milligrams (mg)/ml orally to Resident 56. The lorazepam bottle did not have an open date on the medication bottle or the carton box it came in. A review of the manufacturer's label with LVN 1 indicated to discard the medication after 90 days. LVN 1 acknowledged it should have been labeled with an open date. 2b. During a concurrent observation and interview on [DATE], at 11:42 a.m., in the Station 2 and 3 Medication Room with the DON and LVN 2, an inspection of the medication refrigerator identified: -One opened latanoprost (medication to treat glaucoma) eye drop bottle without an open date and with an expiration date of ,d+[DATE] -Thirteen 1-ml injectable vials of lorazepam 2 mg/ml for Resident 30 who was already discharged . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One Victoza (medication that helps control blood sugar levels and used to treat type 2 diabetes) injectable pen 18mg/3ml for Resident 3 with an expiration date [DATE] -Three Trulicity (medication that helps control blood sugar level) injectable pens 0.75 mg/0.5ml for Resident 50 with an expiration date of [DATE]. During this inspection, the DON and LVN 2 acknowledged the medications were expired. The DON stated Resident 30's lorazepam should have been removed from active stock to avoid medication error and loss. 2c. During a concurrent observation and interview on [DATE], at 02:32 p.m., an inspection of Station 1 Medication Cart with LVN 3 identified the following: -Three opened lidocaine (local anesthetic) 1% 200mg/20ml multi-dose vials without open date -One opened Sterile Water (for mixing medications) vial for single use -Two latanoprost eye drops bottles without open date; the manufacturer's label indicated to discard 6 weeks after opening -One Alphagan P (medication to treat open-angle glaucoma or high fluid pressure in the eye) eye drop without the pharmacy label -One latanoprost eye drop bottle for Resident 15 with two labels on it: latanoprost 0.005% solution 1 drop into left eye at bedtime and timolol (medication to treat glaucoma) 0.5% 1 drop into left eye daily -One ear drop mediation was stored with multiple eye drops in one compartment -One 887ml bottle of Pro-Stat sugar free liquid protein opened [DATE] with an expiration date of [DATE] -One Covid 19 reagent was stored with multiple eye drops with an expiration date of [DATE] During this inspection, LVN 3 stated she was not a regular staff in the facility so she could not comment but acknowledged the above findings. 2d. During a concurrent observation and interview on [DATE], at 04:11 p.m., an inspection of Station 2 Medication Cart with LVN 7 identified the following: -One Humulin R insulin (medication to control high blood sugar) vial for Resident 57 with an expiration date of [DATE] -Two opened Breo Ellipta (medication used to treat asthma and chronic obstructive pulmonary disease (COPD-group of diseases that cause airflow blockage and breathing-related problems) inhalers without open date; a review of the manufacturer's label indicated to discard 6 weeks after opening or when dose counter is 0, whichever comes first. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the inspection, LVN 7 acknowledged the insulin had expired, and the two Breo inhalers did not have open date. During a review of facility's P&P titled, Expiration Dating (Beyond-use dating), revised ,d+[DATE], P&P indicated, C. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic (eye medications) .once opened, require shorter than the manufacturer's expiration date to insure medication purity and potency. During a review of facility's P&P titled, Storage of Medications, revised ,d+[DATE], P&P indicated, Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During a review of facility's P&P titled, Medication Labeling and Storage, Revised February 2023, P&P indicated, 5. Multi-dose vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless manufacturer specifies a shorter or longer date for the open vial.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 34975 Based on staff interviews and review of facility documents, the facility failed to comply with Federal regulations related to the oversight of food service operations when the facility did not have a full-time dietitian and the requirements were not met as specified in established standards (California Code, Health and Safety Code - HSC S 1265.4) for food service managers which required, employment of a full-time, qualified dietetic supervisor when the dietitian was not full time. The lack of qualified, full time person to supervise the Food and Nutrition Services Department had the potential to result in unsafe food practices and food borne illness for 69 residents eating facility prepared foods. Findings: According to the California Code, Health, and Safety Code - HSC S 1265.4: A licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. Subdivision (b) includes the following: The dietetic services supervisor shall have completed at least one of the following educational requirements: (1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility. (2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration. (3) A graduate of a dietetic assistant training program approved by the American Dietetic Association. (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision. (7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6). (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the job description titled Dietary Supervisor signed by the Dietary Supervisor (DS) on 10/1/23, showed This position must provide supervision for the Dietary Department, ensuring quality food. The Dietary Supervisor will direct and assist the preparation and service of regular meals and therapeutic diets, order food and supplies, maintain area and equipment in sanitary condition, and assure the smooth operation with other nursing facilities departments. During the Re-certification Survey from 1/8/24-1/12/24, multiple issues were identified regarding Food and Nutrition staff competency (Cross-reference F802); following he planned menu (Cross-reference F803); providing palatable food (Cross-reference F804); serving substitution food and drink of equal nutritive value (Cross-reference F806); ensuring food was stored, prepared, and served in a safe and sanitary manner (Cross-reference F812). In an interview on 1/8/24 at 10:10 a.m., DS stated she was the full-time kitchen supervisor. She stated she was not qualified for the position and said she was working toward becoming a Certified Dietary Manager (CDM). DS stated she was finished with her coursework for the CDM, but still needed to take the exam to become certified. In an interview on 1/10/24 at 10 a.m., the Registered Dietitian (RD) stated she worked at this facility and another facility. She stated she was worked at the facilities from 8:30 a.m., to about 5 p.m., and split time between the facilities so she was at this facility about 20 hours a week. In an interview on 1/11/24 at 9:50 a.m., the RD stated her typical day and/or week included participating in the facility stand-up meeting in the morning where she might learn about things pertinent to her, such as resident Change of Conditions (COC), weight loss, swallowing issues, and dietary preferences. She stated she did nutrition assessments for new admissions, and MDS (Minimum Data Set; a tool for implementing standardized assessment and for facilitating care management) annual and quarterly assessments. The RD stated she also did any consults requested by a doctor. The RD stated most of her daily/weekly work was clinical, not kitchen related. The RD stated DS informed her if there were issues in the kitchen than needed to be addressed. In an interview on 1/11/24 at 11:50 a.m., the Administrator stated he just reviewed DS's qualifications and coursework and found she did not have documentation of coursework toward a CDM certification.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49091 Based on observation, interview and facility document review, the facility failed to ensure kitchen staff were competent regarding job duties when kitchen staff did not know the appropriate procedures for cleaning equipment and utensils using the three-compartment sink. This failure had the potential to result in contamination of kitchen equipment and/or utensils leading to illness caused by pathogens (harmful organisms) for 69 residents who received food from the kitchen. Findings: During a concurrent observation and interview in the kitchen on 1/9/24, at 9:57 a.m., Cook 1 stated the three-compartment sink would be used to clean dishes if the dish machine was not working. Cook 1 demonstrated the steps for manual dish washing using the three-compartment sink. She stated the first sink was filled with water and used for washing the dishes with soap. When she was asked what the water temperature should be for washing the dishes in the first sink, she stated that temperature of wash water should be warm, and stated she did not know the temperature. During the demonstration for use of the sink, Cook 1 stated the third sink was used for sanitizing items. When asked how long items were to be submerged in the sanitizer, Cook 1 stated she thought about three to four minutes. During a concurrent observation and interview in the kitchen on 1/10/24, at 11:15 a.m., the Dietary Supervisor (DS) stated that the temperature of wash water, rinse water and sanitizer in the 3-compartment sink should be over 110 degrees F. DS also stated items should be submerged in the sanitizer for 30 seconds. A record review of facility policy and procedure (P&P) titled, Sanitation, revised 11/2022, P&P indicated that manual washing and sanitizing is a three-step process for washing, rinsing, and sanitizing: a. scrape food particles and wash using hot water and detergent, b. rinse with hot water to remove soap residue, and c. sanitize with hot water (at least 171 degrees F for 30 seconds) or chemical sanitizing solution. Chemical sanitizing solution (e.g., chorine, iodine, quaternary ammonium compound) are used according to manufacturer's instructions. A record review of manufacturers instructions titled, Ecolab Oasis 146 Multi Quat Sanitizer indicated all surfaces of equipment, ware and utensils should be immersed in sanitizing solution for no less than one minute. According to the U.S. Department of Food and Drug Administration (USDA) Food Code (2022), the temperature of the wash solution in manual warewashing equipment shall be maintained at not less than 43oC (110oF) or the temperature specified on the cleaning agent manufacturer's label instructions.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49091 Based on observation, interview and record review, the facility failed to ensure the menu was followed when: 1. An entree on the menu was not prepared because an ingredient was not purchased. 2. Diet salad dressing was not purchased and was on the lunch menu for residents on a Heart Healthy diet. This failure had to the potential to result in resident dissatisfaction of meals and/or the residents not receiving the appropriate nutrients as set forth by the planned menu for 69 residents who received food from the kitchen. Findings: A review of the facility policy and procedure (P&P) titled, Substitutions, revised 4/2007, indicated substitutions should only be made when unavoidable. A review of the job description titled, Dietary Supervisor, signed by the Dietary Supervisor (DS) on 10/1/23, indicated the DS will direct and assist the preparation of regular and therapeutic diets. The DS is responsible for meeting the quality and quantity of food to meet each resident's needs in accordance with physician order in compliance with approved menus. In addition, the DS is responsible for transmitting orders for appropriate food and supplies. 1. During a review of kitchen document titled, Winter Menu, the lunch menu for 1/9/24 indicated maple chicken was to be served for all diets. In addition, cornbread dressing and poultry gravy was to be served to all residents except for residents on a Consistent Carbohydrate diet (CCHO, typically prescribed to promote blood sugar control), Heart Healthy diet (typically prescribed when a person has or is at risk for heart disease) and Renal diet (typically prescribed to a person with kidney disease). During a concurrent observation and interview on 1/9/24, at 9:20 a.m., Cook 1 prepared lunch and stated the lunch being served was teriyaki chicken, rice, and carrots. Cook 1 confirmed the menu indicated maple chicken was the entree and said teriyaki chicken was substituted because the kitchen was out of chicken thighs and only diced chicken was available. Cook 1 stated she used diced chicken to prepare the teriyaki chicken. She also said rice was being served instead of cornbread stuffing to go with the chicken teriyaki. A review of the recipe titled, Maple Chicken, dated Winter 2023-24 Week 1, indicated ingredients included, but were not limited to, chicken thighs with bone and maple syrup. A review of the recipe titled, Chicken Teriyaki, dated Fall 2023 Week 3, indicated ingredients included, but were not limited to, chicken thighs with bone. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/10/24, at 9:49 a.m., with DS, DS stated the lunch menu entree was changed on 1/9/24 because the kitchen was out of chicken thighs and diced chicken was in stock. When the surveyor pointed out the teriyaki chicken recipe also called for chicken thighs, the DS stated they were also out of maple syrup. The DS stated food deliveries from the food supply vendor were on Tuesdays and Fridays. DS stated when the food order was placed on 1/4/24, maple syrup was not available to order from the food supply vendor for the Friday food delivery. The DS stated she could go to the local grocery store to get needed items if the Administrator (ADM) was on-site so she could get his credit card to use for the purchase. During an interview on 1/11/24, at 9:40 a.m., with the Registered Dietitian (RD), when asked if maple syrup was available, would the entree have been changed from Maple Chicken to Teriyaki chicken for lunch on 1/9/24. The RD stated the menu still had to be changed because the facility was out of chicken thighs. When the surveyor pointed out chicken thighs were called for in the recipe for Maple Chicken and Teriyaki Chicken, she stated she guessed if maple syrup was available, the Maple Chicken could have been prepared. During an interview on 1/12/24, at 9:56 a.m., with ADM, ADM stated he was on-site at the facility on 1/5/24, 1/8/24, and during 1/9/24 and was not approached regarding the necessity to get items from the grocery store or lunch menu preparation. The ADM stated DS had ample time to purchase maple syrup from the grocery store for preparation of lunch on 1/9/24. The ADM also stated the DS had purchased needed items from the local grocery store in the past using her own funds and had been reimbursed by the facility. 2. During a review of kitchen document titled, Winter Menu, the lunch menu for 1/9/24 indicated residents on a Heart Healthy diet received diet dressing with the salad. During an observation on 1/9/24, at 11:15 a.m., kitchen staff prepared lunch trays for residents. Trays with a tray ticket which indicated residents were on a Heart Healthy diet received the same salad dressing as those with Regular diets (a diet without therapeutic restrictions). During an interview on 1/9/24, at 11:30 a.m., with Dietary Aide 1 (DA 1), all residents received the same Caesar dressing and DA confirmed diet dressing was not available. During an interview on 1/9/24, at 11:37 a.m., with RD and DS, the RD confirmed diet dressing was on the menu for Heart Healthy diets and stated she was not aware residents were not receiving diet dressing when it was on the menu. The DS stated she did not order diet dressings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49091 Based on observation, interviews, and record review, the facility failed to ensure food was palatable when recipes were not followed and foods were bland, as well as over-seasoned. This deficient practice placed 69 residents who received food from the kitchen at risk for decreased nutrient intake leading to nutrition related medical complications. Findings: During an interview on 1/8/24, at 10:50 a.m., Resident 10 stated the food at the facility was bad. During an interview on 1/8/24, at 10:55 a.m., Resident 41 stated the food sucks. During an interview on 1/8/24, at 3:00 p.m., Resident 48 stated the food is not good. During a record review of recipe titled, Chicken Teriyaki, dated 8/21/23, the ingredients for the sauce included pineapple juice, water, soy sauce (low sodium), garlic powder, ginger ground, brown sugar, cornstarch, and water. During a record review of recipe titled, Carrots with Dill, dated 12/6/23, the ingredients included sliced frozen carrots, dill weed, seasoned salt, and margarine. During a record review of recipe titled, Rice, Steamed, dated 12/6/23, the ingredients included long grain white rice, salt, white pepper, and boiling water. During a concurrent observation and interview on 1/9/24, at 9:20 a.m., Cook 1 prepared chicken teriyaki for the lunch meal. Cook 1 stated the ingredients she used to prepare the teriyaki chicken were diced chicken and one bottle of ready-made teriyaki glaze. Cook 1 stated she was not following the standardized recipe for the teriyaki chicken. Cook 1 stated she also prepared white rice, and carrots. Cook 1 stated the ingredients she used for the carrots were carrots, dill, and butter. On 1/9/24, at 12:55 p.m., a sample test tray with regular and pureed consistency lunch items were tasted by two surveyors, the Registered Dietitian (RD), and the Dietary Supervisor (DS). The surveyors stated the regular textured carrots had a slight dill and butter taste but were still bland, and the pureed carrots did not have a dill or butter taste and were bland. The surveyors stated both the regular texture and pureed rice were bland. The RD stated the carrots and rice were bland. The DS stated additional salt was not added in food preparation, even if called for in the recipe. Both surveyors agreed that regular and pureed chicken teriyaki was very salty. In an interview on 1/10/24, at 9:49 a.m., DS stated all foods were made without adding salt to try to cater to all residents including residents on regular and no added salt diets. She stated if residents wanted to add salt to their food, they could use the salt packet provided on the meal tray. DS stated recipes should be followed. DS stated if salt was in the recipe, maybe the cook could add some salt, but not enough to taste any salt. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 1/10/24, at 10:00 a.m., the RD stated recipes should be followed. In an interview on 1/11/24, at 9:50 a.m., the RD stated she was not aware ready-made teriyaki sauce was used in place of following the recipe. She agreed the nutrient content could be different if a ready-made sauce was used in place of following the recipe. The RD stated she did not approve or was asked about using ready-made items. During a recipe review of kitchen document titled, Standardized Recipes, dated 4/2007, the document indicated, Only tested , standardized recipes will be used to prepare foods. A review of the job description titled, Cook Department: Dietary, signed by Cook 1 on 11/5/15, indicated the cook position essential functions included, but were not limited to: follow recipes and prepare foods that correspond to the menu cycles and recipes; and prepare palatable, nutritionally adequate meals according to the diet type. A review of the job description titled, Dietary Supervisor, signed by DS on 10/1/23, indicated the DS position was responsible for directing and participating in food preparation and service of food that is safe and appetizing and is of the quality and quantity to meet each resident's needs in accordance with physician's order in compliance with approved menus. A review of the job description titled, Registered Dietitian, signed by RD on 7/5/23, indicated the RD was responsible for assisting the coordination of nutrition care services with the DS; monitoring food services operations to ensure nutritional and quality standards; and monitoring food control systems such as preparation methods to ensure food was prepared in an acceptable manner.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34975 Based on observation, interview, and facility document review, the facility failed to provide a food/drink substitute of similar nutritive value and/or provide an alternate means of meeting the residents' nutritional needs when: 1. Milk was indicated on the planned lunch menu and was not provided for 43 residents out of 69 residents who received food from the kitchen; and 2. An alternate of equal nutritional value was not provided during a lunch meal for residents who did not like chicken. These failures had the potential for residents who ate food from the kitchen to receive a diet that did not meet their nutritional needs. Findings: Review of the policy and procedure titled Menus revised 2017, showed menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal. If a food group is missing from a resident's daily diet (e.g., dairy products), the resident is provided an alternate means of meeting his or her nutritional needs (e.g., calcium supplementation or fortified non-dairy alternatives). 1. Review of the Daily Cook's Menu dated Standard Winter 2023-24 1/9, and used for lunch on 1/9/24, showed residents on all diets except for renal diets, received milk for lunch. Review of the Winter Menu dated Week 1 and provided as the week menu from 1/8/24 - 1/14/24, showed milk served at each meal typed at the bottom of the menu. An observation of trayline food service and concurrent interviews with the Dietary Supervisor (DS) and the Registered Dietitian (RD) on 1/9/24 at 12 p.m., showed residents who's tray tickets did not indicate milk under the standing orders section, did not receive milk on their tray. The Dietary Supervisor (DS) stated milk was not provided on trays for meals unless milk was indicated standing orders on the tray ticket. She stated, if a resident wanted milk, the resident let her know. The Registered Dietitian (RD) stated she was aware not all residents received milk, but milk should be provided if it was on the menu. The RD confirmed milk was part of the approved menu and milk was included in the nutrient analysis of the menu. She stated sometimes a substitution for milk was provided such as yogurt, but only if it was preferred by the resident. The RD said she did not necessarily make sure residents received a substitute for milk to make up for the nutrients, such as calories, protein, calcium, and vitamin D, milk provided. The RD said she did not recommend supplements such as Vitamin D, unless lab results showed the resident was low in the vitamin. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of 69 resident tray tickets used for lunch on 1/9/24 showed 43 residents were on a diet that allowed milk according to the Daily Cook's menu dated Winter 2023-24 1/9 (renal diets, and lactose intolerant/allergy were not counted), and the tray tickets did not show milk under the standing order section. 2. Review of the Daily Cook's Menu dated Standard Winter 2023-24 1/9, and used for lunch on 1/9/24, showed two ounces of chicken was served for the regular entree. An observation of trayline food service on 1/9/24 at 12 p.m., showed chicken was served as the main entree and cheese tortellini was served as an alternate for the entree. In an interview on 1/10/24 at 10 a.m., the RD stated she approved tortellini as an alternate for the entree, which was two ounces of chicken, for lunch on 1/9/23. She stated she told the cook to serve 4 ounces (1/2 cup) of tortellini. She stated 4 ounces of cheese tortellini was probably not the same amount of protein as two ounces of chicken. In an interview on 1/10/24 at 3:45 p.m., the RD stated she reviewed the cheese tortellini nutrition information, and the tortellini was not a good alternate for the chicken entree. She stated the tortellini had significantly less protein than the meat served for lunch on Tuesday (1/9/24). Review of the undated nutrition facts for the [NAME] - Tricolor Tortellini provided as the nutrition facts for the tortellini served as an alternate entree for lunch on 1/9/24, showed the tortellini provided 9 grams of protein for 3/4 of a cup (which meant a 1/2 cup portion equaled 6 grams of protein). According to the United States Department of Agriculture (USDA), boneless, skinless cooked chicken contains 32.1 grams of protein for a 100 gram portion. Which means a two ounce portion of chicken equals 18.2 grams of protein.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in a safe and sanitary manner when: 1. A resident's (Resident 1) personal refrigerator was not monitored for temperature, food expiration dates, and cleanliness. 2. Unpasteurized (not heated to kill dangerous pathogens which can cause foodborne illness), undercooked eggs were served to a resident. 3. Two of two ice machines were not clean. 4. Prepared, leftover Time/Temperature Control for Safety (TCS) food (food requiring time and temperature controls to limit the growth of illness causing bacteria) was not monitored for cooldown. 5. Refrigerated TCS food was not labeled to show when it was to be used-by or discarded. 6. Frozen raw fish stored in the freezer was not covered and open to air. 7. A kitchen staff member did not follow hand hygiene practices. 8. Surface sanitizer solution was not at the appropriate temperature for testing the sanitizer strength. 9. Kitchen walls, ceilings, cabinets, tray-line preparation table, light fixtures, vents, a portable air conditioner filter, and equipment were not clean. 10. Walls, ceilings, the dry food storeroom floor, and the handwashing sink area were not maintained in good repair. 11. Food preparation and food service equipment stored for use were not clean. 12. An industrial can opener was not maintained clean. 13. The microwave was not maintained clean and in good repair. 14. A scoop was stored inside of a bulk storage bin containing rice. 15. Ready-to-eat food came into contact with equipment that was not cleaned and sanitized. These failures placed 69 residents who received food from the kitchen, at risk for food-borne illnesses. Findings: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. In an interview on 1/10/24, at 2:30 p.m., Licensed Vocational Nurse (LVN) 5 stated there was one resident, Resident 1, in the facility who had a refrigerator to store food brought in by family and/or visitors. LVN 5 stated the refrigerator was located in Resident 1's room. A record review for Resident 1 indicated Resident 1 was [AGE] years old and initially admitted on [DATE]. Diagnoses included but were not limited to paraplegia, muscle weakness, and need for assistance with personal care. During an observation and concurrent interview on 1/10/24, at 2:40 p.m., with Resident 1, Resident 1 was awake and lying in bed with the lights off, and the room was dark. Resident 1 stated it was okay to look inside the small refrigerator/freezer unit stored on the floor in the middle of the room. When the refrigerator was opened, there was a stale food odor. There was no light in the refrigerator, so a flashlight was used to view the contents. The refrigerator was packed with a variety of foods. There was a large plastic grocery bag stored on the bottom shelf. The bag had brown and yellow residue on the surface and the plastic was fraying. There was tape on the inside surface of the bag with brown residue imbedded in the tape. There were several items in the bag including a reusable container with a clear plastic lid, holding food which appeared to be some type of unidentifiable cooked food. There was no label on the container to show what the food was, when it was made, or when to use-by. Also in the bag, was a store bought container of raw milk cheese and the container lid showed perishable, keep refrigerated. There were a couple unlabeled, undated small reusable containers with unidentifiable contents. Food items stored on the top shelf of the refrigerator included a container cream cheese, a package of cheese, and a container of cottage cheese. In the door shelf, there was an opened container of half and half. The shelving and the inside walls of the refrigerator had a significant amount of black and brown residue on the surfaces. A thermometer was not located in the refrigerator. Resident 1 stated her son brought her food twice a month. Resident 1 stated her son cleaned the refrigerator. She stated she only liked to eat her own food and did not like the facility food. During an interview on 1/10/24, at 3:14 p.m., the Director of Staff Development (DSD) stated food brought in for residents from family and visitors could be stored up to 72 hours. DSD confirmed resident 1 had a refrigerator in her room. When the DSD was asked who was responsible for monitoring the refrigerator and cleaning it, she did not know and said she would get back with that information after she looked into it. On 1/10/24, at 3:30 p.m., Resident 1's refrigerator located in her room was observed with the DSD. The DSD stated she could not locate a thermometer inside the refrigerator. The DSD opened the freezer compartment and there were several fillets of raw, frozen fish wrapped in plastic with no dates to identify how long the fish was stored. Resident 1 confirmed there was raw fish stored in her refrigerator. When the DSD was asked her thoughts about the cleanliness of the refrigerator, she did not answer. During an interview on 1/11/24, at 11:50 a.m., the administrator (ADM) stated all of Resident 1's food stored in her refrigerator/freezer was discarded because it was not labeled and dated to determine how long it was stored in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility Policy and Procedure (P&P) titled, Foods Brought by Family/Visitors, revised March 2023, indicated food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Family members are asked to inform nursing staff when foods are brought for a resident. Food brought by family/visitors that is left with the resident to consume later is labeled. Perishable foods are stored in re-sealable containers that are labeled with a use-by date. The nursing staff will discard perishable foods on or before the use-by date. A review of the facility P&P titled, Refrigerators and Freezers, revised 11/2022, indicated the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration dates. Refrigerators keep food at or below 41 degrees Fahrenheit (F). Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. All food is appropriately dated to ensure proper rotation by expiration dates. Use-by dates are completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food are observed and use-by dates are indicated once food is opened. Supervisors are responsible for ensuring food items in refrigerators and freezers are not past use-by or expiration dates. Refrigerators and freezers are kept clean, free of debris, and sanitized on a scheduled basis and more often if necessary. 2. During an observation during the initial tour of the kitchen on 1/8/24, starting at 10: 10 a.m., a large box of raw, shell eggs were stored in a kitchen reach-in refrigerator. The box did not indicate the eggs were pasteurized and there was no marking on the eggs to show they were pasteurized. During an interview and concurrent observation on 1/9/24, at 9:20 a.m., Cook 1 confirmed the large box of eggs in the reach-in refrigerator were unpasteurized eggs and she used the unpasteurized eggs for fried eggs for resident breakfasts. During an interview on 1/9/24, at 10:37 a.m., with the Registered Dietitian (RD) and the Dietary Supervisor (DS), DS and RD stated runny eggs were served to residents upon request. DS stated one resident (Resident 17) asked for runny eggs this morning and runny eggs were prepared and served for Resident 17. DS stated the white part of the egg was cooked but the yoke was runny. During a concurrent interview and observation in the dry storeroom on 1/10/24 at 11:35 a.m., with RD and DS, RD stated the raw, shell eggs ordered and used to cook runny eggs should be pasteurized. When the RD looked at the eggs stored in the reach-in refrigerator, she confirmed the eggs were not pasteurized. The DS stated she thought the eggs she ordered were pasteurized. DS also looked at the eggs in the refrigerator and confirmed they were not pasteurized. When the DS was asked if it was okay to serve undercooked, unpasteurized eggs, she stated she needed to look into it. The RD stated unpasteurized, undercooked eggs should not be served to residents because the residents were immunocompromised and could get very sick. A review of the P&P titled, Food Preparation and Service, revised 2022 showed only pasteurized shell eggs are cooked and served when residents request undercooked, soft-served, or sunny side up eggs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. An observation during an initial tour of the kitchen and a concurrent interview with DS on 1/8/24, starting at 10:10 a.m., indicated an ice machine located in the kitchen. A flashlight was used to look into the ice chute. Pink residue was visible on the inner surface of the ice chute. A white napkin was used to wipe the inside of the ice chute and pink, slimy, moist residue wiped off onto the napkin. DS confirmed there was pink, slimy residue on the inner surface of the ice chute. During a concurrent observation and interview on 1/10/24, at 10:50 a.m., the Maintenance Staff (MS) stated he began working at the facility this past December, and he had not yet cleaned this ice machine. MS stated he believed ice machines should be cleaned monthly with hot water and food-safe sanitizer, and an outside company would clean inside the unit with chemicals. MS opened the ice machine so the inside could be viewed. There was brown residue on the outer surface of the evaporator plate (a metal grid component where water runs over and ice freezes and is formed) plastic cover. MS removed the evaporator plate cover, and the majority of the inside surface was covered with pink residue. The plastic around the evaporator plate had pink, black, and brown residue on the surface. In addition, the tray below the evaporator plate had brown and pink residue on the underneath surface which faced the bin holding formed ice. Review of manufacturer's manual for the ice machine titled, [Model Name] Ice Machines Installation, Operation and Maintenance Manual, revised 02/9/17, showed the ice machine was to be cleaned and sanitized every six months for efficient operation. If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company to test the water quality and recommend water treatment. An extremely dirty ice machine must be taken apart for cleaning and sanitizing. An observation and interview with RD on 1/10/24, at 11:40 a.m., showed an ice machine (Ice Machine #2) located in a room used to store single use food service items and was also used as the RD's office. The RD stated she did not think the ice machine was in service, however it was turned on and full of ice. Black and pink residue was visible inside ice chute and bin unit, and the residue came off on a white napkin when the inside of the chute was wiped down. During an interview with Certified Nursing Assistant 3 (CNA 3) on 1/10/24, at 2:26 p.m., CNA 3 stated she usually retrieved ice for residents from the ice machine in the ice machine room and pointed in direction of RD office. During an interview on 1/10/24, at 2:27 p.m., CNA 4 stated she usually received ice for residents from the ice machine located in the room where the RD's office was located. She stated she received ice for residents from that ice machine yesterday (1/9/24) but was told not to use it today. During an interview with CNA 2 on 1/10/24, at 2:28 p.m., CNA 2 stated he usually got ice for residents from the ice machine located in RD's office. Review of manufacturer's manual for the ice machine located in the RD's office titled [Ice Machine Brand] Ice Systems Installation and User Manual dated 2/2014, showed it was the user responsibility to keep the ice machine and ice storage in a sanitary condition. Without human intervention, sanitation would not be maintained. Sanitize the ice storage bin as frequently as local health codes require, and every time the ice machine is cleaned and sanitized. According to the 2022 Federal Food Code, equipment food-contact surfaces are to be clean to sight and touch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. An observation and interview during the initial tour of the kitchen on 1/8/24, at 10:45 a.m., showed inside a reach-in refrigerator was a metal container holding breakfast sausage, a brown ground substance, and bacon. The container was covered with foil and had 1/8/24 handwritten on the foil. Cook 1 stated the meat was left over from the breakfast trayline and she saved the items to use as an alternate food for residents. She said the brown, ground substance in the container was ground sausage. Temperatures of the food were measured with the surveyor's calibrated thermometer. The sausage was 49.8 degrees Fahrenheit (F), and the ground sausage was 44.4 degrees F. Cook 1 stated she placed the meat in the refrigerator after the breakfast trayline, about 8:30 a.m. She stated she did not monitor or document cooldown temperatures for the leftover meat. In an interview on 1/8/24, at 2:40 p.m., DS stated any leftovers should be monitored for cooldown, such as the breakfast sausage. In an interview on 1/10/24, at 10 a.m., when the surveyor asked to view the cooldown log, DS stated she did not know where the cook kept the log. DS stated she typically reviewed all logs but said the cooks did not cool food. DS stated she was not aware cooks were cooling breakfast meat such as sausage. During an interview and observation in the kitchen with DS, on 1/10/24, at 11:30 a.m., a metal container containing chopped, cooked meat was stored in the reach-in refrigerator. The container was covered with foil and a handwritten label showed, Beef 1/9/24, 1/10/24. DS confirmed the meat was cooked at the facility and left over and could be used as an alternate food. She stated the meat should be on the cooldown log. DS stated she was not aware the leftover cooked meat was stored in the refrigerator. DS stated there was not a cooldown log available to show the meat was cooled safely. A record review of document titled, Food Receiving and Storage, revised 11/2022, showed Potentially hazardous foods are cooled rapidly. This is defined as cooling from 135 F to 70 F within two hours, and then to a temperature of 41 F or below within the next four hours. The total cooling time between 135 F and 41 F is not to exceed six hours. According to U.S. Food and Drug Administration Federal Food Code 2022, the person in charge must ensure that employees are using proper methods to rapidly cool TCS foods that are not held hot or are not for consumption within 4 hours, through daily oversight of the employees routine monitoring of food temperatures during cooling. 5. An interview and observation during the initial tour of the kitchen with DS, on 1/8/24, starting at 10:10 a.m., showed an opened, half-full plastic container of tuna salad stored in a reach-in refrigerator with 11/28 handwritten on the lid. The DS stated the tuna salad was safe to eat until the expiration date on the container, which she stated she could not read because it was rubbed off. In an interview and observation on 1/8/24, at 2:40 p.m., DS stated the 11/28 date written on the tuna container lid was the date the tuna was received. She reviewed multiple lists posted in the refrigerator/dry food storage room which showed food storage times. She stated tuna salad was not on the lists. DS could not answer how long tuna salad could be stored once the container was opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview with DS, in the kitchen, on 1/10/24, at 10:30 a.m., a half-full gallon container of milk was observed in the kitchen refrigerator, and there was no opened-date label. The DS stated that milk was safe to be used until the manufacturer's expiration date printed on the container and did not need an opened-date label on it. In an interview on 1/12/24, at 11:20 a.m., DS stated she looked up tuna salad on the USDA (United States Department of Agriculture) website which showed tuna salad could be stored for three to five days. She stated all websites she saw gave the same information about tuna salad storage time. Review of the policy and procedure titled, Refrigerators and Freezers, revised 11/2022, showed the facility will ensure safe refrigerator and freezer maintenance and will observe food expiration dates. All food is appropriately dated to ensure proper rotation by expiration dates. Expiration dates on unopened food are observed and use by dates are indicated once food is opened. Supervisors are responsible for ensuring food items in refrigerators are not past use by or expiration dates. 6. An observation and interview during the initial tour of the kitchen on 1/8/24, starting at 10:10 a.m., showed a box containing six, raw fish filets stored in a reach-in freezer. The box was not sealed with fish open to air (not securely wrapped in plastic). DS confirmed the fish was not covered and stated the box containing the fish should be closed. Review of P & P titled, Food Receiving and Storage, revised 11/2022, showed all foods stored in the freezer are to be covered. 7. During an observation on 1/9/24, at 9:30 a.m., Dietary Aide 1 (DA 1) entered the kitchen. She washed and dried her hands, then touched the lid of a garbage container, located at the dirty side of the dish machine, to throw away a paper towel. DA 1 then put on gloves and began to handle clean plates and pots/pans from the clean side of the dish machine. In an interview on 1/9/24, at 9:35 a.m., DS stated the garbage container at the dirty side of the dish machine was used by the person at the dirty side of the dish machine without handling the soiled dishes. According to the U.S. Food and Drug Administration Federal Food Code 2022, food employees are to wash their hands and exposed portions of their arms immediately before working with clean equipment and utensils and after handling soiled equipment, before donning gloves, and after engaging in activities that contaminate the hands. 8. During an interview and observation in the kitchen, on 1/9/24, at 9:57 a.m., Cook 1 demonstrated how to test the surface sanitizer strength. Cook 1 filled a red bucket with a solution dispensed from a hose above the three-compartment sink. Cook 1 dipped a quaternary ammonia test strip into the solution then removed the strip and compared to the color chart located in the test strip container. Cook 1 stated she never measured the temperature of the solution. The temperature of the solution was measured with a surveyor's calibrated thermometer and was 60.2 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation in the kitchen and interview with DS on 1/10/24, at 10:00 a.m., DS described how to test the surface sanitizer solution for proper strength using test strips. When asked what temperature the sanitizer should be, DS stated the sanitizer solution should be between 65-75 degrees F when testing the strength of the sanitizer solution according to the instructions in the test strip container. DS filled a red bucket to test the strength of the sanitizer. The temperature of the solution was measured and was 58 degrees F. She stated she had to call the outside vendor to adjust the temperature of the dispensed solution. Review of quaternary ammonia test strip instructions located inside the test strip container, for the test strips used by Cook 1 and DS, showed when testing the sanitizer solution, the solution temperature should be between 65 and 75 degrees F. 9. An observation during the initial kitchen tour of the kitchen, on 1/8/24, starting at 10:10 a.m., showed gray, fuzzy buildup on the kitchen ceilings in the food preparation areas, on the surface of a large ceiling vent, on the ceiling sprinklers located in the dry food storeroom, on the portable air conditioner vent tubing, on ceiling light fixtures in the food preparation area and in the dry storeroom, on top of oven back surface, in the vent of the juice machine, and on various conduit for electrical wiring. A consecutive observation during the initial tour of the kitchen, on 1/8/24, starting at 10:10 a.m., showed multiple cabinets holding items such as single use food service utensils, boxes of parchment paper, and clean rags, located along the back wall of the kitchen under food preparation counters, had residue brown and black sticky residue build-up on the inside of cabinet doors as well as loose particles on the surface of the shelving inside the cabinets. The cabinets also had peeling paint on the inside surfaces. In a consecutive observation and interview with DS during the initial tour of the kitchen on 1/8/24, starting at 10:10 a.m., DS stated cabinets should be wiped down daily. She looked at the cleaning schedule which showed drawers should be cleaned twice a week. DS stated cabinets were not on the cleaning schedule. DS stated the sign-off on the cleaning schedule showed Cook 1 cleaned the drawers which meant she also cleaned the cabinets. DS stated kitchen staff cleaned the walls and maintenance was responsible for cleaning vents and filters. In an interview and observation on 1/8/24, at 2:40 p.m., DS looked at areas around the kitchen such as the surface of the top, back stove area, cords, and plugs above a reach-in refrigerator in the food preparation kitchen area, and the wall beside reach in refrigerator, and confirmed there was gray, fuzzy residue in these areas. She stated the build-up was dust. DS stated kitchen staff were not really responsible for cleaning these areas. She stated kitchen staff were responsible for cleaning higher traffic areas such as counters. In an interview and observation on 1/9/24, at 9:25 a.m., Cook 1 opened the cabinet doors under the preparation table along the wall at the back of the kitchen. Cook 1 stated when she cleaned the cabinets, she did not clean the inside, she only wiped down the outside surface of the cabinets. An observation on 1/9/24, at 9:57 a.m., showed a gap between two tray-line tables with what resembled food crumbs, and brown residue imbedded in the gaps. In addition, a light colored block, was used to assemble the trayline shelving and the block created a crevice between the block and a hot water well. There was brown build-up imbedded in the crevice, resembling food residue and crumbs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview and observation with MS on 1/10/24, at 11:05 a.m., MS stated staff were supposed to document maintenance needs in a maintenance binder located in 2 nursing stations. MS stated he was not aware there were vents and filters in the kitchen areas that needed cleaning because he was not in the kitchen much since he just started working for the facility in December. He stated he was not informed the vents and filters were dirty. He said anything that had a filter, he was responsible for cleaning and/or fixing. MS stated vents, ceilings, walls, equipment, without filters should be cleaned by housekeeping staff and/or kitchen staff. He stated he would help with the cleaning if he was asked. MS stated and confirmed there were dusty vents in the kitchen areas. MS stated he removed the filter from the portable air conditioning (AC) unit located in the dry food storeroom yesterday (1/9/24) and the filter was very dusty. MS1 stated filters should be cleaned every three months. He stated there were no logs to show when the AC filter was cleaned prior to his cleaning yesterday. MS confirmed light fixtures throughout the kitchen were dusty. MS also confirmed the ceilings were dusty. In an interview and observation on 1/10/24, at 11:33 a.m., MS looked at the block holding up the stainless steel shelving above the trayline. He confirmed the area around the block was dirty and there were imbedded particles between the two trayline tables. He stated the areas should be flush, so crumbs and residue did not collect. MS stated he did not think the trayline shelving was assembled correctly with the use of the block. He stated all the parts should be stainless steel and he thought the block holding up the shelving was silicone. Review of the policy and procedure titled, Sanitation, revised 11/2022, showed kitchen areas are kept clean, free from garbage and debris, and protected from rodents and insects. All counters, shelves, and equipment are to be kept clean, maintained in good repair and free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Review of the policy and procedure titled, Departmental (Maintenance) - Plumbing, HVAC and Related Systems, revised 2011, showed to inspect air-conditioning unit drains and filters weekly. Change filters at least monthly during use. Clean air vents and air handling units at least annually. According to the 2022 Federal Food Code, food is to be protected by storing food where it is not exposed to dust; intake air ducts are to be cleaned so they are not a source of contamination by dust, dirt, and other material; equipment food-contact surfaces are to be clean to sight and touch; and nonfood-contact surfaces of equipment are to be kept free of an accumulation of dust, dirt, and other debris. 10. An observation during an initial tour of the kitchen on 1/8/24, starting at 10:10 a.m., showed white flecks of peeling paint on the kitchen ceiling in the food preparation area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	As the initial tour continued, observation and interview on 1/8/24, starting at 10:10 a.m., showed a tall metal shelving rack between the table holding the juice machine and a reach-in refrigerator. The rack had various pieces of equipment and utensils stored on the shelves such as water/juice pitchers and cutting boards. The rack had plastic liners on the shelves. There were particles on the surface of the plastic liner resembling food crumbs. Two pitchers stored on the rack had a sticky residue on the outside surface and two of four cutting boards had a black sticky residue on the surface as well as scratches and cut grooves with pieces of white, plastic coating flaking off the surface. DS stated the cutting boards were not clean and confirmed they had pieces of coating peeling off. She also confirmed the outside surface of the pitchers were sticky and the pitchers were used for water and juice. As the initial tour continued, observation and interview on 1/8/24 starting at 10:10 a.m. showed a food processor was stored on a table next to the stove. Cook 1 stated the food processor was just cleaned in the dish machine. Inside the food processor bowl and on the inside surface of the bowl lid, there was white, wet residue. Cook 1 stated the food processor was not clean. As the initial tour continued, observation and interview on 1/8/24, starting at 10:10 a.m., showed a large mixer covered in plastic stored on a table next to the stove. The plastic covering the mixer was removed. Inside the bowl of the mixer was a yellow liquid equal to about a teaspoon in measurement. In addition, the mixing paddle and safety guard had brown residue on the surface resembling food residue. Cook 1 stated the mixing machine was used weekly. DS confirmed the mixer was not clean. In an interview and observation on 1/8/24, at 2:40 p.m., DS stated if items cleaned in the dish machine came out of the dish machine with residue still on them, the items should be scrubbed and rewashed. The tall metal rack with the plastic liners used to store clean equipment and utensils was viewed with the DS. She confirmed there was debris on the plastic lining and stated staff should wipe the plastic lining, but it was not on the cleaning schedule. An observation on 1/9/24, at 9:46 a.m., showed utensils and equipment hanging from a rack above the trayline area. A cheese grater hanging from the rack was sticky to the touch and had a layer of light, gray and white residue resembling dust on the outside surface. There was also orange residue resembling dried cheese on the outside surface of the grater. In a consecutive observation and interview with DS, on 1/9/24, at 9:48 a.m., DS stated the cheese greater hanging above the trayline area was dusty and confirmed it was sticky with food residue on the surface. DS stated the cheese grater should be clean, but it was visibly dirty. An observation and interview on 1/9/24, at 11:40 a.m., showed Cook 1 setting up trayline for the lunch food service. She removed food scoops from a plastic container and placed the scoops in pans of fo [TRUNCATED]

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 34975 Based on interview and document review, the facility failed to have a refrigerator to store perishable food brought into the facility for residents by families and visitors. This failure to store perishable food belonging to residents had the potential for a decreased intake of food preferred by residents for 69 residents who ate food by mouth. Findings: In an interview on 1/10/24 at 2:35 p.m., Licensed Vocational Nurse (LVN) 5 stated when food was brought in by visitors and/or family members for a resident, staff encouraged the resident to eat the food and what was not eaten was trashed because there were no refrigerators to store resident food. She also stated there was not a microwave to heat resident food. In an interview on 1/10/24 at 3:14 p.m., the Director of Staff Development (DSD) stated food brought in for residents by family or visitors could be stored in a refrigerator for 72 hours. When she was asked which refrigerator the food was stored in, she stated the facility did not have a refrigerator to store resident food. The policy and procedure titled Food Brought by Family/Visitors revised 2022 was reviewed with the DSD in a consecutive interview on 1/10/24 at 3:16 p.m. The DSD confirmed the policy and procedure showed that perishable food brought in by family or visitors, to be consume later for the resident, would be stored for the resident in a refrigerator and nursing staff will label any stored perishable foods with a use by date. DSD confirmed the policy and procedure did not provide guidance on time frames for use by dates.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36087 Based on observation, interview, and record review, the facility failed to accurately document entries for one of 30 sampled residents (Resident 24), when resident's current physician orders did not reflect oxygen (O2) and nebulizer (a device to take medication in the form of a mist that is inhaled into the lungs) use. This deficient practice resulted in incomplete and inaccurate records and had the potential for Resident 24 to not receive care, services, and treatments as needed. Findings: A review of Resident 24's Admission Record, printed 1/10/24, indicated Resident 24 was admitted in March 2023, with diagnosis of chronic respiratory failure (a condition in which the lungs have a hard time loading the blood with O2 or removing carbon dioxide) with hypoxia (low levels of O2 in the body). A review of Resident 24's Care Plan titled, Difficulty Breathing related to Acute and Chronic Respiratory Failure with Hypoxia, undated, indicated, Administer medication/puffers as ordered. Monitor for effectiveness and side effects .Provide oxygen as ordered . Further review of Resident 24's care plan titled, Respiratory - Shortness of Breath, undated, indicated, Administer medications as ordered. Monitor for side effects/adverse reactions and effectiveness .Administer nebulizer treatments as ordered . A review of Resident 24's clinical record titled, Order Details, order date 11/1/23, indicated, Oxygen - at (@) 1-3Liters/Min Via Nasal Cannula as needed (PRN) to Maintain O2 Saturation (Sats) Greater Than 90 Percent (%). A review of Resident 24's clinical record titled, Medication Administration Record (MAR), dated 1/1/2024 - 1/31/2024, indicated, Start Date - 12/22/2023, Ipratropium-Albuterol Solution 0.5-2.5 (3) milligram/3milliliter (MG/3ML) 3 ML inhale orally every 6 hours for respiratory failure via nebulizer. A review of Resident 24's clinical record titled, Order Summary Report, active orders as of 1/8/24, indicated, 12/26/23 Ipratropium-Albuterol Solution 0.5-2.5 (3) milligram/3milliliter (MG/3ML) 3 ML inhale orally every 6 hours for respiratory failure. Resident 24's Order Summary Report did not indicate an O2 or nebulizer treatment/use. During an observation on 1/8/24, at 10:17 a.m., in Resident 24's room, Resident 24 was noted receiving O2 from a portable O2 concentrator (a medical device that delivers O2) running at 4 liters per minute (LPM) via undated nasal cannula tubing. Resident 24 also had a nebulizer machine on top of his bedside table with connecting undated mask cannula tubing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 1/8/24, at 2:42 p.m., with Registered Nurse Supervisor (RNS), in Resident 24's room, Resident 24 received continuous O2 at 4LPM via nasal cannula from a portable O2 concentrator. Resident 24's current Order Summary Report with active orders, dated 1/8/24, were reviewed and indicated no order for O2 and nebulizer use. RNS stated Resident 24 ran the risk of not receiving oxygen treatment as needed or risk of medication error for the licensed nurses. A review of the facility policy and procedure (P&P) titled, Oxygen Administration, revised October 2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . A review of facility P&P titled, Administering Medications Through a Small Volume (Handheld) Nebulizer, revised October 2010, indicated, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Obtain a physician's order as needed. Review the resident's care plan, current orders, and diagnoses to determine resident needs . A review of facility P&P titled, Oxygen Therapy, undated, indicated, It is the policy of this facility that oxygen therapy is administered as ordered by the physician or as an emergency measure until a physician's order can be obtained. When implemented in an emergency without a physician's order, the physician will be notified as soon as possible after the resident immediate needs are met

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49498 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Two out of three nurses failed to disinfect the blood pressure (BP) cuff before and/or after use for two of three sampled residents (Residents 28 and 52), 2. Two out of three nurses during medication administration were observed not using the appropriate disinfectant to clean and disinfect shared glucometers for two out of three sampled residents (Residents 24 and 52), and 3. Resident 25's foley catheter (tube inserted thru the urethra to drain bladder) equipment was lying on the ground. These failures had the potential for the spread of infections and communicable diseases among residents and placed Resident 25 at risk of urinary tract infection (UTI, infection of the urinary tract). Findings: 1. During a medication administration observation on 01/08/24, at 10:01 a.m., Licensed Vocational Nurse (LVN) 3 was observed taking the shared BP apparatus (BP monitor and BP cuff) from the hallway to Resident 28's room without disinfecting the blood pressure cuff then proceeded to wrap it around Resident 28's left arm to check the blood pressure. During an interview on 01/08/24, at 10:22 a.m., LVN 3 acknowledged she should have disinfected the blood pressure cuff before using it for Resident 28. During a medication administration observation on 01/09/24, at 08:51 a.m., LVN 6 was observed placing the shared BP cuff on top of the medication cart without cleaning or disinfecting it after checking Resident 52's BP. During an interview on 01/09/24, at 9:08 a.m., LVN 6 stated she was not informed by the facility staff that blood pressure cuff should be disinfected after use. During an interview on 01/09/24, at 09:37 a.m., the Director of Staff Development/Infection Preventionist (DSD/IP) stated the BP cuff should be disinfected between resident use. A review of facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised in September 2022, P&P indicated, c(1) Non-critical resident-care items (are those that come in contact with intact skin but not mucous membranes) include bedpans, blood pressure cuffs .; 5. Reusable items are cleaned and decontaminated (the process of removing contaminants on an object or area, including chemicals, micro-organisms, or radioactive substances) or sterilized (any process that removes, kills, or deactivates all forms of life and other biological agents present in or on a specific surface, object, or fluid) between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During the medication administration observation on 01/08/24, at 12:22 p.m., LVN 1 was observed wiping down the shared glucometer (medical equipment used to measure and display the amount of sugar (glucose) in the blood) with an alcohol prep pad (an antiseptic wipe saturated with 70% isopropyl alcohol) prior to checking Resident 24's blood sugar. She stated the glucometer is being shared among residents receiving BS checks. Shortly after the medication administration for Resident 24, on 01/08/24, at 12:27 p.m., LVN 1 was observed wiping down the shared glucometer with an alcohol prep pad after checking Resident 24's blood sugar. During an interview on 01/08/24, at 12:33 p.m., LVN 1 stated she has been using alcohol prep pad since morning to disinfect the shared glucometer. LVN 1 acknowledged she should have used the Micro-kill Germicidal (to kill germs) wipes to disinfect the glucometer, and that alcohol does not kill all bacteria or viruses. LVN 1 stated she did not receive orientation or training from the facility of what disinfecting wipes to use and has been using alcohol prep pad based on experience. During a concurrent medication administration observation and interview on 01/09/24, at 09:08 a.m., LVN 6 was observed wiping down the shared glucometer with an alcohol prep pad after checking Resident 52's blood sugar. LVN 6 stated she was not oriented as to what type of disinfectant wipe to use for shared glucometer, and there were no germicidal wipes available in the medication cart. During an interview on 01/09/24, at 09:37 a.m., the Director of Nursing (DON) and the DSD/IP stated the alcohol prep pad was not acceptable for cleaning/disinfecting shared glucometers, and the staff should use the disinfecting wipes based on the manufacturer's guidelines. A review of glucometer manufacturer's guidelines indicated the list of validated products for disinfecting the device, and alcohol prep pad is not included in the list. A review of facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised in September 2022, P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Center for Disease Prevention and Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogen (microorganisms such as viruses or bacteria that are carried in blood and can cause disease in people) Standard; 5. Reusable items are cleaned and decontaminated or sterilized between residents. A review of an online publication by the CDC titled Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration, reviewed 3/2/11, indicated, The disinfection solvent should be effective against HIV, Hepatitis C, and Hepatitis B virus . 70% ethanol solutions are not effective against viral bloodborne pathogens . Healthcare personnel should consult the manufacturers of blood glucose meters in use at their facilities to determine what products, meeting the criteria specified by the FDA, are compatible with their meter prior to using any EPA-registered disinfectant for disinfection purposes. (https://www.cdc.gov/injectionsafety/providers/blood-glucose-monitoring_faqs.html; accessed 1/18/24). 46658 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 25's admission record indicated Resident 25 was admitted in 2018 for hemiplegia (the loss of muscle function on one side of the body), hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body), neuromuscular dysfunction (loss of muscle control due to nerve dysfunction) of the bladder and need for assistance with personal care. A record review of Resident 25's minimum data set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 10/12/23, indicated Resident 25 was dependent on the staff for toileting hygiene. A record review of Resident 25's care plan titled, The resident has a foley catheter (tube inserted thru the urethra to drain bladder) related to neurogenic bladder (loss of control of bladder function), dated 12/22/23, was reviewed. The care plan indicated staff ensure privacy cover is placed on foley bag (bag to contain urine from foley catheter.) During a review of Resident 25's physician order set titled, Order Summary Report, dated 1/10/24, the order set indicated Resident 25 had an order for foley catheter daily care. During an observation on 1/8/24, at 10:00 a.m., Resident 25 was in his room lying in bed with the covers over him. Resident 25 had a foley catheter in place. The foley catheter tubing was lying directly on the ground and the foley bag was hanging on the side of the bed without a privacy cover. During a concurrent observation and interview, on 1/9/24, at 2:30 p.m., with Licensed Vocational Nurse 4 (LVN 4), Resident 25 was in his room lying in bed with the covers over him. Resident 25 had a foley catheter in place. LVN 4 observed the foley catheter tubing lying directly on the ground. The foley bag had a privacy cover, but was lying directly on the ground. LVN 4 picked up the foley bag and hung it on the side of the bed. LVN 4 then picked up the catheter tubing and affixed it to the bed in a way it was no longer lying directly on the floor. LVN 4 stated the foley bag and tubing needed to be off the ground to prevent urinary tract infection (UTI). LVN 4 stated she did not know how the tubing and bag got on the floor. During an interview on 1/11/24, at 2:45 p.m., with Infection Preventionist (IP), IP stated staff were expected to check proper placement of resident foley catheter equipment at least every shift and when providing incontinence care. IP stated the foley bag should have a privacy cover and tubing should be off the ground at all times to prevent UTI. During a review of facility policy and procedure (P&P) titled, Care of Catheters, undated, the P&P indicated staff always keep catheter collection bag in a privacy bag make sure the catheter tubing and drainage bag are kept off the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055239	A. Building B. Wing	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Bay Post-Acute	20259 Lake Chabot Road Castro Valley, CA 94546

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 49091 Based on observation, interview and record review, the facility failed to ensure essential kitchen equipment was in operational working condition when: 1. The right hand side of double oven unit was not operational. 2. A plate warmer was not operational. Findings: In a concurrent interview and observation on 1/9/24, at 09:20 a.m., Cook 1 stated that the right side of the oven was broken for about three months, making it difficult for her to cook all necessary food at times. Cook 1 also stated that the Dietary Supervisor (DS) was aware part of the oven was not working. Cook 1 stated that the plate warmer was broken for two days. In an interview on 1/10/24, at 10:50 a.m., with the Maintenance Supervisor (MS) in the kitchen, MS stated maintenance issues are communicated to him through a group chat via phone, and also via a maintenance binder located in two nursing stations. In a concurrent interview and observation on 1/10/24, at 11:47 a.m., in the kitchen, Cook 2 stated she told someone that the oven was not working about two weeks ago. DS stated an outside company came to the facility to fix the oven more than two weeks ago. MS stated he was not aware the oven or plate warmer was broken and he would be responsible for fixing the equipment if the issues with the equipment were not major. MS looked at the oven and confirmed one side was not working. MS said the pilot was not on. In In interview on 1/10/24, at 3:30 p.m., in Administrator (ADM) office, the ADM stated he was not aware that part of the oven or the plate warmer was not working, and that when equipment broke it should be documented in the maintenance log, and staff should let a manager know. He also stated he was not aware an outside company was in the kitchen at any point to repair the oven. In an interview on 1/11/24, at 9:50 a.m., with the Registered Dietician (RD), the RD stated she was not aware that the plate warmer was broken, and that she was aware the oven was not working, but thought it was fixed weeks ago, according to the DS. In an interview on 1/11/24, at 10:32 a.m., with the DS, the DS stated the oven was broken and fixed a while ago, and she would look for a repair receipt to validate this. DS stated there was no documentation to show that the plate warmer was reported broken, but discussed the problem with the MS and the ADM. DS stated she told the ADM that a new plate warmer should be purchased. DS also stated when equipment is broken, it should be entered into the maintenance log, but that she had never done that. It was noted that DS did not provide a receipt/invoice to show the oven was repaired. In a policy and procedure (P&P) document titled, Work Orders, Maintenance, revised 4/2010, P&P indicated that maintenance orders shall be completed in order to establish a priority of maintenance service, and: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director. 2. It shall be the responsibility of the department directors to fill out and forward such work orders to the Maintenance Director. 3. A supply of work orders is maintained at each nurses station. 4. Work order requests should be placed in the appropriate file basket at the nurses station. Work orders are picked up daily. 5. Emergency requests will be given priority in making necessary repairs. In a P & P document titled, Maintenance Service, revised 12/2009, P&P indicated, The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 44823 Based on observation, interview, and record review, the facility failed to ensure one of 30 sampled residents (Resident 34) had access to his call device. This failure resulted in Resident 34 not being able to get staff assistance when needed. Findings: A review of Resident 34's face sheet, undated, indicated Resident 34 was admitted in February 2019, with diagnoses of hemiplegia (paralysis) and hemiparesis (partial weakness) of left side of body following cerebral infarction (stroke - blood supply to the brain is cut off), arthritis (inflammation of joints), and muscle wasting (decrease in size of muscles). During a concurrent observation and interview on 1/8/24, at 10:47 a.m., with Resident 34, there was no call device found for Resident 34. Resident 34 stated he had no call light for the last 3 days. Resident 34 stated he needed the call light to call staff for any needs especially at nighttime but could not. During a concurrent observation and interview on 1/8/24, at 11:00 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 went to Resident 34's room, looked under the bed and surrounding areas and could not locate Resident 34's call device. LVN 2 asked Resident 34 where his call light was, and Resident 34 responded he did not have one. LVN 2 stated Certified Nursing Assistant (CNA) should have checked that Resident 34 had a call device. LVN 2 confirmed Resident 34 did not have a call device. During an interview on 1/9/24, at 8:15 a.m., with Housekeeper (HSKG) 1, HSKG 1 stated LVN 2 notified him on the morning of 1/8/24 that Resident 34 did not have a call device. HSKG 1 stated he went to the room and found a call device's cable unplugged from the wall. HSKG 1 stated when cleaning the room, the cable might have been accidentally hit and unplugged. HSKG 1 stated he did not know whose responsibility it was to enter a missing call device on the maintenance log. During an interview on 1/9/24, at 12:10 p.m., with LVN 2, LVN 2 stated when a call device cable was unplugged from the wall, there would be no light showing on the panel located in front of the nursing station to alert staff. LVN 2 stated not having a call light could compromise patient care. During an interview on 1/9/24, at 3:00 p.m., with Resident 34, Resident 34 stated he was moved to another bed three days ago and did not get a call device. Resident 34 further stated he wanted a call device to use if an item dropped on the floor and he needed staff help. A review of the facility's policy and procedure (P&P) titled, Call Lights, dated 1/20/24, the P&P indicated, Staff shall ensure that call lights are placed within reach of the resident.