| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 055240 | A. Building<br>B. Wing | 08/19/2024 |

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| Watsonville Nursing Center | 535 Auto Center Drive<br>Watsonville, CA 95076 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>50855<br><br>Based on observation, interview and record review, the facility failed to ensure dignity and privacy was upheld for 1 of 2 sampled Residents (Resident 12) when Resident 12's Suprapubic catheter [SP Catheter, a device inserted into your bladder (organ that collects urine) to drain urine if you cannot urinate on your own made of a semi-flexible plastic tube, one end inserted into the bladder and the other end attached to a bag that collects urine] drain bag was left uncovered.<br><br>This failure had the potential for adverse effects on the psychosocial well-being and health of Resident 12.<br><br>Findings:<br><br>During a review of Resident 12's Facesheet (FS, a document that gives a resident's information at a quick glance), undated, the FS indicated, admission diagnoses include End Stage Renal Disease (ESRD, condition in which the kidneys lose the ability to remove waste and balance fluids).<br><br>During a review of Resident 12's physician order dated, 7/8/2024 indicated, an order for a Suprapubic Catheter due to diagnosis of obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow).<br><br>During an observation on 08/13/24 at 04:18 p.m., in Resident 12's Room. Resident 12 was lying in bed, urine bag hanging on the right inside of resident bed, yellow colored urine is visible from drainage bag, was uncovered. Resident stated, he just came back few hours ago from dialysis.<br><br>During an interview with Certified Nursing Assistant B (CNA B) on 08/13/24, at 04:32 p.m., CNA B stated, Resident 12's drainage bag was not covered. CNA B stated, we need the thing to always cover the urinary drainage bag.<br><br>During an interview with Licensed Vocational Nurse A (LVN) on 08/13/24, at 04:35 p.m., LVN A stated, Resident 12's drainage bag should not be left uncovered. LVN A stated, urinary drainage bag should have covered with privacy/dignity bag all the time.<br><br>During an interview with Director of Nursing (DON) on 08/19/24, at 03:00 p.m., DON stated, Urinary drainage bag should be always covered with privacy or dignity bag. Inside or outside the facility.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of facility's policy and procedure (P&P) titled, Dignity revised February 2023, the P&P indicated, Residents are treated with dignity and respect at all times. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>49345<br><br>Based on interview and record review, the facility failed to obtain an informed consent for one of two sampled residents (Resident 44), for the medication lorazepam (medication used for anxiety).<br><br>This deficient practice had the potential for the resident or the representative not to be informed of the risks, benefits, and alternatives of the given treatment (medication) and may lead to the inability to exercise the rights to a preferred choice or alternative treatment.<br><br>Findings:<br><br>A record review of Resident 44's clinical record, indicated medical diagnoses including Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Catatonic Schizophrenia (a rare and severe mental disorder that's characterized by extreme changes in movement, behavior, and communication).<br><br>A record review of Resident 44's Physician Orders indicated an order dated 7/4/2023 for Lorazepam, give 1 milligram (mg, unit of measurement) by mouth three times a day for Catatonic Schizophrenia, started on 7/4/2023.<br><br>A review of Resident 44's Informed Consent form for Ativan (other name for Lorazepam) 1 mg indicated, a physician's signature dated 7/10/2023 and a signature of licensed nurse verification of informed consent being obtained by physician dated 7/4/2023. It also indicated that consent was obtained by phone. However, it neither indicated if consent was given by Resident 44 or by a surrogate decision maker.<br><br>During concurrent interview and record review on 8/14/2024 at 11:42 a.m. with Director of Nursing (DON), DON confirmed there was no name written on the Informed Consent form for Ativan from whom consent was obtained.<br><br>A review of facility's policy and procedure (P&P) titled Psychotropic Medication Use/Informed Consent dated March 2004, the P&P indicated, Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or the resident's representative .If the resident or resident's representative cannot sign the form, a licensed nurse can sign the form and document the name of the person who gave the consent and the date. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583<br><br>Based on interview and record review, the facility failed to report a suspected allegation of resident abuse in a timely manner for two of two residents (Residents 196 and 24) when:<br><br>1. The alleged missing money of Resident 196 was not reported to the California Department of Public Health (CDPH, a state department responsible for public health in California), Adult Protective Services (APS) and Office of the Long Term Care Ombudsman ( LTCO, an advocate for residents of nursing homes, assisted living facilities, and other residential care communities) when it was first reported to the Social Services Director (SSD) on 11/18/2022; and<br><br>2. The alleged Resident/Patient/Client Abuse (Resident to Resident) incident on 12/31/22 was not reported to CDPH , Ombudsman , and Law Enforcement when the incident was first reported on 12/31/22 not until 1/3/23. When Resident 24 randomly struck another Resident on the face at the hallway while alleged victim was self-propelling in wheelchair.<br><br>These failures had the potential to delay identification and implementation of appropriate corrective action and put the residents at risk for abuse.<br><br>Findings:<br><br>1. Review of Resident 196's clinical records titled, Admission Record, dated August 19, 2024, indicated Resident 196 was admitted to the facility on [DATE] with diagnoses including cerebral aneurysm (also known as brain aneurysm, a weak spot in the brain's arterial circulation that balloons and fills with blood), nonruptured, acute embolism (an obstruction of an artery, typically by a clot of blood or an air bubble) and thrombosis (clotting of the blood in a part of the circulatory system) of unspecified deep veins of right lower extremity, and bilateral (both) primary osteoarthritis [type of arthritis (painful inflammation and stiffness of the joints) more common in older people having joint pain, and after rest or inactivity, stiffness for a short period of time] of knee. Further review indicated Resident 196 was discharged on [DATE].<br><br>Review of Resident 196's quarterly minimum data set (MDS, an assessment tool), dated 12/21/2022, indicated Resident 196's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]; a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact) score was 12.<br><br>Review of Resident 196's SSD's note dated 11/18/2022, indicated, the SSD met with Resident 196 to hear a concern. Further review indicated, Res (resident) reported missing money that were brought to her by her friend .res asked to file police report .SSD educated patient about financial responsibility by choosing to manage her own finances.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 196's SSD's note, dated 12/13/2022, indicated the SSD met with Resident 196 to follow up on LTCO's visit on 12/13/2022. The LTCO instructed SSD to file the SOC 342 (a report of suspected dependent adult/elder financial abuse) regarding the reported lost money on 11/18/2022. Further review indicated, Resident stated during the interview that she does not remember the exact date of the incident, but she remembers she had reported it to the Social Worker. Translator asked the resident if the lost money she had reported to the Ombudsman was the same report she had made previously to the Social Worker and she said yes .Resident reports she has no idea how her money went missing and that it was about $345. 00<br><br>Review of the Resident 196's interdisciplinary team's [IDT, (a group of health care professionals from diverse fields who work toward a common goal for residents)] review note, dated 12/14/2022, indicated, IDT met to review resident grievance report and new report filed for possible misappropriation of funds per ombudsman request .Resident states that she left her money in an envelope on her bedside table when she went to shower and noticed later that it was gone. The new filed report for possible misappropriation of funds was the same reported by Resident 196 to SSD on 11/18/2022.<br><br>During an interview with SSD on 8/19/2024 at 11:32 a.m., SSD stated any reported lost properties should be reported right away to CDPH, LTCO and police.<br><br>During an interview with director of nursing (DON) on 8/19/2024 at 2:22 p.m., DON confirmed the reported Resident 196's lost money on 11/18/2024 and 12/13/2022 was the same incident. DON stated she was not aware that the Resident 196's reported lost money was not reported to CDPH and LTCO on 11/18/2022. DON further stated it should have been reported to CDPH and LTCO on 11/18/2022.<br><br>During an interview with the administrator (ADM) on 8/19/2024 at 4:15 p.m., ADM stated she couldn't find any documentation why Resident 196's lost money was not reported on 11/18/2022 to CDPH and LTCO.<br><br>During a review of the facility's policy and procedure titled, Abuse Investigation and Reporting, date revised July 2017, indicated, Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24 hours) if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 3. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.<br><br>46553<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of Resident 24's clinical record indicated she was initially admitted on [DATE] and had the diagnoses Dementia (term for loss of memory, language, problem -solving and other thinking abilities that are severe enough to interfere with daily life) unspecified severity with other behavioral disturbance ; major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), anxiety disorder (characterized by feeling of worry, anxiety, or fear), Epilepsy (disorder in which nerve cell activity in the brain is disturbed , causing seizure).<br><br>Review of Resident 24's quarterly BIMS score dated 5/29/24, was 7 (0-7 indicates severe cognitive impairment).<br><br>During a review of Confidential Report-Not Subject to Public Disclosure -SOC 341 faxed by the facility to the Department dated 1/3/23 which indicated Resident randomly struck another Resident in the face in station 5 hallway while he was self-propelling in wheelchair.<br><br>During a concurrent interview and record review on 8/19/24 at 3:15 p.m., with Director of Nursing (DON), stated she remember the incident and was reported late to her, it should be reported ASAP or within 2 hours to the appropriate agency. DON further stated monitoring within 72 hours.<br><br>During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated revised July 2021, indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and /or injuries of unknown source(abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulation) and thoroughly investigated by facility management. Findings of abuse investigation s will also be reported. Reporting 2. All alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involve abuse OR has resulted in serious bodily injury, or twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583<br><br>Based on observation, interview, and record review, the facility failed to develop a baseline care plan to include instructions on care of oxygen use for one of three residents (Resident 190). This failure resulted in improper level of oxygen administration for Resident 190 and had the potential to result in oxygen toxicity such as lung damage.<br><br>Findings:<br><br>Review of Resident 190's Admission Record indicated, Resident 190 was admitted to the facility on [DATE] with diagnoses including displaced (the pieces of the bone moved so much that a gap formed around the broken bone) supracondylar fracture of left femur (when the thigh bone is broken at the knee), morbid obesity (a person weighing more than 100 pounds over the ideal weight for men and 80 pounds for women) and obstructive sleep apnea (a common sleep disorder that causes breathing to pause during sleep due to a blocked or narrowed airway).<br><br>Review of Resident 190's physician's order dated 8/2/2024, indicated, Oxygen @ [at] 0.5 liter/min [liter per minute] via [thru] Nasal Cannula [NC - a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration] at bedtime, as needed.<br><br>Review or Resident 190's physician order dated 8/5/2024, indicated, the order of oxygen at 0.5 liter/min was changed to 1 liter/min at bedtime, as needed.<br><br>During an observation on 8/12/2024 at 10:25 a.m., inside Resident 190's room, Resident 190 was asleep, the oxygen's NC was in placed and the level of oxygen administration was at 1.5 liter/min.<br><br>During a concurrent interview with registered nurse D (RN D) and record review on 8/14/2024 at 1:49 p.m., RN D confirmed Resident 190 had an oxygen order since admission on 8/2/2024. RN D stated there should be a baseline care plan for Resident 190's oxygen use.<br><br>During an interview with minimum data set nurse (MDSN) on 8/15/2024 at 9:33 a.m. MDSN stated admission nurses should initiate the baseline care plan after they completed their assessment. MDSN further stated the interdisciplinary team (IDT, team composed of members from different departments involved in resident's care) should review the baseline care plan with the resident or resident's responsible party (RP, a person empowered to make decisions for the resident/ person legally responsible and liable for a decision or an action).<br><br>During a concurrent interview with MDSN and record review on 8/15/2024 at 9:39 a.m., MDSN reviewed Resident 190's baseline care plans. MDSN confirmed there was no baseline care plan regarding the oxygen use of Resident 190.<br><br>During an interview with director of nursing (DON) on 8/19/2024 at 2:12 p.m., DON stated the baseline care plan for Resident 190's oxygen use should have been developed within 72 hours of admission since oxygen use was ordered upon Resident 190's admission.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the Long Term Care Solutions postings titled, Baseline Care Plan Requirements Outlined by CMS [Centers for Medicare and Medicaid Services], date posted 5/14/2024, indicated, Long term care facilities must develop and implement a baseline care plan for each resident within 48 hours of admission . the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care, including but not limited to: initial goals based on admission orders, physician orders . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583<br><br>Based on observation, interview, and record review, the facility failed to develop and implement care plans for five of five residents (Residents 19, 66, 78, 238, and 59):<br><br>1. For Resident 19, the facility did not develop care plan for activities of daily living (ADLs, a term used to describe the basic skills needed to independently care for oneself) to address hygiene and did not implement the anticoagulant therapy (sometimes called blood thinning medicines that reduces blood clots and can cause bleeding) care plan;<br><br>2. For Resident 66, the facility did not develop care plan for Urinary Tract Infection (UTI- an illness that often start when bacteria get into the tube through which urine leaves), and the physician order of Ciprofloxacin Hydrochloride (medication for bacterial infections).<br><br>3. For Resident 78, the facility did not develop care plan for UTI and the physician order of Cephalexin Oral Capsule (medication for bacterial infections).<br><br>4. For Resident 238, the facility did not develop care plan for the use of two medication Zoloft (medication for depression) and Aripiprazole (an antipsychotic medication).<br><br>5. For Resident 59, the facility did not develop care plan for alendronate sodium (a medication to prevent bone breakdown and increase bone thickness) and for concave mattress (also called a scoop mattress, designed with raised edges, or contoured sides that 'scoop' upward, creating a barrier to help prevent users from rolling off the bed) used.<br><br>These failures had the potential to result in not having the specific care and services necessary to meet Residents 19, 66, 78, 238, and 59's needs.<br><br>Findings:<br><br>1a. Review of Resident 19's Admission Record, indicated Resident 19 was admitted to the facility with diagnoses including nondisplaced (still broken bones, but the pieces weren't moved far enough during the break to be out of alignment) intertrochanteric fracture of left femur (broken thigh bone), colles fracture of left radius (break in forearm bone, near the wrist), type 2 diabetes mellitus (DM, occurs when the body is unable to regulate glucose [sugar] in the blood), unspecified atrial flutter (a type of heart rhythm disorder in which the heart's upper chambers beat too quickly), and sheltered homelessness (people spend the night in emergency shelters or in transitional, or temporary housing). Further review indicated Resident 19 was a female.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 19's admission minimum data set (MDS, an assessment tool) assessment dated [DATE], indicated, Resident 19's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]); [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] score was 15. Further review indicated, Resident 19 required partial/moderate physical assist (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with personal hygiene and upper body dressing.<br><br>During an observation on 8/12/2024 at 10:47 a.m., at the hallway near Resident 19's room, Resident 19 was seated on a wheelchair and was able to propel self along the hallway with the used of her legs. Resident 19 was observed to have noticeable black and gray mustache and beard.<br><br>During a concurrent observation and interview with Resident 19 on 8/13/2024 at 4:30 p.m., inside Resident 19's room, she was in bed, her shirt had some food dripping stains, still with facial hair and fingernails were about half inch long with brownish substance build up underneath. Resident 19 confirmed she did not want to be shaved. Resident 19 stated, if only she had the cream to apply to her mustache and beard, it would easily fall off. Resident 19 also declined to trim her fingernails.<br><br>During an interview with licensed vocational nurse H (LVN H) on 8/16/2024 at 9:54 a.m., LVN H stated Resident 19 refused to be shaved when they attempted. LVN H confirmed Resident 19 was admitted with facial hair and it should have been care planned for staff to know how to care for Resident 19.<br><br>During an interview with director of nursing (DON) on 8/19/2024 at 2:16 p.m., DON stated Resident 19 should have a care plan for staff to know how to manage her hygiene.<br><br>During a review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting, date revised March 2023, indicated, 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) .5. Interventions to improve or maintain a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.<br><br>During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, date revised March 2023, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The care plan interventions are derived from analysis of the information gathered as part of the comprehensive assessment .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.<br><br>1b. Review of Resident 19's physician's order, dated 6/18/2024, indicated, Apixaban [Brand name: Eliquis, an anticoagulant medication] Oral Tablet 2.5 MG [milligram, unit of measurement] (Apixaban) Give 1 tablet by mouth two times a day for dvt [deep vein thrombosis, occurs when a blood clot forms in one of more of the deep vein in the body, usually in the legs] prophylaxis [the prevention of disease or the control of its spread].<br><br>(continued on next page) |

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| Watsonville Nursing Center | 535 Auto Center Drive<br>Watsonville, CA 95076 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 19's care plan titled, Anticoagulant therapy, dated 6/19/2024, interventions indicated, Daily skin inspection. Report abnormalities to the nurse. Monitor/document/report to MD [medical doctor] PRN [pro re nata, which means as needed] s/sx [signs and symptoms] of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB [shortness of breath], Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s [vital signs: blood pressure, respiration rate, temperature, heart rate].<br><br>During a concurrent interview with LVN H and record review on 8/16/2024 at 9:44 a.m., LVN H reviewed Resident 19's medication administration record (MAR). LVN H confirmed Resident 19 was taking an anticoagulant. LVN H stated, nurses should have monitored Resident 19 for any s/sx of bleeding. LVN H further stated, they usually document the monitoring of s/sx of bleeding in the MAR but LVN H confirmed it was not documented.<br><br>During an interview with interim director of nursing (IDON) on 8/16/2024 at 1:11 p.m., IDON stated, nurses should have monitored Resident 19 for s/sx of bleeding for anticoagulant use.<br><br>During an interview with DON on 8/19/2024 at 2:36 p.m., DON stated, there should be monitoring of s/sx of bleeding for Resident 19 as care planned. DON further stated, the monitoring should be documented in Resident 19's MAR.<br><br>During a review of the facility's policy and procedure titled, Anticoagulation - Clinical Protocol, date revised November 2023, indicated, The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. A. If an individual on anticoagulation therapy show signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.<br><br>46553<br><br>2. Review of Resident 66's Admission Record, indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including Encounter for Palliative Care(specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), Obstructive and reflux uropathy (a condition in which the flow of urine is blocked), personal history of malignant neoplasm (refer to an abnormal growth of tissue).<br><br>Reviewed of Resident 66's admission MDS assessment dated [DATE] indicated, Resident 66's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]); [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] score was 13.<br><br>Review of Resident 66's physician's order, dated 5/9/2024, indicated, Ciprofloxacin Hydrochloride Oral Tablet 500 MG [milligram, unit of measurement] Give 1 tablet by mouth at bedtime for status post nephrostomy (a tube that lets urine drain from the kidney through an opening in the skin on the back) placement for 2 days.<br><br>(continued on next page) |

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|---|---|---|---|
| | 055240 | A. Building<br>B. Wing | 08/19/2024 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 66's Antibiotic Time Out Record, indicated with presenting clinical symptoms of UTI, positive Morganella Morganii (a gram -negative considered as an unusual opportunistic pathogen [organism or agent that can produce disease] that mainly causes post-operative wound and urinary tract infections.<br><br>During a record review of Resident 66's clinical records, no care plan was developed for UTI and for the medication Ciprofloxacin Hydrochloride Oral Tablet 500 MG.<br><br>During a concurrent interview and record review on 8/15/24 at 10:30 a.m., with Minimum Data Set Nurse (MDSN), she confirmed no care plan was develop for Urinary Tract Infection (UTI an illness that often start when bacteria get into the tube through which urine leaves) and the medication Ciprofloxacin Hydrochloride. MDSN stated I don't see a care plan for the UTI. There should be a care plan for UTI and the use of Ciprofloxacin HCL.<br><br>3. Review of Resident 78's Admission Record, indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including Fractured of Shaft (a long slender cylindrical [ a tubular form] body or part) of Right Femur, Asthma (a condition in which a person's airway become inflamed, narrow, and swell, and produce extra mucus, which makes it harder to breath. Hypertension (a condition in which the force of the blood against the artery walls is too high. Bilateral primary osteoarthritis of hips (the cartilage in the hip joint gradually wears away over time), pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral region.<br><br>Reviewed of Resident 78's quarterly MDS assessment dated [DATE] indicated, Resident 78's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]); [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] score was 8.<br><br>Review of Resident 78's physician's order, dated 5/30/2024, indicated, Cephalexin Oral Tablet 250 mg Give 2 capsule by mouth every 8 hours for UTI for 5 days.<br><br>During a record reviewed of Resident 78's electronic Medication Administration Record (eMAR) for the month of May 2024. Resident 78 received the medication from 5/30/24, 5/31/24, 6/1/24, 6/2/24, 6/3/24, 6/4/24 Time 06:00, 14:00, 22:00.<br><br>During a record reviewed of Resident 78's clinical records, no care plan was developed for UTI and for the medication order of Cephalexin Oral Capsule.<br><br>During a concurrent interview and record review on 8/15/24 at 10:37 a.m., with MDSN, she confirmed no care plan was developed for UTI and the medication Cephalexin. MDSN stated Care plan are initiated upon admission, then we update the care plan.<br><br>During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person Centered, dated revised March 2023, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical psychosocial and functional needs is develop and implemented for each resident.11. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Review of Resident 238's Admission Record, indicated Resident 238 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder (characterized by feelings of worry, or fear that interfere with one's daily activities), Dementia (loss of cognitive functioning-thinking, remembering, and reasoning) and Depression (condition of mental and behavioral disorder that causes intense shifts in mood, energy levels, thinking patterns and behavior).<br><br>During record review of Resident 238's Order Summary Report for the month of August 2024, Resident 238 has physician order for Aripiprazole Oral Tablet 20 mg (Aripiprazole) Give 1 tablet by mouth one time a day manifested by (m/b) verbalization of sadness verified informed consent signed by MD (Medical Doctor) and Zoloft Oral Tablet 50 mg ( Sertraline HCL ) Give 1 tablet by mouth one time a day for Depression and Anxiety m/b verbalization of sadness; Informed consent obtained and signed by MD with order date of 7/26/24.<br><br>During a record review of Resident 238's clinical records, no care plan was developed for the medication order of Zoloft and Aripiprazole.<br><br>During a concurrent interview and record review on 8/15/24 at 3:15 p.m., with MDSN, she confirmed no care plan was develop for the used of the medication Zoloft and Aripiprazole. MDSN stated any order should be care plan for both medication Zoloft and Aripiprazole (Abilify).<br><br>During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person Centered, dated revised March 2023, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident. 10. When possible, interventions addresses the underlying source(s) of the problem area(s), not just symptoms or trigger. 11. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.<br><br>50855<br><br>5a.<br><br>During a review of Resident 59's Admission Record on 08/16/24 at 09:03 a.m., Indicated, Resident 59 was admitted to the facility on [DATE] with diagnoses includes Contracture(a condition of shortening and hardening of muscles, tendons, or other tissue) of left knee, Hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), asthma (A condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe). Uncomplicated,<br><br>Vitamin D deficiency (don't have enough vitamin D in your body)<br><br>During a review of Resident 59's clinical record indicated, he has a physician order dated, 02/09/2024 Alendronate sodium oral tablet 70 milligram (mg) give one tablet by mouth one time a day every thu (Thursday) for osteoporosis (A condition in which bones become weak and brittle). There was no care plan developed for Osteoporosis and alendronate.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review with the Interim Director of Nursing (IDON) on 08/16/24 at 01:34 p.m., IDON stated, Resident 59 has no care plan developed for Osteoporosis, it should have a care plan in place for osteoporosis.<br><br>5b.<br><br>During an observation on 08/12/24 at10:47 a.m., Resident 59 was lying on bed, using concave mattress with 1/4 bilateral (Both Side) rails up, Watching TV.<br><br>During a concurrent observation and interview with Interim Director of Nursing (IDON) on 08/14/24 at 10:57 a. m., IDON stated, Resident 59 use the concave mattress, there should be a physician order and it should be care planned.<br><br>During a concurrent interview and record review with Interim Director of Nursing (IDON)on 08/14/24 at 11:00a.m., IDON stated, Resident 59 has no concave mattress care plan. IDON stated, not sure why resident 59 is using a concave mattress with bed rails, will find out and comeback to you.<br><br>During a concurrent interview and record review with Infection Prevention (IP) and Interim Director of Nursing (IDON) on 08/14/24 at 01:28 p.m., IP stated, it's a reminder for Resident 59 not to fall out of bed, it is a fall intervention, and it should be care planned. IP confirmed Resident 59 has no care plan related to the use of concave mattress.<br><br>Review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person Centered, dated revised March 2023, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident. 10. When possible, interventions addresses the underlying source(s) of the problem area(s), not just symptoms or trigger. 11. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583<br><br>Based on observation, interview, and record review, the facility failed to ensure that proper care and treatment services for oxygen (O2) was provided for three of three sampled residents (Residents 190, 18 and 36) when:<br><br>1.Resident 190's physician'a order for oxygen administration was not followed and the Oxygen in Use sign was not visible to all passersby (staff, residents and visitors);<br><br>2.Resident 18's physician's order for oxygen administration was not followed; and<br><br>3.Resident 36's physician's order for oxygen administration was not followed.<br><br>These failures had the potential to result in complications related to improper treatment while receiving O2 therapy.<br><br>Findings:<br><br>1a. Review of Resident 190's Admission Record indicated, Resident 190 was admitted to the facility on [DATE] with diagnoses including displaced (the pieces of the bone moved so much that a gap formed around the broken bone) supracondylar fracture of left femur (when the thigh bone is broken at the knee), morbid obesity (a person weighing more than 100 pounds over the ideal weight for men and 80 pounds for women) and obstructive sleep apnea (a common sleep disorder that causes breathing to pause during sleep due to a blocked or narrowed airway).<br><br>Review or Resident 190's physician's order dated 8/5/2024, indicated, the order of oxygen at 0.5 liter/min was changed to 1 liter/min at bedtime, as needed.<br><br>During an observation on 8/12/2024 at 10:25 a.m., inside Resident 190's room, Resident 190 was asleep with O2 at 1.5 liter/min (liter per minute) via (thru) nasal cannula (NC - a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration).<br><br>During a concurrent interview with registered nurse D (RN D) and record review on 8/14/2024 at 1:46 p.m., RN D reviewed Resident 190's oxygen order. RN D confirmed there was an order for oxygen administration at 1 liter/min at bedtime, and as needed.<br><br>During another concurrent interview with RN D and review on 8/14/2024 at 2:00 p.m., RN D reviewed Resident 190's level of oxygen administration taken on 8/12/2024. RN D confirmed Resident 190's level of oxygen administration on 8/12/2024 was at 1.5 liter/min. RN D stated nurses should follow the level of oxygen administration as ordered by the physician.<br><br>1b. During a concurrent observation and interview with registered nurse M (RN M) on 8/12/2024 at 11:16 a.m. , outside Resident 190's room, in front of the door, the Oxygen in use sign was observed posted under the Enhanced Barrier Precaution signage. RN M confirmed above observation. RN M stated the Oxygen in use sign should be posted visible to all staff, visitors, and residents.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with director of nursing (DON) on 8/19/2024 at 2:07 p.m., DON stated the Oxygen in Use posting should be visible and usually posted by the resident's door.<br><br>2.Review of Resident 18's Admission Record indicated, Resident 18 was admitted to the facility with diagnoses including congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), acute (present or experienced in a severe degree) and chronic (persisting for a long time or constantly recurring) respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide) with hypoxia (occurs when oxygen level in the body organs are low), encounter palliative care (a type of medical care that helps people with serious illnesses and their families improve their quality of life), and obstructive sleep apnea.<br><br>Review of Resident 18's physician's order dated 8/9/2024, indicated, Oxygen @4 liter/min via Nasal Cannula continuously every shift.<br><br>During an observation on 8/12/2024 at 10:30 a.m., inside Resident 18's room, Resident 18 was asleep and was on oxygen at 4.5 liter/min via NC.<br><br>During a concurrent interview with RN D and record review on 8/14/2024 at 1:50 p.m., RN D reviewed Resident 18's oxygen order. RN D confirmed Resident 18's oxygen order was supposed to be at 4 liter/min. At 1:54 p.m., RN D reviewed the picture of Resident 18's oxygen level of administration taken on 8/12/2024. RN D confirmed Resident 18's oxygen administration on 8/12/2024 was at 4.5 liter/min.<br><br>3. Review of Resident 36's Admission Record indicated, Resident 36 was admitted to the facility with diagnoses including cerebrovascular disease (referred to as stroke), chronic congestive heart failure, chronic obstructive pulmonary disease (COPD - a long lasting lung disease), and morbid obesity.<br><br>Review of Resident 36's physician's order dated 8/15/2024, indicated, an order for oxygen use at 3 liter/min as needed only for shortness of breath.<br><br>During an observation on 8/12/2024 at 11:00 a.m., inside Resident 36's room, Resident 36 was asleep and had an oxygen in placed at 3.5 liter/min via NC.<br><br>During a concurrent interview with RN D and record review on 8/14/2024 at 1:51 p.m., RN D reviewed Resident 36's oxygen order. RN D confirmed Resident 36's oxygen order should be at 3 liter/min.<br><br>During a concurrent observation and interview with RN D on 8/14/2024 at 1:56 p.m., inside Resident 36's room, Resident 36 was seated at the edge of his bed with oxygen in placed at 3.5 liter/min via NC. RN D confirmed above observation and stated nurses should follow the level of oxygen administration ordered by the physician.<br><br>During an interview with minimum data set nurse (MDSN) on 8/15/2024 at 9:50 a.m., MDSN stated nurses should follow the doctor's order and they should check the order first prior to administration of oxygen.<br><br>During an interview with DON on 8/19/2024 at 2:07 p.m., DON stated nurses should check doctor's order first prior to administration of oxygen whether the order was as needed or a routine order.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure titled, Oxygen Administration, date revised February 2024, 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 the facility protocol for oxygen administration .Place an Oxygen in Use sign in a designated place on or over the resident's bed. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46553<br><br>Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of the bed) for 2 of 24 sampled residents (residents who used bed or side rails), (Residents 39, and 78) when:<br><br>1. There was no physician orders obtained prior to the use of bed rails for Residents 39 and 78;<br><br>2. There was no side rail assessment completed prior to the use of side rails for residents 39 and 78; and<br><br>3. There were no side rail care plans for Residents 39 and 78.<br><br>These failures had the potential to place the residents at risk of entrapment and serious injury.<br><br>Findings:<br><br>1. During an observation on 8/12/24 at 10:15 a.m., inside Resident 78's room, Resident 78 was seated on a wheelchair and her bed was observed with 1/4 bilateral siderails.<br><br>Review of Resident 78's Side Rails Utilization Assessment, dated 7/18/24, indicated there was no documentation and was blank. There was no physician's order for side rails, and care plan regarding the use of side rails.<br><br>During a concurrent interview and record review on 8/15/24 at 3:07 p.m., with Minimum Data Set Nurse (MDSN), stated the Side Rail Utilization Assessment -V 4 was updated on 8/14/24. She further stated it was brought to her attention that the record was inaccurate, and it was not in used and she update it.<br><br>During a concurrent interview and record review on 08/14/24 at 11:30 a.m., with Interim Director of Nursing (IDON), the IDON stated and confirmed there was no physician order for use of 1/4 bilateral side rail and, no side rail current care plan for Resident 78. IDON further stated they should have a physician order and care plan to use side rails.<br><br>50855<br><br>During an observation on 08/12/24 09:38 a.m., Resident 39 was lying in bed with 1/4 mid bilateral (middle both sides) rails.<br><br>During a review of Resident 39's face sheet (FS: a document that gives a resident's information at a quick glance) indicated, Resident 39 was readmitted to facility on 02/22/23. diagnoses includes Chronic obstructive pulmonary disease (COPD, long-term lung disease that makes it hard to breathe), Diabetes Mellitus Type 2 (condition in which the body has trouble controlling blood sugar). Morbid (severe) obesity due to excess calories (body mass index of 40 or higher).<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 39's Clinical record on 08/13/24 at 09:34 a.m., there was no order for 1/4 mid bilateral rails and no care plan for side rails. The Side rails utilization assessment dated [DATE] indicated, side rails are not in use or requested.<br><br>During a concurrent observation and interview with Interim Director of Nursing (IDON) on 08/14/24 at 10:30 a.m., IDON stated, Resident 39 use the 1/4 mid bilateral side rails for repositioning, helps with Activity of daily living (ADL's), also help him with transferring.<br><br>During a concurrent interview and record review with Interim Director of Nursing (IDON) on 08/14/24 at 10:42 a.m., IDON stated, Resident 39 has no physician order for side rails, no current care plan, Side rails utilization assessment indicate, side rails are not in use or requested. IDON stated, prior to installation of side rails it should have Consent, Physician order, Rehab assessment, side rail assessment, and care plan.<br><br>During a review of the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, date revised August 2023, indicated, Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of Bed rails is prohibited unless the criteria for use of bedrails have been met. Use of Bed Rails 2. The use of bed rails or side rails (including temporarily raising the side rails for ) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, resident assessment, and informed consents. |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345<br><br>Based on interview, and record review, the facility failed to provide sufficient social services for one out of three sampled residents (Resident 44) when follow up psychological evaluation was not arranged.<br><br>This failure had the potential to result in unmet psychosocial care needs.<br><br>Findings:<br><br>A review of Resident 44's face sheet (a document that includes pertinent resident information and medical diagnoses) indicated, Resident 44 was admitted on [DATE] with diagnoses including Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and catatonic schizophrenia (a rare and severe mental disorder that's characterized by extreme changes in movement, behavior, and communication).<br><br>During a concurrent interview and record review on 8/14/24 at 11:42 a.m. with the Interim Director of Nursing (IDON), IDON confirmed there was only one psychological evaluation done for Resident 44 since admission. IDON confirmed the only psychological evaluation recorded on Resident 44's progress notes was dated 3/1/23 at 3:00 p.m.<br><br>During a concurrent interview and record review on 8/16/24 at 1:01 p.m. with the Social Services Director (SSD), SSD stated her responsibilities include scheduling follow up appointments for residents. SSD confirmed Resident 44 only had one psychological evaluation done since admission. SSD confirmed the progress notes dated 3/12/24 at 4:04 p.m. indicated that SSD called to schedule a follow up psychological evaluation for Resident 44. However, SSD confirmed that the clinician assigned to resident was on leave. SSD confirmed it had been five months since she had called to schedule an appointment for Resident 44. SSD stated that follow up call should have been made and appointment for psychological evaluation should have been scheduled for Resident 44.<br><br>During an interview on 8/19/24 at 2:07 p.m. with Director of Nursing (DON), DON stated residents with psychological diagnoses were usually seen by a clinician monthly or every two weeks. DON confirmed that SSD is responsible for scheduling and setting up follow up appointments for residents. DON also stated that SSD should have followed up on scheduling an appointment for psychological evaluation for Resident 44.<br><br>A review of facility's undated document titled Director of Social Services, essential duties and responsibilities of SSD included but is not limited to Discharging, appointment setting and arranging transportation for resident. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583<br><br>Based on interview and record review the facility failed to ensure one of two sampled residents (Resident 46) was free from unnecessary medication when the facility failed to provide sufficient documentation to support a diagnosis of Dementia (decline in mental capacity affecting daily function) with psychotic (A mental disorder characterized by a disconnection from reality) disturbance m/b (manifested by) paranoia (An unrealistic distrust of others or a feeling of being persecuted) in one of two sampled residents for unnecessary medication (Resident 46.)<br><br>This deficient practice increased the risk of Resident 46 to receive unnecessary medication.<br><br>Findings:<br><br>During a review of Resident 46's Admission Record on 08/14/24 at 02:11 p.m., indicated, Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses includes Hemiplegia (one-sided weakness) and Hemiparesis (one-sided paralysis), Depression unspecified (constant feeling of sadness and loss of interest, which stops you doing normal activities), Vascular dementia (term describing problems with reasoning, planning, judgment, memory, and other thought processes) severe with other behavioral disturbance.<br><br>During a review of Resident 46's Physician Order dated, 6/18/24 indicated, an order for Quetiapine fumarate Brand name: Seroquel, Antipsychotic medications (type of prescription psychiatric drug to treat symptoms of psychosis and other mental health conditions) 25 milligram (mg) tablet give 2 tablet by mouth at bedtime for dementia with psychotic disturbance m/b paranoia, believes others are out to get him.<br><br>During a review of Resident 46's Hospital Physician notes dated, 5/04/24 indicated, history of dementia continue with home medication, Nursing home placement, started on Seroquel to help with agitation.<br><br>During a review of Resident 46's Facility Physician notes dated, 6/19/24 indicated, Vascular dementia - with recent worsening of mental status likely due to dehydration, and hypernatremia (level of sodium in blood is too high). Cont. Seroquel for agitation.<br><br>During a review of Resident 46's Facility Physician notes dated, 7/14/24 indicated, Vascular dementia - with recent worsening of mental status likely due to dehydration, and hypernatremia. Cont. Seroquel for agitation.<br><br>During a review of Resident 46's Facility Physician notes dated, 8/01/24 indicated, Vascular dementia - back to baseline. Cont. Seroquel for agitation.<br><br>During an interview with Medical Records Director on 08/16/24 at 03:00 p.m., MRD stated, Resident 46 has no psychiatrist (physicians who specialize in mental health) notes, and he is not being followed by a psychiatrist.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review with Director of Nursing (DON) on 08/19/24 at 02:59 p.m., Resident 46's Physician notes dated, 8/01/24 indicated, Vascular dementia - back to baseline. Cont. Seroquel for agitation. DON Stated, no active diagnosis and no psychiatrist notes to support the indication of Seroquel for dementia with psychosis disturbance m/b paranoia, the indication should be vascular dementia with other behavioral disturbance, it should be clarified with the Doctor.<br><br>During a review of facility's policy and procedure (P&P) titled, Review of Psychotropic Medication Use/Informed Consent, dated March 2024, the P&P indicated, Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>46553<br><br>Based on observation, interview, and record review, the facility had a medication error rate of 5.88% when two medication errors occurred out of 34 opportunities during the medication administration for one of four residents (Residents 58). Residents 58 did not receive the medications as ordered. These failures resulted in medications not given according to the physician's orders and had the potential for Resident 58 not receiving the full therapeutic effects of the medications.<br><br>Finding:<br><br>1. During a medication administration observation and interview on 8/13/24 at 9:35 a.m., with Licensed Vocational Nurse (LVN) C, she was observed giving several medications to Resident 58 including a bottle of Zaditor Ophthalmic Solution (Ketotifen Fumarate (Ophth) Eye drops. Upon checking the medication, she verified there was no open date on the Zaditor eye drop. She confirmed the eye drop should have an open date on the bottle of the eye drop. LVN C further stated she will inform and ask the physician to give a new order for Zaditor.<br><br>During a review of Resident 58's physician's order dated 2/19/24, indicated Zaditor Ophthalmic Solution (Ketotifen Fumarate (Ophth) Instill 1 drop in both eyes two times a day for Eye itchiness Strength of medication 0.025%.<br><br>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated revised April 2023, indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber order, including any required time frame. 10. The expiration /beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.<br><br>2. During a medication administration observation on 8/13/24 at 10:25 a.m., with LVN C, she administered several medications to Resident 58 including Levetiracetam (Brand name Keppra used to treat seizure). The stock dose was Levetiracetam 500 mg tab, Generic for Keppra 500 mg tab. Give 3 tablet s (1500 mg) by mouth two times a day for Clonic Seizure. LVN C administered 3 tablets of Levetiracetam 500 mg tab.<br><br>Review of Resident 58's clinical record indicated Resident 58 had a physician's order, dated 8/1/24, for Keppra Oral Tablet 2000 milligram (mg) by mouth every 12 hours for GENERALIZED IDIOPHATIC EPILEPSY AND EPILEPTIC.<br><br>During a concurrent interview and record review on 814/24 on 11:25 a.m., with LVN K, LVN K verified the order was Keppra Oral Tablet 2000 milligram (mg) by mouth every 12 hours for GENERALIZED IDIOPHATIC EPILEPSY AND EPILEPTIC, and the blister pack was Keppra 1500 mg to give 3 tab. LVN K confirmed the order was Keppra oral tab 1000 mg - give 2000 mg by mouth every 12 hours for generalized idiopathic Epilepsy and Epileptic.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated revised April 2023, indicated, Medications are administered in a safe and timely manner, and as prescribed. 7. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>46553<br><br>Based on observation, interview, and record review, the facility failed to ensure expired medications were removed, and medications were labeled and stored according to manufacturer's instructions for two out of three medication rooms and two out of three medication carts when:<br><br>1. There was an outdated vial (cylindrical container) of tuberculin (liquid used to test for tuberculosis) in the medication refrigerator in med storage CC;<br><br>2. There was an open, unlabeled Ozempic (medication used to lower blood sugar) injection pen in the medication refrigerator in med storage CC;<br><br>3. There were three medications in med cart BB that were not refrigerated as ordered;<br><br>4. There were two outdated antiperspirants and one outdated biohazard spill kit (a collection of materials used to clean up blood, vomit, mucus, saliva, and other bodily fluids) in med storage CC;<br><br>5 Two over the counter (OTC) eye medication bottles, for two residents were identified in the medication cart; and<br><br>6. A medication Eplerenone 25 mg tablet on the blister pack label was not the same order as the physician order.<br><br>These deficient practices had the potential for residents to receive medications with reduced potency and had the potential to result in medication errors.<br><br>Findings:<br><br>1. During an observation of med storage CC and concurrent interview with Licensed Vocational Nurse K (LVN K) on 8/12/24, at 2:00 p.m., there was a vial of Tuberculin in the medication refrigerator. The container for the Tuberculin vial had an open date of 7/3/24. The instructions printed on the container indicated to discard 30 days after opening. LVN K confirmed this observation and acknowledged the vial of Tuberculin was outdated.<br><br>During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the 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 the manufacturer specified a shorter or longer date for the open vial.<br><br>2. During an observation of med storage CC and concurrent interview with LVN K on 8/12/24, at 1:56 p.m., there was one open Ozempic injection pen in the medication refrigerator. The box was labeled with the resident's name, but the Ozempic injection pen itself was unlabeled. LVN K verified this observation and acknowledged that if the box were lost or destroyed, the unlabeled Ozempic injection pen had the potential to result in a medication error.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage dated 2/2023, the P& P indicated, 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.<br><br>3a. During an observation and concurrent interview with LVN A on 8/14/24, at 3:30 p.m., there were two unopened bottles of latanoprost ophthalmic solution 0.005% eye drops (medication used to treat glaucoma) in med cart BB. The instructions printed on the medication packaging indicated, REFRIGERATE. LVN A confirmed this observation and acknowledged the medication was not refrigerated.<br><br>3b. During an observation and concurrent interview with LVN A on 8/14/24, at 3:45 p.m., there was an unopened Insulin Glargine U 100 pen (medication used to lower blood sugar) in med cart BB. The instructions printed on the medication packaging indicated, REFRIGERATE. LVN A confirmed this observation and acknowledged the medication was not refrigerated.<br><br>3c. During a concurrent medication cart inspection and interview on 8/14/24 at 3:45 p.m., with LVN Q, an unopened Insulin Humalog 100-unit pen was on the med cart EE drawer not stored in the refrigerator. On the medication packaging indicated REFRIGERATE, LVN Q verified the medication was not opened and not stored in refrigerator. LVN Q stated it should be refrigerated if not yet in use.<br><br>During an interview with the Interim Director of Nursing (IDON) on 8/16/24, at 1:55 p.m., the IDON stated if the facility receives new medications from the pharmacy, the medications should be refrigerated and not removed until used.<br><br>During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage dated 2/2023, the P&P indicated, 6. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location. Medications are stored separately<br><br>4. An inspection of the medication storage CC, was conducted with LVN L on 8/12/24, at 2:06 p.m., as follows:<br><br>a. An unopened plastic of Biohazard (a biological substance that poses a threat to the health of living organism, primarily that of human) Spill Kit (used to handle liquid biohazards like blood) with expiration date of 03/13/21. LVN L confirmed that was expired and not being used.<br><br>b. Two bottles of anti -perspirant deodorant spray with expiration of 06/24. LVN L confirmed that was expired and stated those are part of house supply.<br><br>During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated, Medication Ordering and Receiving from Pharmacy, dated April 2024, the P&P indicated, Medication are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy can modify or change prescription labels.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. During a concurrent medication cart BB inspection and interview with LVN A on 8/14/24 at 3:38 p.m., two over the counter (OTC) eye medication bottles, for two residents were identified in the medication cart: 2 bottles of Artificial Tears (for eye lubrication). The eye drops were labeled (handwritten) with only residents' room number and date open on the carton. They had no residents' names on the eye drop. LVN A verified the findings and acknowledge patients have room change from time to time, and the labeling had the potential for the resident to receive this medication in error. She further stated the medication should have a name on the bottles.<br><br>During an interview on 8/16/24 at 2:00 p.m., with Interim Director of Nursing (IDON), stated room number is not acceptable, because there are times room changes. The name of resident and date open should be in the bottle itself.<br><br>During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, dated April 2024, the P&P indicated, Medication are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy can modify or change prescription labels. A. Labels are permanently affixed to the outside of the prescription container. No medication is accepted with the label inserted into a vial. If a label does not fit directly on the product, e.g., eye drops, the label may be affixed to an outside container or carton, but the resident 's name, at least, must be maintained directly on the actual product.<br><br>6. During a concurrent medication cart AA inspection and interview with LVN K on 8/14/24 at 11:17 a.m., a medication Eplerenone 25 mg tablet on the blister pack label Take 1 tablet (25 mg total) by mouth daily with medication order of Eplerenone Oral Tablet 50 MG (Eplerenone) Give 1 tablet by mouth one time a day for Hypertension (HTN) HOLD for SBP under 110. LVN K verified the medication order was Eplerenone 50 mgs. LVN K acknowledge it can cause medication error.<br><br>During an interview on 8/16/24 at 1:52 p.m., with IDON, she stated nurses giving medication pass should follow the 5 Rights, making sure the bubble pack is right and compared with the physician order.<br><br>During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, 7. If medication container has missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instruction |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>49345<br><br>Based on observation and interview, the facility failed to ensure the dietary staff had the appropriate competencies and skills set to carry out the functions of the food and nutrition services when:<br><br>1. A pair of tongs with visual residues was found in the kitchen drawer;<br><br>2. Dietary cook E (DC E) was not able to state the cool down process; and<br><br>3. Dietary aide G (DA G) did not demonstrate the correct process of checking the chemical sanitation concentration of the dish machine.<br><br>These failures had the potential to negatively impact the facility's ability to ensure foods were prepared in competent and efficient manners that prevent food borne illnesses.<br><br>Findings:<br><br>1. During the initial kitchen tour on 8/12/24 at 9:32 a.m. with Registered Dietician (RD) and Dietary Supervisor (DS), a pair of tongs with residual substance was found inside a kitchen drawer. DS stated it should not be stored in the drawer if there were visible residual substance. DS then took the pair of tongs and asked another staff to have it washed.<br><br>A review of facility's policy and procedure (P&P) titled Sanitization revised on October 2008, the P&P indicated 2. All utensils .shall be kept clean .<br><br>2. During an interview on 8/12/24 at 2:07 p.m. with DC E in the facility kitchen, DC E was asked about the cool down process of food. DC E stated I don't know.<br><br>A review of facility document titled In-Service Meeting Minutes dated 4/12/24, indicated, RD was the lecturer of the in-service with the topic Food Temperature/Danger Zone. Summary of lecture indicated, Discussed temperature danger zone, hot and cold temps for food safety. Food temps prior to food service and proper reheating techniques. The document indicated that DC E attended the in-service. A page titled Cooling Food included in the document indicated the steps of the cool down process.<br><br>3. During a concurrent observation and interview on 8/13/24 at 3:48 p.m. with DA G and DS, DA G was asked to demonstrate the correct process of checking the chemical concentration of the facility dish machine. DA G took a test strip (measure the concentration of sanitizer) and stuck the strip on the running water coming out of the metal drain from the dish machine. DA G then compared the tip of the strip that turned into a purplish color onto the plastic vial that indicated multiple colors with corresponding numerical values. DS stated, We test the strip right on the plate and not from the drain.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of facility document titled In-Service Meeting Minutes dated 4/15/24, indicated, RD was the lecturer of the in-service with the topic Dishwasher. Summary of lecture indicated, How to test sanitation concentration. Check temps and daily record. When to test and how often. The document indicated that DA G attended the in-service. An untitled page included in the document indicated, Check chemicals! Steps on how to check the chemical concentration of dish machine was not included in the document.<br><br>Manufacturer's recommendation document was requested but was not provided. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>49345<br><br>Based on observation, interview, and record review, the facility failed to ensure recipe was followed for puree diet.<br><br>This failure had the potential to not meet adequate nutritional value and nutritional requirements for the residents.<br><br>Findings:<br><br>During a concurrent observation and interview on 8/13/24 at 11:42 a.m. in the facility kitchen with Dietary Aide (DA) F and Registered Dietician (RD), DA F was preparing pureed bread. DA F put a cut whole loaf of bread in the food processor machine. DA F then transferred the processed bread in a rectangular steel container. DA F brought the metal container under the hot water machine and let the water run onto the container. When DA F was asked how much water must be added onto the mixture, DA F stated, I don't measure water. RD stated Typically, we have a recipe, but we are also watching for consistency.<br><br>A review of facility provided menu for Pureed Bread indicated, Scratch method: Place portions of bread/margarine into a food processor, process to fine crumbs. For every 5 portions needed, add 1 cup of warm milk or water . |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure the food was prepared by methods that conserved nutritive value and appearance when eight out of 18 resident sample (Residents 51, 6, 26, 20, 17, 192, 59, and 41) stated facility food was served cold without flavor and not at the appropriate texture.<br><br>These deficient practices had the potential to decrease the food intake of residents and negatively impact their nutritional status.<br><br>Cross Reference F803<br><br>Findings:<br><br>During an interview on 8/12/24 at 10:12 a.m. with Resident 51, Resident 51 stated food is not very good and had no taste.<br><br>During an interview on 8/12/24 at 10:15 a.m., with Resident 6, Resident 6 stated that food was absolutely horrible.<br><br>During an interview on 8/12/24 at 10:23 a.m. with Resident 26, Resident 26 stated food was inedible, and meat was tough.<br><br>During an interview on 8/12/24 at 10:34 a.m., with Resident 20 and Resident 17, Resident 20 stated that meatloaf was bland and had no seasoning. Resident 17 stated she was served fried egg that was hard to cut with a knife. Resident 17 also stated that on weekends, foods served were not to Resident 17's liking.<br><br>During an interview on 8/12/24 at 10:46 a.m., with Resident 192, Resident 192 stated food was horrible and was hard to chew.<br><br>During an interview on 8/12/24 at 10:47 a.m., with Resident 59, Resident 59 stated that chicken was too dry.<br><br>During an interview on 08/13/24 at 11:33 a.m. with Resident 41, Resident 41 stated, Food is bad and sometimes cold.<br><br>A test tray evaluation was conducted due to resident complaints on 8/13/24 at 1:39 p.m. with Registered Dietician (RD) and Dietary Supervisor (DS) for the regular and puree meals. The meal was tested for taste, temperature, and palatability. The chicken and vegetables for both textures tasted bland. The pureed chicken was dry. The pureed bread was bland. The food temperatures were: pureed vegetables, 114.1 Fahrenheit (F, unit of temperature measurement), pureed bread, 118 F, pureed chicken 113.9 F, pureed rice, 117.4 F, regular chicken 112.9 F, regular rice, 116.5 F, and cold milk, 50.8 F.<br><br>(continued on next page) |

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|---|---|---|---|
| | 055240 | A. Building<br>B. Wing | 08/19/2024 |

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| Watsonville Nursing Center | 535 Auto Center Drive<br>Watsonville, CA 95076 |

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|---|---|
| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of facility document titled In-Service Meeting Minutes dated 4/12/24, indicated, RD was the lecturer of the in-service with the topic Food Temperature/Danger Zone. Summary of lecture indicated, Discussed temperature danger zone, hot and cold temps for food safety. Food temps prior to food service and proper reheating techniques. The document indicated, Cold food items need to be at 41 or below. Hot food items need to be at 135 or above.<br><br>According to the New Dining Practice Standards dated in 2011 by the [NAME] Regulatory Task Force, food and dining requirements are core components of quality of life and quality of care in nursing homes .<br><br>50855 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>49345<br><br>Based on observation, interview and record review, the facility failed to store and prepare food under sanitary conditions in accordance with professional standards when:<br><br>1. Steel trays with black stains were found inside the kitchen freezer;<br><br>2. The ice machine had black substance build up found inside and yellow stain on the baffle;<br><br>3. Dietary staffs did not wear hairnet/beard restraints while inside the facility kitchen and;<br><br>4. Facility did not follow their policy and procedure regarding labeling of foods brought in by family or visitors for one out of two sampled residents (Resident 237).<br><br>These failures had the potential to expose residents to contaminants that could cause foodborne illness.<br><br>Findings:<br><br>1. During the initial kitchen tour on 8/12/24 at 9:44 a.m. with Dietary Supervisor (DS), two steel trays with visible black stains on the edges were found inside the facility freezer. DS took out the trays from the freezer.<br><br>A review of facility's policy and procedure titled Sanitization revised October 2008, the P& P indicated, 2. All utensils, counters, shelves and equipment shall be kept clean and maintained in good repair<br><br>2. During a concurrent observation and interview on 8/12/24 at 2:15 p.m. with Registered Dietician (RD), the facility ice machine had black substance build up inside. RD stated that housekeeping department cleans the ice machine once every month and a contracted company comes every six months to check and clean the ice machine as per manufacturer guidelines.<br><br>During a concurrent observation and interview on 8/12/24 at 2:41 p.m. with Housekeeping Manager (HKM) and Maintenance Supervisor (MS), HKM opened the top part of the ice machine and took out the baffle. HKM and MS confirmed yellow stain and black substance build up were observed along the edges of the baffle. HKM stated that housekeeping department cleans the ice machine once a month.<br><br>A review of facility's policy and procedure (P&P) titled Sanitization revised October 2008, P&P indicated, Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy<br><br>3. During an observation on 8/12/24 at 2:03 p.m. with DS in the facility kitchen, DS confirmed Dietary [NAME] (DC) E, had a head cap on and hair was not fully covered, Dietary Aide (DA) J wore a head cap, long hair in loose braid without hairnet and Dietary Aide (DA) F had facial beard exposed without covering. DS stated they should have worn a hairnet and beard must be covered.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 8/12/24 at 2:22 p.m. with DA F, DA F stated Sometimes, I forget to cover my beard.<br><br>A review of facility document titled In-Service Meeting Minutes dated 4/12/24, indicated, RD was the lecturer of the in-service with the topic Hair Restraint and Fingernail/Hand Hygiene. Summary of lecture indicated, Proper use of hairnets, caps, and beardguards during food prep, service and all duties within the kitchen. Appropriate fingernail length and coatings. The document also indicated, .Hairnets or other hair restraints need to cover all hair to prevent it falling into food and other contact surfaces. Hat comes off hairnet goes on!!! .Staff who have facial hair need to wear a beard restraint. DC E, DA J and DA F were listed as attendees of the in-service.<br><br>A review of facility's policy and procedure (P&P) titled Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices revised October 2017, the P&P indicated, 12. Hair nets, caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.<br><br>4. During a concurrent observation and interview on 8/19/24 at 10:39 a.m. with Licensed Vocational Nurse (LVN) K of a facility refrigerator which stored foods brought-in by resident's relatives, LVN K confirmed a re-sealable bag of cooked French fries had a written date of 8/17/24 and Resident 237's name. LVN K also confirmed another re-sealable bag of cooked chicken strips with written date of 8/17/24 had Resident 237's name. LVN K stated the written date on both bags was the date on when it was received. LVN K stated they usually keep brought- in foods for three days.<br><br>During a concurrent interview and record review on 8/19/24 at 2:37 p.m. with Director of Nursing (DON), DON confirmed that according to facility's policy and procedure regarding brought-in foods, brought-in foods should be labeled with the date on when it should be discarded. DON agreed they should follow the facility policy and procedure.<br><br>A review of facility's policy and procedure (P&P) title Foods Brought by Family/Visitors revised December 2021, the P&P indicated, Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the 'use by' date (maximum of 72 hours). |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>44583<br><br>Based on observation, interview, and record review, the facility failed to implement infection control practices when:<br><br>1. Certified nursing assistant N (CNA N) and certified nursing assistant O (CNA O) did not perform hand hygiene when serving lunch trays;<br><br>2. Resident 187's nebulizer mask (a device used to convert a drug from liquid form into a mist, inhaled through the mask) was not properly stored when not in used and undated;<br><br>3. Licensed Vocational Nurse C (LVN C) did not disinfect the blood pressure (BP) apparatus (BP apparatus, a cuff that is wrapped around the arm to measure BP) in between residents;<br><br>4. Resident 238's nebulizer tubing was outdated and left on top of the resident's bedside table;<br><br>5. Resident 50's humidifier bottle was on the floor;<br><br>6. Registered nurse I (RN I) did not follow manufacturer's instructions for disinfecting the glucometer (device used to check blood sugar levels); and<br><br>7. Nursing Assistant (NA) P did not do hand hygiene in between residents' assistance during lunch.<br><br>These failures had the potential to compromise resident's health and safety in the facility.<br><br>Findings:<br><br>1. During observation of lunch tray distribution on 8/12/2024 at 12:52 p.m., at the hallway, CNA N touched, and pushed the food cart then, parked it in front of Resident 42's room. CNA N touched and opened the food cart, took out Resident 42's lunch tray without performing hand hygiene. CNA N delivered the lunch tray and set it up for Resident 42. At 12:53 p.m., CNA N touched the food cart, pull it in front of Resident 189's room. CNA N took Resident 189's lunch tray without performing hand hygiene and served it to Resident 189. At 12:54 p.m., CNA N and CNA O touched, pushed the food cart, and parked in front of Resident 187's room. CNA N prepared coffee without performing hand hygiene. CNA O took Resident 187's lunch tray and served it to Resident 187 without performing hand hygiene.<br><br>During an interview with CNA N on 8/12/2024 at 12:54 p.m., CNA N confirmed above observation and stated she should have performed hand hygiene before she touched Resident 42 and Resident 189's lunch tray. CNA N further stated she should have performed hand hygiene before she prepared coffee because food cart could be dirty.<br><br>During an interview with CNA O on 8/12/2024 at 12:58 p.m., CNA O confirmed above observation and stated, I should have sanitized my hands before touching [Resident 187's] lunch tray.<br><br>During an interview with infection preventionist (IP) on 8/16/2024 at 1:55 p.m., IP stated hand hygiene should be performed in between residents and after staff touched a possible dirty area.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, date revised October 2023, indicated, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.<br><br>2. During an observation on 8/12/2024 at 9:58 a.m., inside Resident 187's room, Resident 187 was awake but observed to be confused. Resident 187's nebulizer's mask was placed on top of Resident 187's bedside drawer. There was no date labeled in the nebulizer kit (tubing, mask, nebulizing chamber.<br><br>During a concurrent observation and interview with registered nurse M (RN M) on 8/12/2024 at 11:05 a.m., inside Resident 187's room, RN M confirmed above observation. RN M stated nurses should have rinsed the nebulizer kit, airdried and stored inside a bag when not in used. RN M confirmed the nebulizer kit was undated and there was no nebulizer kit bag available in Resident 187's bed side drawer. RN M stated they should change the nebulizer kit once a week.<br><br>During an interview with IP on 8/16/2024 at 1:55 p.m., IP stated the nebulizer kit should be changed once a week. IP further stated the nebulizer kit should be stored in a black mesh bag when not in used and the black mesh bag should be changed monthly.<br><br>During an interview with director of nursing (DON) on 8/19/2024 at 2:13 p.m., DON stated the nebulizer kit should be changed once a week or as needed when visibly soiled. DON further stated the nebulizer kit should have been stored in a bag and the bag should be changed once a month.<br><br>During a review of the facility's policy and procedure titled, Cleaning and Disinfecting, date revised May 2023, indicated, .for medical devices and equipment, standard cleaning and disinfection procedures for healthcare facilities are practiced as recommended in the cleaning and disinfecting policies.<br><br>46553<br><br>3. During a medication pass observation on 8/13/24 at 10:22 a.m., with LVN C in Resident 58's room, LVN C took Resident 58's BP with a BP apparatus. LVN C did not disinfect the BP apparatus before and after using it.<br><br>During an interview with LVN C on 8/13/24 at 10:53 a.m., LVN C confirmed she did not disinfect the BP apparatus before and after using it on Resident 58. LVN C stated she was supposed to disinfect it with a disinfectant wipe before and after using it.<br><br>During an interview with the infection preventionist (IP) on 8/19/24 at 10:51 a.m., the IP stated the nurses should disinfect the BP apparatus in between residents to prevent the spread of infection.<br><br>A review of the facility's policy and procedure titled Cleaning and Disinfecting, revised 5/2023, indicated, Non-disposable medical equipment used for that resident is cleaned and disinfected according to the manufacturer's instruction and facility policies before use on another resident.<br><br>4. During an observation on 8/12/24 at 9:53 a.m., Resident 238's nebulizer mask and tubing were on the resident's bedside table. The mask and tubing were dated 7/2/24.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview with LVN C on 8/12/24 at 1:01 p.m., LVN C verified Resident 238's nebulizer mask and tubing were outdated. LVN C stated the mask and tubing should be changed every week and as needed. LVN C stated these items should be stored in a plastic bag when not in use.<br><br>5. During an observation on 8/12/24 at 9:29 a.m., Resident 50 was lying in bed receiving oxygen. The humidifier bottle attached to the oxygen concentrator (a machine that supplies oxygen) was on the floor.<br><br>During a concurrent observation and interview with LVN C on 8/12/24, at 10:41 a.m., LVN C verified Resident 50's oxygen humidifier bottle was on the floor. LVN C stated the humidifier bottle should not be on the floor.<br><br>Review of the facility's policy and procedure titled Cleaning and Disinfecting, revised 5/2023, indicated, Standard cleaning and disinfection practices in accordance with the Centers for Disease Control and Prevention, measures are implemented when areas, material or equipment have likely been contaminated.<br><br>6. During a medication pass observation on 8/13/24 at 4:42 p.m., RN I removed a glucometer from the medication cart. RN I cleaned the glucometer with an alcohol swab and checked Resident 189's blood sugar. After checking Resident 189's blood sugar, RN I removed a wipe from a container with a lavender-colored top and wiped the glucometer. The container indicated the product was Micro Kill One Germicidal Alcohol Wipes.<br><br>During an interview with RN I on 8/13/24 at 4:54 p.m., RN I confirmed she wiped the glucometer with an alcohol swab before using it and used Micro Kill One Germicidal Alcohol Wipes to disinfect the glucometer afterwards.<br><br>During an interview with the IP on 8/19/24 at 10:54 a.m., the IP stated the glucometer should have been disinfected with an EPA-registered product, such as Clorox (a specific brand of disinfectant). The IP confirmed the facility did have Clorox wipes, which were in a container with a blue top.<br><br>The manufacturer's instructions for the facility's glucometer, dated 10/2023, indicated to obtain a commercially available EPA-registered disinfectant or germicidal wipe and clean/disinfect the glucometer by following step-by-step instructions.<br><br>49345<br><br>7. During dining observation on 8/12/24 at 12:35 p.m., NA P applied clothing protector to five residents without hand hygiene in between.<br><br>During dining observation at 8/12/24 at 12:46 p.m., NA P picked up something off the floor, put it on an empty tray and proceeded to clear out a table without doing hand hygiene.<br><br>During an interview on 8/12/24 at 1:02 p.m. with NA P, NA P confirmed hand hygiene was not done in between assisting residents with clothing protector, and right after picking up something off the floor. NA P stated hand hygiene should have been done in both instances.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of facility's policy and procedure (P&P) titled Handwashing/Hand Hygiene revised October 2023, the P&P indicated, .Hand hygiene is indicated: a. immediately before touching a resident; .c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583<br><br>Based on observation, interview, and record review, the following multi-resident rooms provided less than 80 square feet per resident.<br><br>Findings:<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 77.7 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 74 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 77.7 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 76 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 77 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 70 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 71 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 74 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 74 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 74 square feet per resident<br><br>(continued on next page) |

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|---|---|
| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | room [ROOM NUMBER], 2 beds, 76 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 78.5 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 71 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 72 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 72 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 70.8 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 70.8 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 73 square feet per resident<br><br>room [ROOM NUMBER], 2 beds, 70.8 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 70.5 square feet per resident<br><br>room [ROOM NUMBER], 3 beds, 72.3 square feet per resident<br><br>During multiple observations on 8/12/2024 to 8/19/2024, none of the rooms were observed to inhibit the staff providing care. The staff and the residents moved freely in the rooms. The residents and staff stated the square footage of the rooms was not a concern.<br><br>Continuance of the room waiver is recommended. |