STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055289	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodi Creek Post Acute	321 West Turner Road Lodi, CA 95240

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 40841 Based on interview and record review, the facility failed to ensure two of 20 sampled residents (Resident 11 and Resident 20) had an informed consent for the use of antipsychotic medications (drugs that mainly treat psychosis-related conditions and symptoms), when: 1. Resident 11's antipsychotic informed consent was not updated every six months; and, 2. Resident 20 had no informed consent for an antipsychotic. This failure decreased the facility's potential to ensure residents or their responsible person(s) were fully informed of the risks, benefits, and alternative treatment options prior to the use of an antipsychotic medication. Findings: A review of Resident 11's Admission Record, inidcated Resident 11 was admitted to the facility in 2021 with diagnoses including depression (a serious medical illness that negatively affects how you feel, the way you think and how you act) and bipolar disorder (a mental health condition that causes extreme mood swings). The record further indicated Resident 11's sister was the Responsible Party (RP, a person designed to make healthcare decisions for the resident). A review of Resident 11's Order Summary Report, dated 9/5/24, indicated Resident 11 had orders for aripiprazole (antipsychotic medication) 15 milligrams (mg, a unit of measurement) by mouth one time a day for bipolar disorder. Resident 11 had buspirone (an antianxiety medication) 100 mg by mouth at bedtime and venlafaxine (a depression medication) extended release (cannot be crushed) 75 mg by mouth in the morning for crying spells. A review of Resident 11's Verification of Informed Consent Physical Restraint & Psychotropic Medications, dated 6/16/21, indicated Resident 11 had informed consent for buspirone, aripiprazole, and venlafaxine in 6/16/21. During an interview on 9/6/24 at 10:42 a.m. with the Director of Nursing (DON), the DON was aware Resident 11's informed consents for the psychotropic medications were last obtained in 2021 and confirmed informed consents needed to be updated every six months. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Informed Consent, dated 6/2021, indicated, .Obtaining informed consent is the responsibility of the licensed healthcare practitioner acting within the scope of his/her professional licensure performs . The policy further stipulated, The facility staff shall verify the resident or his/her surrogate has given informed consent . prior to the initiation of psychotherapeutic drugs . 34328 A review of Resident 20's Admission Record, indicated Resident 20 was admitted in October 2023 with diagnoses including dementia (a decline in cognitive abilities that affects a person's ability to think, remember, and perform daily activities), psychotic disturbance, and schizophrenia (serious mental illness that affects a person's thoughts, feelings, and behaviors). A review of Resident 20's Minimum Data Set (MDS; a tool used to assess the health status of residents in nursing homes), dated 6/19/24, indicated Resident's 20 Brief Interview on Mental Status (BIMS) score was four out of 15 with severe cognitive impairment. A review of Resident 20's Physician's Order Summary Report, indicated on 12/8/23 Resident 20 was orderd half tablet, 25 mg of quetiapine fumarate (a medication used to treat certain mental/mood disorders) by mouth two times a day for schizophrenia manifested by paranoia (the irrational and persistent feeling that people are out to get you or that you are the subject of persistent, intrusive attention by others), striking out, auditory hallucinations (hearing voices) informed consent by medical doctor. A review of Resident 20's Medication Administration Record, dated 8/24, indicated Resident 20 was receiving half tablet of quetiapine 25 mg by mouth two times a day for schizophrenia. A review of Resident 20's MD progress notes, dated 8/26/24, indicated an informed consent for quetiapine was not completed. A review of Resident 20's Psychiatric Visit Progress Report, indicated Resident 20 was seen by a psychiatrist on 5/10/23 and 8/11/23. A review of Resident 20's electronic record indicated there were no progress notes that indicated an informed consent had been obtained by the physician nor by the psychiatrist. During an interview on 9/4/24 at 3:30 p.m., with Licensed Nurse 5 (LN 5), LN 5 stated licensed nurses might not start residents on antipsychotic medications until the physician had obtained an informed consent from the resident or RP. LN 5 further stated the physican was in charge of explaining and obtaining the informed consent for the prescribed antipsychotic and the licensed nurse should have called or talked to the resident or the RP to ensure the discussion occurred with the prescriber on the new medication and if they agreed to the medication and once this was confirmed then the medication can be started as prescribed to the resident. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24 at 4:25 p.m., with the DON, DON stated the practice in the facility was the physician who ordered the antipsychotic medication must obtain the informed consent from the resident or RP. The physician will then document the informed consent was obtained in the clinical record of the resident. The informed consent has to be verified by the licensed nurse and then the medication or treatment can begin. DON further stated in general nurses could not give the medication unless the informed consent was verified, or in case of an emergency the physician will be notified and the physician might approve for the medication to be given. During an interview on 9/4/24 at 10 a.m. with the DON, DON stated there was no informed consent completed from 12/8/2023 through 9/3/24 for Resident 20. DON confirmed Resident 20 was started on quetiapine since 12/8/2023 through 9/3/24 without a duly completed informed consent. DON further stated an informed consent should had been verified before the administration of any antipsychotic medication. During an interview on 9/4/24 with the Quality Services Consultant (QCS), QSC stated nurses could not begin an antipsychotic medication without an informed consent being obtained by the physician and residents must have an informed consent before beginning the antipsychotic medication unless it was an emergency. QSC further stated the expectations were licensed nurses must verify with the resident or the RP that an informed consent was discussed, and completed by the physician. A review of facility's policy and procedure titled, Informed Consent, revised June 2021, indicated: 1. The facility shall ensure the resident's rights are maintained and a copy of these rights and pertinent policies are made available to the resident and to any representative of the resident. Among these rights under this section are the right to: a. Receive in advance all information that is material to a decision to accept or refuse treatment, Guidelines 2. The facility staff shall verify the resident or his/her surrogate has given informed consent to the proposed treatment or procedure prior to the initiation of psychotherapeutic drugs, antipsychotic drugs . A review of an All Facilities Letter (AFL) 24-07 dated February 28, 2024 indicated: .Effective January 1, 2024, AB (Assembly Bill) 48 codifies existing regulations that state residents have the right to be free of psychotherapeutic drugs .Examination and Signatures .Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or or the resident's representative along with, the signature of the health care professional declaring the required material has been provided .Medical records .The signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures .Renewals of Informed Consents .Facilities must renew the written informed consent every 6 months .Updates to Federal Regulations for SNFs [Skilled Nursing Facility], ICFs [Intermediate Care Facility] and Hospices [specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life] .AB 48 updates references to Federal regulations found in the HSC [Health and Safety Codes] section 1599.1(i)(2). The updated references align with the 2017 version of Title 42 of the Code of Federal Regulations (CFR).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47563 Based on observation, interview and record review, the facility failed to ensure a baseline care plan (instructions needed to provide effective and person-centered care for the resident developed within 48 hours of admission) for one of 20 sampled residents (Resident 331), when Resident 331's baseline care plan did not include an indwelling urinary catheter (IUC; a medical device that drains and collects urine from the bladder). This failure had the potential to place Resident 331 at risk for unmet care needs. Findings: A review of Resident 331's admission record indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included urinary tract infection (when bacteria multiply in the urinary tract [kidneys, ureters, bladder and/or urethra]), sepsis (a severe response to infection which can lead to organ damage) and chronic kidney disease (when kidneys are damaged and can't filter blood properly). During an observation on 9/3/24 at 10:29 a.m., in Resident 331's room, Resident 331 was walking with use of a walker in his room while an IUC drainage bag was hanging from the walker. A review of Resident 331's Order Summary Report, dated 9/4/24, indicated Resident 331 had an active order for an IUC and was started on 8/19/24. A review of Resident 331's care plans, initiated 8/19/24, did not indicate any care plan for an IUC. During an interview on 9/4/24 at 4:11 p.m. with Licensed Nurse 3 (LN 3), LN 3 stated if a resident had an IUC then she would expect the resident's care plan to indicate it, so staff will know the care the resident required. During a concurrent interview and record review on 9/4/24 at 4:24 p.m. with the Director of Staff Development (DSD), Resident 331's care plan was reviewed. The DSD confirmed Resident 331's care plan did not indicate Resident 331 had an IUC. The DSD confirmed Resident 331 was admitted with an IUC and she expected the IUC to be reflected on the resident's baseline care plan. The DSD added, the care plan is used to communicate to staff the care a resident needed and if an IUC was not on the care plan, staff might not know that an IUC existed or what care the resident needed related to it. During an interview on 9/6/24 at 10:43 a.m., with the Assistant Director of Nursing (ADON), ADON stated care plans were important to provide guidance on how to care for the resident and expected a resident's IUC to be on the baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy and procedure titled, Care Plans-Baseline, dated March 2022, indicated, .A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . the baseline care plan includes instructions needed to provide effective, person-centered care of the resident . and must include .but not limited to the following . physician orders .the baseline care plan is used until the staff can conduct the comprehensive assessment and develop a .comprehensive care plan (no later than 21 days after admission) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34328 Based on observation, interview and record review the facility failed to revise and implement a communication care plan for one of 20 sampled Residents (Resident 20) who did not speak English. This failure increased Resident 20's potential to receive inadequate and inaccurate care. Findings: A review of Resident 20's Admission Record, indicated she was admitted with diagnoses of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), apraxia (a neurological disorder that makes it difficult to perform purposeful movements or tasks, even though the person understands the request and is willing to do it). During an observation on 9/3/24 at 11:24 a.m., Resident 20 was sitting in her wheelchair. The Department was unable to communicate with Resident 20 in English. Resident 20 was observed communicating in a different language and had no communication board in her room. During an interview on 9/3/24 at 11:26 a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated he was assigned to Resident 20. CNA 4 confirmed Resident 20 spoke a different language and would communicate by gesturing. CNA 4 stated he communicated with Resident 20 by gesturing and she seemed to understand. CNA 4 was not certain what language Resident 20 was speaking. CNA 4 stated he could not find the communication board and if needed Resident 20 had a relative who worked in the dietary department and would be asked to interpret for the staff. During an interview on 9/3/24 at 11:35 a.m. with the Licensed Nurse 4 (LN 4), LN 4 confirmed Resident 20 spoke a different language and would communicate by gestures. LN 4 communicated with Resident 20 using gesturing. LN 4 was aware of a relative that worked in the kitchen who would be the interpreter and was not sure about the language Resident 20 was speaking. LN 4 was not aware if the facility had any translator services available. During an interview on 9/3/24 at 1:30 p.m. with the Director of Staff Development (DSD), DSD stated there were a language communication board and translator services available via phone. The translation services book had listed as Mien and translation services were available 24 hours a day seven days a week via phone. A review of Resident 20's Electronic Health Record (EHR) Resident Detail indicated Resident 20 spoke Laotian. During an interview on 9/4/24 at 2:30 p.m. with the Dietary Aide 2 (DA 2), DA 2 stated she had the same last name as Resident 20 but they were not relatives. DA 2 spoke the same language as Resident 20 and would help out whenever she was at work. DA 2 confirmed she was not the official interpreter for the facility and was only helping out when it came to interpreting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 20's care plan identified on 10/3/20, indicated Resident 20 had a psychosocial well-being problem related to problem solve and had language barrier. Care plan interventions indicated to increase communication between resident/family caregivers about care and living environment. During an interview on 9/5/24 at 3 p.m. with the Director of Nursing (DON), DON stated for residents with language communication problems who could not speak English, the staff if they spoke the resident's language would be asked to act as an interpreter. The use of a translation service interpreter was available 24 hours a day via phone. DON confirmed Resident 20 had a language barrier and some command of English and had a relative that would act as an interpreter. Other helpful tools would be a communication board at the resident's bedside and could be obtained from the activities department. The DON confirmed and stated the interpreter services and the language interpreter services via phone were not part of Resident 20's care plan interventions. The DON also confirmed the care plan was last revised on 10/3/2020 and the interpreter services should have been part of the interventions. A review of facility policy titled, Translation and/or Interpretation of Facility Services, revised 11/2020, indicated: .This facility's language access program will ensure that individuals with limited Engligh proficiency (LEP) shall have meaningful access to informationand services provided by the facility .When encoutering LEP individuals, staff members will conduct the initial language assessment (e.g., I Speak Cards) and notify the staff person in charge of the language access problem. A review of facility's policy tiltled, Care Plans, Comprehensive Person - Centered, revised 3/22, indicated: .A comprehensive, person centered care plan that include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47563 Based on observation, interview, and record review the facility failed to provide care and services in accordance with acceptable professional standards of quality for two of 20 sampled residents (Resident 331 and Resident 135) when: 1. Resident 331's peripherally inserted central catheter intravenous line (PICC IV: used to deliver medications into a vein over a long period of time) flushes (a procedure that uses a mixture of salt and water to clear an IV line and reduce the risk of infection) were not documented in accordance with professional standards; and, 2. Resident 135's urinary drainage bag was not enclosed in a privacy bag, the urinary drainage bag collection tube was not kept properly positioned and kept free from kinks for optimal drainage. These failures decreased the facility's potential to prevent worsening of the residents' clinical condition. Findings: 1. A review of Resident 331's admission record, indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included urinary tract infection (UTI: when bacteria multiplies in the urinary organs), sepsis (a severe response to infection which can lead to organ damage), and chronic kidney disease (when kidneys are damaged and can't filter blood properly). A review of Resident 331's Order Summary Report, dated 9/4/24, indicated an order for Resident 331's PICC IV to be flushed every shift. During an interview on 9/4/24 at 2:49 p.m. with Licensed Nurse 5 (LN 5), LN 5 stated the nurse who performed a PICC IV flush was expected to document they did it. LN 5 added, it was not acceptable for a nurse who did not perform the flush to document that another nurse had done it. During an interview on 9/4/24 at 4:11 p.m. with LN 3, LN 3 stated when a nurse gave a medication then that same nurse should have documented giving the medication and it was not acceptable for a nurse who did not give the medication to document it was given. During a concurrent interview and record review on 9/4/24 at 4:24 p.m. with the Director of Staff Development (DSD), Resident 331's August 2024 medication administration record (MAR) and August 2024 progress notes were reviewed. The DSD confirmed the MAR indicated the PICC IV flush scheduled for 10 p. m. on dates 8/20-8/31/24 indicated a code nine on each date. The DSD stated code nine meant there should be a progress note related to the administration. The DSD reviewed Resident 331's progress notes from 8/21/24 through 8/31/24 and confirmed the progress notes indicated a nurse documented either a different nurse had done the flush or the other nurse would do the flush. The DSD stated she expected the nurse who administered a medication or flush to document they gave it on the resident's MAR. The DSD confirmed it was not acceptable for one staff member to document that another staff member gave a medication or flush. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/6/24 at 10:43 a.m. with the Assistant Director of Nursing (ADON), Resident 331's August 2024 MAR and August 2024 progress notes were reviewed. The ADON confirmed from 8/20/24-8/31/24 the 10 p.m. PICC IV flush was documented code nine and corresponding notes indicated a nurse had documented that another nurse had either administered the PICC IV flush or would administer the PICC IV flush. The ADON acknowledged the documentation related to the flushes were not aligned with facility expectations, and the nurse who administered a medication or flushed must document they did it. The ADON confirmed the documentation did not align with professional standards expected of nurses. A review of facility's policy and procedures (P&P) titled, administering medications, dated April 2019, indicated, . medications are administered in a safe and timely manner, and as prescribed . Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so medications are administered in accordance with prescriber orders . the individual administering the medication initials the resident's MAR on the appropriate line after given each medication . A review of the facility's P&P titled, Peripheral and Midline IV catheter Flushing and Locking, dated March 2022, indicated, .document procedure in treatment administration record . 34328 2. A review of Resident 135's Admission Record, indicated Resident 135 was admitted to the facility with diagnoses of pneumonia (lung infection), urinary retention, and the presence of a urine catheter. During an observation on 9/3/24 at 12 p.m. Resident 135 had a foley catheter (a flexible tube that drains urine from the bladder into a bag outside the body) which was connected to a drainage bag. The drainage bag was draining amber colored clear urine and was found hanging on the resident's top bedside rail. The head of the bed was elevated approximately 30 - 35 degrees. The drainage bag was positioned higher than the resident's bladder, this prevented the free flow and drainage of urine from the bladder. There was no privacy bag to conceal the urinary drainage bag from view. Also, the drainage bag's collecting tubing was found to be kinked near the drainage bag. The presence of a kink in the collecting tubing prevented the free flow of urine into the drainage bag. During an interview on 9/3/24 at 1230 p.m., with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated Resident 135's drainage bag must be enclosed in in a privacy bag and confirmed the drainage bag must not be hanging from the top siderail and must be hanging lower than the resident's bladder. CNA 3 also stated the drainage bag must be below the level of the bladder of the resident and confirmed a kinked urine collection tubing. CNA 3 stated the kink in the collecting tubing, prevented the flow of urine into the drainage bag. During a concurrent interview on 9/6/24 at 11:19 a.m. with the Director of Nursing (DON), (ADON) and the Quality Services Consultant (QSC), they all confirmed the expectations were all the residents' foley drainage bags must be positioned lower than the level of the resident's bladders. The urinary drainage bag must be off the floor, and should have no kinks in the collecting drainage tube. All urinary drainage bags must be covered with a privacy bag. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Catheter Care, Urinary, revised 9/14, indicated: .Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter tubing free of kinks. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the bladder.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 40841 Based on observation, interview, and record review, the facility failed to provide a communication board or use translator during assisting care for one resident (Resident 1) of 20 sampled residents. This failure decreased the facility's potential to meet Resident 1's ability to communicate her basic needs. Findings: A review of Resident 1's Admission Record, indicated, Resident 1 was admitted to the facility in 2022 with diagnoses including depression (a serious medical illness that negatively affects how you feel, think, and act). A review of Resident 1's undated care plan titled, [Resident 1] has a communication problem [related to] language barrier. Primary language is Portuguese, indicated the interventions were: Listen attentively and allow ample time to communicate. Provide communication board. Utilize help of a translator or interpreter if applicable. During a concurrent observation and interview on 9/3/24 at 9:03 a.m. with Certified Nursing Assistant 2 (CNA 2) in Resident 1's room, CNA 2 confirmed she did not use translator nor communication pictures to communicate with her, but rather used body language, gesture or pointing to objects. During an interview on 9/3/24 at 12:01 p.m. with Resident 1's son, Resident 1's son stated Resident 1 spoke Portuguese and the facility's staff did not communicate well with Resident 1 and did not use the translator. During an interview on 9/6/24 at 8:39 a.m. with Licensed Nurse 4 (LN 4), LN 4 stated she used English and Spanish when speaking to Resident 1. LN 4 stated she used the son as a translator and did not use a translator service. During an interview on 9/6/24 at 10:40 a.m. with the Director of Nursing (DON), the DON stated the facility staff should have used communication board or phone translator when assisting Resident 1 with her daily living. A review of facility's policy titled, Translation and/or Interpretation of Facility Services, dated 11/2020, indicated, The facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. The policy further stipulated, Family members and friends shall not be relied upon to provide interpretation services for the resident.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 45718 Based on observation, interview, and record review, the facility failed to ensure two of 20 sampled residents (Resident 282 and Resident 331) who had Vascular Access Devices (VAD, thin flexible tube that provides access to veins for the delivery of IV [Intravenous, administered into a vein] medications) received the necessary care and services when: 1. Resident 282's Midline catheter (a type of VAD used for intravenous treatments of more than six days) was not monitored for signs and symptoms of infection every shift as ordered; and, 2. Resident 331's peripherally inserted central catheter intravenous line (PICC IV: a type of VAD used to deliver medications into a vein over a long period of time) was not monitored for signs and symptoms of infection every shift as ordered. These failures placed the residents at risk for VAD related infections. Findings: 1. A review of Resident 282's clinical record indicated he was admitted to the facility summer of 2024 with multiple diagnoses that included cellulitis (potentially serious bacterial skin infection) of the left lower limb. During an observation on 9/3/24 at 9:23 a.m. in Resident 282's room, Resident 282 was lying in bed with midline IV at left upper arm and dressing intact. Resident 282 stated he was getting IV antibiotics for his left leg cellulitis. A review of Resident 282's Order Summary, dated 8/28/24, indicated Assess midline site for S/S [signs/symptoms] of infection QS [every shift] and notify MD [Medical Doctor] if noted (Ensure all lumens have injection caps, lumens not in use are clamped) . A review of Resident 282's care plan indicated, Resident is on IV Medications r/t [related to] left leg cellulitis . Check dressing at site as ordered .Monitor and report to MD PRN [as necessary] s/sx [signs and symptoms] of infection at the site: drainage, inflammation, swelling, redness, warmth . A review of Resident 282's Medication Administration Record (MAR) indicated to Assess midline site for S/S of infection QS and notify MD if noted (Ensure all lumens have injection caps, lumens not in use are clamped) QS every shift . MAR further indicated from 8/28/24 to 9/4/24, out of 23 shifts, nine shifts were not signed as ordered. During a concurrent interview and record review on 9/5/24 at 9:19 a.m. with Licensed Nurse 6 (LN 6), LN 6 confirmed Resident 282's administration record to assess midline IV site every shift had nine shifts with no signature. LN 6 stated it should have been signed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/5/24 at 10:30 a.m. with the Director of Nursing (DON), DON confirmed Resident 282's administration record to assess IV midline had shifts that were not signed. DON stated, If the order says it's every shift, then it should be signed every shift. When asked if the order was not signed does it mean it was not done, the DON did not answer. During an interview on 9/5/24 at 11:15 a.m. with the Infection Preventionist (IP), IP stated he expected the midline IV to be monitored for signs and symptoms of infection every shift. IP stated midline IV was an easy portal of entry for infections that could affect Resident 282 because the route of entry for infection was faster. A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, .Each resident's comprehensive person-centered care plan is consistent with the resident's rights to .receive the services and/or items included in the plan of care . 47563 2. A review of Resident 331's admission record indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included, urinary tract infection (when bacteria multiply in the urinary organs), sepsis (a severe response to infection which can lead to organ damage) and chronic kidney disease (when kidneys are damaged and can't filter blood properly). A review of Resident 331's order summary report, dated 9/4/24, indicated an active order for .Assess PICC line on (RUA) [right upper arm] for S/S of infection QS and notify MD if noted (Ensure all lumens have injection caps, lumens not in use are clamped) QS every shift . A review of Resident 331's PICC IV care plan, initiated 8/19/24, indicated, .Risk for infection R/T [related to] catheter direct access to blood .interventions . Visually inspect I.V. [PICC IV] site QS, note any redness, swelling, pain or drainage, gently palpate areas around the insertion site for tenderness, phlebitis, inflammation or infiltration . During an interview on 9/4/24 at 2:49 p.m. with LN 5, LN 5 stated registered nurses (RNs) are expected to assess a PICC IV site and to document it was done in the residents' MAR. During an interview on 9/4/24 at 4:11 p.m. with LN 3, LN 3 confirmed RNs are responsible for PICC IV site assessments and were expected to document the assessment was done in the residents' MAR. During a concurrent interview and record review on 9/4/24 at 4:24 p.m. with the Director of Staff Development (DSD), Resident 331's August 2024 MAR was reviewed. The DSD confirmed Resident 331's August MAR indicated the PICC IV site was expected to be assessed for signs and symptoms of infection on each shift and there was no documentation that the PICC IV site was assessed on the following scheduled dates and times: 6 a.m. on 8/25/24, 2 p.m. on 8/19-8/24/24, 8/26/24, 8/28/24, and 8/31/24, and 10 p.m. 8/19-8/31/24. The DSD stated the lack of documentation for those dates and times indicated the assessments were not done as ordered by the doctor. During a concurrent interview and record review on 9/6/24 at 10:43 a.m. with the Assistant Director of Nursing (ADON), Resident 331's August 2024 MAR was reviewed. The ADON confirmed Resident 331's PICC IV site assessments were not done as ordered by Resident 331's doctor and the missing assessments put Resident 331 at higher risk of getting an infection to the PICC IV site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Central Venous Catheter Care and Dressing Changes, revised March 2022, indicated, .the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infection that are associated with contaminated, loosened, soiled, or wet dressings . perform site care and dressing change at established intervals assessment observe insertion site and surrounding area for complications documentation .should be recorded in the resident's medical record .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45718 Based on observation, interview, and record review, the facility failed to provide the necessary care and services for one of 20 sampled residents (Resident 281) who received hemodialysis (HD, a medical procedure that helps remove waste and excess fluid from the blood when the kidneys are unable to perform this function), when her output was not accurately measured as ordered. This failure increased Resident 281's risk in developing fluid overload. Findings: A review of the clinical record indicated Resident 281 was admitted to the facility in summer of 2024 with multiple diagnoses that included end stage renal disease (ESRD, permanent kidney failure that requires a regular course of dialysis or a kidney transplant) and fluid overload. During a conccurent observation and interview on 9/3/24 at 1:10 p.m. in Resident 281's room, Resident 281 was eating lunch. She stated she was feeling tired the day after HD, was urinating in the bathroom and was continent. A review of Resident 281's Order Summary dated 8/30/24, indicated to record intake and output (I&O) in milliliters (ml; a unit of measure) every shift for fluid restriction and if Resident 281 was incontinent to put the number of incontinence episodes. A review of Resident 281's care plan indicated, ESRD with interventions that included monitor fluid restrictions as ordered and monitor intake and output . A review of Resident 281's Medication Administration Record (MAR) for Fluid restriction I&O: Record intake & output QS [every shift] . from 8/30/24 to 9/4/24 indicated, Resident 281's output was marked as x number of times urinated and not the amount of output in ml. During a concurrent interview and record review on 9/5/24 at 9:19 a.m. with Licensed Nurse 6 (LN 6), LN 6 stated Resident 281 was continent. Resident 281's MAR for fluid restriction I&O was reviewed and LN 6 stated [Resident 281] was using the toilet, so I just asked for the number of times she went to the toilet. LN 6 confimed the order for I&O and stated because she is continent there should be an amount of output there . if [Resident 281] is incontinent you can write the number of times she was changed . During a concurrent interview and record review on 9/5/24 at 10:35 a.m. with the Director of Nursing (DON), Resident 281's MAR for fluid restriction I&O was reviewed. The DON stated staff should have entered the amount of the output because it was in the order. A review of facility's policy titled, Output, Measuring and Recording, revised October 2010, indicated .Verify that there is a physician's order for this procedure .The following information should be recorded on the bedside intake and output record and/or in the resident's medical record .The amount (in mLs) of output . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy titled, End-Stage Renal Disease, Care of a Resident with, revised September 2010, indicated Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45718 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of a census of 81 residents, when the emergency Kit (E-Kit, limited number of medications for use in an emergency) log was not filled out for two opened E-Kits. This failure increased the potential for the facility to not have the needed medications available during emergencies that could jeopardize residents' health and safety. Findings: During a concurrent observation and interview on 9/4/24 at 10:01 a.m. with Licensed Nurse 3 (LN 3), stations one and two medication storage rooms had three E-Kits with injectable medications (medications to be administered by injection into the vein or muscle) with blue plastic locks. LN 3 stated the three E-kits with blue locks were recently opened. LN 3 confirmed two out of three E-kits were not logged in the E-kit log. LN 3 stated she does not know when the two E-kits were opened and the yellow form inside it were to be filled out and faxed to the pharmacy letting them know the E-kits were opened, then the yellow form will be placed in the binder and the white form should be placed inside the E-kits. LN 3 confirmed there were no yellow forms for the 3 opened E-kits in the binder. During a concurrent interview and record review on 9/4/24 at 10:30 a.m., the Assistant Director of Nursing (ADON) verified, the 2 opened E-kits were not logged in the E-Kit log. During an interview on 9/5/24 at 10:23 a.m., with the Director of Nursing (DON), DON stated she expected the staff to fill out the E-kit log form as soon as they took out the medication. A review of the facility's policy titled, Emergency Pharmacy Service and Emergency Kits, dated 2007, indicated .Upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. The hard copy will be retained in the nursing care center .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40841 Based on interview and record review, the facility failed to ensure one resident (Resident 11) out of 20 sampled residents received proper monitoring for psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) when there was no manifestation, no diagnosis identified, and no side effect monitoring for Resident 11's buspirone (an antianxiety medication). These failures placed Resident 11 at risk for unnecessary psychotropic medication use side effects. Findings: A review of Resident 11's Admission Record, indicated Resident 11 was admitted to the facility in 2021 with diagnoses including depression (a serious medical illness that negatively affects how you feel, the way you think and how you act) and bipolar disorder (a mental health condition that causes extreme mood swings). A review of Resident 11's Minimum Data Set (MDS, an assessment tool), dated 6/20/24, indicated Resident 11 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating her cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was mildly impaired. A review of Resident 11's Order Summary Report, dated 9/5/24, indicated Resident 11 had buspirone 100 milligram (a unit of measure) by mouth at bedtime. There was no diagnosis, manifested by, and side effect monitoring for buspirone in the orders. During a concurrent interview and record review on 9/5/24 at 9:53 a.m. with the Medical Record Director (MRD), the MRD confirmed she did not see documentation of the side effect monitoring for buspirone in the Medication Administration Record. During an interview on 9/6/24 at 9:07 a.m. with the Director of Nursing (DON) and Assistant DON (ADON), the ADON confirmed a psychotropic medication should have a diagnosis, manifested by or evidence by, and inform consent and stated without diagnosis, manifested by, and inform consent, the order would be an incomplete order. ADON further stated the resident or family member would not know why the resident is taking the psychotropic medication. A review of the facility's policy titled, Psychotropic Medication Use, dated 7/2022, indicated, Psychotropic medication management includes: indications for use and monitoring of behavior . adequate monitoring for efficacy and adverse consequences .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40841 45718 Based on observation, interview and record review, the facility failed to ensure medications were labeled, stored, and disposed of consistently according to standards of practice for a census of 81, when: 1. Expired medications were not removed from the medication cart and the medication storage room; 2. Pharmaceutical products were found in the medication storage room and the medication cart without an opened date; 3. Pharmaceutical products with an unclear and torn label was found in a medication cart; 4. Loose medications were found in a medication cup in the first drawer of the medication cart; and, 5. A white powdered medication in medication cups were left unattended at the resident's bedside. These failures had the potential to result in the lack of effectiveness of the medications, increase the potential for medication administration errors and jeopardize residents' health and safety. Findings: 1.During a concurrent observation and interview on 9/4/24 at 10:01 a.m. with Licensed Nurse 3 (LN 3), in station one and two medication storage room there was an opened bottle of pantoprazole suspension (medication to treat high levels of stomach acid) with a discard date of 7/10 in the medication refrigerator. LN 3 stated, It's [pantoprazole] past the date .should have been discarded. During a concurrent observation and interview on 9/4/24 at 12:36 p.m. with LN 1, in station one medication cart two, LN 1 confirmed there was an opened regular insulin(a medication used to control high blood sugar) 100 units/milliters (u/ml; a unit of measure) vial with an opened date of 7/22/24 and labelled to discard after 31 days. LN 1 stated the insulin should have been discarded on 8/22/24. During an interview on 9/5/24 at 10:35 a.m. with the Director of Nursing (DON), DON stated if the medication was expired, then it should have been destroyed. A review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, indicated, . Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 9/4/24 at 10:01 a.m. with LN 3, in station one and two medication storage room, LN 3 confirmed there was an opened vial of tuberculin purified protein derivative (PPD, solution used to help diagnose tuberculosis) without an opened date and discard date. During a concurrent observation and interview on 9/4/24 at 12:36 p.m. with the Quality Services Consultant (QSC), in station one medication cart two, QSC confirmed there was an opened umeclidinium (a medication to treat chronic obstructive pulmonary disease) 62.5 micrograms (mcg; a unit of measure) inhaler and an opened fluticasone furoate/vilanterol (a medication to treat asthma; a lung disease) 100mcg/25mcg inhaler without an opened date and discard date. During a concurrent observation and interview on 9/4/24 at 1:09 p.m. with LN 1, in station one medication cart two, LN 1 confirmed there was a bottle of valproic acid (a medication to treat seizures or mental or mood problems) 250 milligrams (mg; a unit of measure)/five ml oral solution and a bottle of lactulose (a medication used to treat constipation) 10 grams (g: a unit of measure)/15ml solution without opened date and discard date. During an interview on 9/5/24 at 10:23 a.m. with the DON, DON stated when the staff opens the medication it should be dated on the date it was opened. A review of the facility's policy titled, Administering Medications, revised April 2019, indicated, .When opening a multi-dose container, the date opened is recorded on the container . A review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, indicated, . Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial . 3. During a concurrent observation and interview on 9/4/24 at 12:36 p.m. with QSC, in station one medication cart two, QSC confirmed there was an opened albuterol sulfate (a medication to treat asthma) 90 mcg inhaler with a torn label and an opened budesonide and formoterol fumarate dihydrate (a medication to treat asthma) 160 mcg/4.5 mcg inhaler with a torn and unclear label. A review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, indicated, .1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions .8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items . 4. During a concurrent observation and interview on on 9/4/24 at 1:14 p.m. with LN 7, in station three medication cart three, a medication cup with two blue and white colored capsules and one pink colored tablet were found in the first drawer of the cart. LN 7 stated she was supposed to discard the capsule and the tablet. LN 7 further stated the capsules were empty and the pink tablet fell out of the pack and she was going to waste it later in the medication room at station one medication disposal bin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/5/24 at 10:23 a.m. with the DON, DON stated loose pills should be thrown in the drug buster (a medication disposal system that uses a solution to deactivate or dissolve medications) in the medication cart. DON further stated loose and opened pills are not supposed to be kept in the medication cart and should be disposed immediately in the drug buster. A review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, indicated, 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received .2. The nursing staff is responsible for maintaining medication storage .in a safe manner . 11. Medications may not be transferred between containers . 5. During an observation on 9/3/24 at 12:26 p.m. in a resident's room, there were white powdered medications in two cups placed at resident's bedside. During an interview on 9/3/24 at 12:33 p.m. with LN 3, LN 3 confirmed the white powdered medication should not be at the resident's bedside and stated it should have been stored in the medication cart or treatment cart. LN 3 further stated there were residents who wander in the facility and they could have access to the medication if not stored properly. During an interview on 9/6/24 at 1:28 p.m. with the DON, DON confirmed the medication should have been stored and locked in the cart or medication room to prevent other residents from getting it. A review of the facility's policy titled, Medication Labeling and Storage, dated 2/2023, indicated The facility stored all medications and biological in locked compartments .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34328 Based on observation, interview and record review the facility failed to accurately check and test sanitizing solutions in the kitchen for a census of 81, when: 1. The dishwasher sanitizing solution was not accurately checked for effectiveness; and, 2. The Quatenary Ammonium Compound (QAC; a type of chemical that is used to kill bacteria, viruses, and mold) was not tested at the right temperature and concentration. These failures had the potential to expose residents to foodborne illnesses from improperly sanitized eating utensils served with the residents' meals. Findings: 1. During a concurrent observation and interview with the Registered Dietitian (RD) and the Dietary Aide 1 (DA 1) on 9/4/24 at 1:34 p.m. in the kitchen, the dishwashing activity was observed. DA 1 stated she was doing the dishwashing and the dishwashing machine was a low temperature dishwasher. DA 1 also stated she did not know what should the low temperature dishwashing machine's minimum operational temperature be. The temperature gauge of the machine while operating was observed and registered a temperature of 110 degrees Fahrenheit (a unit of temperature measurement). DA 1 demonstrated how the sanitizing solution was checked to ensure it was at an effective concentration level, stated the sanitizing solution used was Chlorine, took a test strip and placed it into the liquid collected at the bottom of the machine. DA1 confirmed the Chlorine testing indicated a reading of 100 parts per million (ppm; described concentrations of chemicals dissolved in a solvent, typically water) after she compared it with the testing bottle's colored bars. The test strips container's color bars were observed to be faded and hard to read. The test strips container expiration date was also faded and difficult to visualize. DA 1 confirmed that the test strips container's color bars were faded and the expiration date was not visible and stated she compared the color to as close as she could to the faded color bars. RD confirmed the color bars were faded and the expiration date of the test strip container was also faded and difficult to read and stated the accuracy of the Chlorine test would be hard to visually verify the accuracy of the readings. 2. During a concurrent observation and interview with DA 1 on 9/4/24 at 1:34 p.m. in the kitchen, DA 1 demonstrated how to wash dishes with a three compartment sink. DA 1 stated QAC was used for the sanitation of dishes and the disinfection of the kitchen surfaces with a red bucket container. DA 1 conducted testing with a test strip after mixing a QAC solution and water form a QAC mixing station. DA 1 dipped the QAC test strip for 10 seconds and read the result, which was 400 ppm. The QAC testing strip instructions from the manufacturer were to dip the chemical strip into the formula at a temperature of 65 to 75. DA 1 measured the temperature in the QAC red bucket using the kitchen's digital thermometer which indicated 63 degrees Fahrenheit. DA 1 confirmed the solution was tested in cold water and was below the manufacturer's recommendation for testing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Duirng an interview on 9/4/24 at 2 p.m. with the RD, RD stated the QAC chemical test strip per manufacturer's recommendation must be tested at a minimum temperature of 65 degrees Fahrenheit. The temperature reading was verified with the RD and was below the manufacturer's recommendation. RD confirmed the QAC testing result was at 400 ppm and stated the manufacturer's recommendation must be followed to ensure the accuracy of the readings. A review of the Food and Drug (FDA) 2022 Food Code section 4-501.116 on Warewashing (dishwashing) Equipment, Determining Chemical Sanitizer Concentration it indicated that the effectiveness of chemical sanitizers is determined primarily by the concentration and pH of the sanitizer solution. Therefore, a test kit is necessary to accurately determine the concentration of the chemical sanitizer solution. The FDA Food Code further explained in section 4-703.11 on Hot Water and Chemical Sanitation that Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization.

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Lodi Creek Post Acute	321 West Turner Road Lodi, CA 95240

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34328 Based on observation, interview, and record review the facility failed to follow infection control practices for a census of 81 when: 1. Laundry Aide (LA) did not maintain hand hygiene practices while handling clean and soiled linen in the laundry; 2. Enhanced based precautions (EBP) were not initiated timely for Resident 331's indwelling medical devices; 3. Staff did not ensure Resident 335 performed hand hygiene before being served lunch on 9/3/24; and 4. The ice machine was not properly cleaned. These failures had the potential to spread infection among residents. Findings: 1. During an observation on 9/5/24 at 12:10 p.m. with LA at the laundry area, LA was handling cleaned linen with gloved hands. There was no hand hygiene prior to wearing gloves to handle clean linen. Then LA removed gloves and put on new gloves, gown, and face mask to handle soiled linen. There was no hand hygiene performed after removing and putting on gloves. While handling soiled linen, LA removed gloves and put on new gloves in three different occasions and did not perform hand hygiene practices. During an interview on 9/5/24 at 12:30 p.m. with LA, LA confirmed she did not perform hand hygiene practices before touching clean linen, before donning and after removing gloves. LA stated there could be a contamination of soiled and clean linen. During an interview on 9/6/24 at 10:33 a.m. with the Infection Preventionist (IP), the IP expected staff to wash hand or use hand sanitizer prior to put on and removing gloves. A review of the facility's policy titled, Department (Environmental Services) - Laundry and Linen, dated 1/2014, indicated Wash hands after handling soiled linen and before handling clean linen. The policy further stipulated, Always wash hands after completing the task and removing gloves. Wash hands before handling clean linen. A review of the facility's policy titled, Handwashing/Hand Hygiene, dated 8/2019, indicated, Hand hygiene is the final step after removing and disposing of personal protective equipment. 40841 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 331's admission record, indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included, urinary tract infection (UTI; when bacteria multiply in the urinary organs), sepsis (a severe response to infection which can lead to organ damage), and chronic kidney disease (when kidneys are damaged and can't filter blood properly). A review of Resident 331's Order Summary Report, dated 9/4/24, indicated Resident 331 had an active order that started on 8/19/24 for an indwelling urinary catheter (IUC: a medical device that drains and collects urine from the bladder) and a peripherally inserted central catheter intravenous line (PICC IV: a long thin tube put into a vein used to deliver medications over a long period of time). During an interview on 9/4/24 at 1:52 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated a timely set up of personal protective equipment (PPE: supplies, such as gloves, gowns, face masks, goggles, to minimize exposure to hazards) and signage indicating a resident was on a transmission based precaution (TBP: the use of additional PPE is required when a resident is suspected or known to be infected or a carrier of a transmissible agent) or EBP was important. CNA 2 added if TBP/EBP were not set up timely, staff could be going in and out of the room without use of recommended PPE and risk the spread of germs to residents and staff. During a concurrent observation and interview with Resident 331 on 9/4/24 at 2:13 p.m., outside Resident 331's room was a posted sign indicating Resident 331 was on EBP and listed the recommended PPE to wear when assisting him. Next to the door was a cart with PPE supplies. Resident 331 stated he had been in the facility for over two weeks and was placed on EBP today. Duirng an interview on 9/4/24 at 2:27 p.m. with CNA 7, CNA 7 stated residents with indwelling medical devices would be put on EBP and staff relied on the nurse who processed the resident's admission to set up TBP/EBP signage and supplies when indicated, so staff would know how to prevent the spread of infections while working with the resident. During an interview on 9/4/24 at 3:02 p.m. with the IP, the IP stated EBPs were important in controlling the spread of infections in the facility and the facility will implement EBP for residents with indwelling medical devices such as an IUC and PICC IV. The IP confirmed Resident 331 was admitted over two weeks ago with a PICC IV and IUC but had not been put on EBP until today. The IP acknowledged the best practice was to initiate EBP as soon as possible to limit the spread of infection and Resident 331's EBP should have been implemented sooner. A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated August 2022, indicated, . enhanced barrier Precautions (EBPs) are used as an infection prevention and control intervention .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not apply .EBPs are indicated for residents with wounds and/or indwelling medical devices . the EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical devices that places them at increased risk . 3. A review of Resident 335's admission record, indicated Resident 335 was admitted to the facility in August of 2024 with diagnoses that included heart disease, muscle weakness, and UTI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 335's minimum data set (MDS: an assessment tool), dated 8/21/24, indicated Resident 335 did not have memory problems and required staff supervision and assistance with personal hygiene including washing hands. A review of Resident 335's care plan, initiated 8/17/24, indicated, [Resident 335] is a high risk for infection . interventions .observe good hand hygiene . During an observation on 9/3/24 at 11:48 a.m., in the communal dining room, Resident 335 was sitting at a table when facility staff asked Resident 335 to return to her room and Resident 335 left the dining room. At 11:59 a.m. Resident 335 returned to dining room and sat at a table waiting for lunch while no staff offered to assist Resident 335 with hand hygiene. At 12:06 p.m. Resident 335 was served her lunch meal. During an interview on 9/3/24 at 12:09 p.m., Resident 335 stated staff had not helped her or ensured she performed hand hygiene prior to serving her lunch. During an interview on 9/3/24 at 12:10 p.m. with Restorative Nursing Assistant 1 (RNA 1), RNA 1 stated staff were expected to offer residents hand sanitizer prior to meals. RNA 1 further stated staff had just forgot today to offer Resident 335 hand sanitizer when she returned. During an interview on 9/3/24 at 12:19 p.m. with RNA 2, RNA 2 acknowledged when a resident left the dining room and came back, the resident should have been offered hand sanitizer before eating. During an interview on 9/6/24 at 12:08 p.m. with CNA 3, CNA 3 stated he is often assigned to work in the dining room during lunches. CNA 3 confirmed staff were expected to offer and or assist residents with hand hygiene prior to getting served their food to prevent residents from getting sick. During an interview on 9/6/24 at 12:12 p.m. with the IP, IP stated he expected staff to offer residents hand hygiene prior to meals for infection prevention purposes. A review of the facility's P&P titled, 'Handwashing/Hand Hygiene, dated August 2019, indicated, .this facility considers hand hygiene the primary means to prevent the spread of infections .all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in prevention the transmission of healthcare-associated infections use an alcohol-based hand rub or, alternatively, soap . and water for the following situations .before and after eating or handling food . 4. During a concurrent observation and interview on 9/3/24 at 10:31 a.m. with the Maintenance Director (MD), the kitchen's ice machine was inspected. On the top panel of the ice machine there was a white plastic covering the cascading water portion of the ice machine, the plastic cover was lifted up and exposed the left and right bottom portions of the ice machine. A white paper napkin was used to wipe the bottom left and right side portions of the ice machine. The bottom right and left hand corner of the ice machine was observed to have the presence of a blackish colored material that adhered to the white paper napkin. MD confirmed the findings found on the white paper napkin and stated the blackish growth should not be there and the ice machine was not clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/3/24 at 10:45 a.m. with the Administrator (ADM) and the Certified Dietary Manager (CDM), CDM confirmed the presence of the blackish growth and stated it should not be there and the ice machine was not clean. ADM also confirmed the blackish growth that was on the white napkin. A review of facility's policy and procedure, titled Ice Machines and Ice Storage Chests, revised 1/12, indicated: .Ice machines and ice storage/ distribution containers will be used and maintained to assure a safe and sanitary supply of ice .Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. 47563

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 34328 Based on observation, interview and record review the facility failed to maintain an essential kitchen equipment in good working order and repair for a census of 81, when freezer number (#) six was observed to have an internal temperature of 10 degrees Fahrenheit (a unit of measure for temperature) and was not in good repair. This failure had the potential for residents to become sick from food borne illnesess. Findings: During a concurrent observation and interview on 9/3/24 at 8:25 a.m. with the Certified Dietary Manager (CDM) in the kitchen dry storage area, freezer # six was inspected and the thermometer inside the freezer indicated the temperature was 10 degrees Fahrenheit. A box of turkey ham was stored in the freezer and was rock hard to touch. CDM confirmed the thermometer indicated 10 degrees Fahrenheit and stated the freezer temperature must be kept at zero degrees Fahrenheit or lower. CDM further stated Freezer # six's door seals were not forming a tight seal. Freezer # six had an accumulation of frost inside the top part of the freezer. CDM stated a latch at the bottom part of the freezer door was needed so it can be in closed and locked position and to ensure a tight seal was maintained. CDM confirmed freezer # six's seals were loose and there was a built-up of frost in the freezer because of the inadequate seal and stated she regularly had been removing the frost built up and a new freezer was needed. A review of the facility's policy titled, Food Storage, dated 1/1/17, indicated: .Frozen foods shall be stored and displayed in their frozen state unless being thawed in accordance with the current Food Code. A review of the Food and Drug Administration article titled, Refrigerator Thermometers - Cold Facts about Food Safety, dated 3/5/24, indicated To ensure that your refrigerator is doing its job, it is important to keep its temperature at 40 F[Fahrenheit] or below; the freezer should be at 0 F.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 48140 Based on observation, interview and record review the facility failed to ensure six residents (Resident 14, 26, 30, 38, 42, and 51) out of 20 sampled residents had call lights (equipment used by a patient to alert or communicate with a caregiver) within easy reach or call lights that were operable. This failure had the potential for residents to be unable to contact nursing staff when needed. Findings: A review of Resident 51's Admission Record, indicated Resident 51 was admitted to the facility in October 2021 with diagnoses which included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a concurrent observation and interview on 9/3/24 at 10:37 a.m. with Resident 51, in Resident 51's room, Resident 51's call light was observed coiled on the wall where the call light attaches, broken, without a button to push. Resident 51 statedvI don't know where my call light is. During a concurrent observation and interview on 9/3/24 at 12:58 p.m. with Certified Nursing Assistant 9 (CNA 9), in Resident 51's room, CNA 9 confirmed Resident 51's call light was out of reach and inoperable. CNA 9 stated It doesn't work, the button is broken. A review of Resident 51's care plan indicated Resident 51 was at risk for falls and staff needed to place call light within easy reach. A review of Resident 42's Admission Record, indicated Resident 42 was admitted to the facility in April 2023 with diagnoses which included senile degeneration of the brain (loss of intellectual ability). During a concurrent observation and interview on 9/3/24 at 10:55 a.m. with Resident 42, in Resident 42's room, Resident 42's call light cord was observed wrapped around the bed rail hanging off the right side of the bed close to the floor. When questioned if Resident 42 could reach the call light, Resident 42 stated, I can't find the call light, they should have that where I can reach it. During a concurrent observation and interview on 9/3/24 at 11 a.m. with CNA 9, in Resident 42's room, CNA 9 confirmed Resident 42's call light was not easily within reach. A review of Resident 42's care plan indicated Resident 42 was at risk for falls and staff needed to be sure the resident's call light is within reach and encourage the resident to use it. A review of Resident 14's Admission Records, indicated Resident 14 was admitted to the facility in February 2022 with diagnoses which included hemiplegia (paralysis on one side of the body) and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/3/24 at 3:35 p.m. in Resident 14's room, Resident 14 was unable to locate the call light. Resident 14 attempted to locate the call light in the bed; however, with contractures (limited range of motion) to Resident 14's right hand, Resident 14 was unable to locate the call light on the right side of the bed. During a concurrent observation and interview on 9/3/24 at 3:40 p.m. with CNA 6 in Resident 14's room, CNA 6 was unable to locate Resident 14's call light. CNA 6 had to dig under two of Resident 14's pillows to locate the call light. CNA 6 stated, [Resident 14's] right hand is very contracted and needs the call light closer to [Resident 14's] left hand. A review of Resident 14's care plan indicated Resident 14 was at risk for falls and injuries and to keep call light within reach. Resident 14's care plan also indicated Resident 14 had a self-care deficit and to [keep] call light within reach and answer promptly. A review of Resident 38's Admission Record, indicated Resident 38 was admitted to the facility in March 2023 with diagnoses which included encephalopathy (any brain disease that alters brain function or structure) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe). During a concurrent observation and interview on 9/3/24 at 3:47 p.m. with CNA 5 in Resident 38's room, CNA 5 confirmed that Resident 38 did not have a call light available. During a concurrent observation and interview on 9/3/24 at 4:06 p.m., with the Maintenance Director (MD) in Resident 38's room, the MD confirmed Resident 38 did not have a call light. The MD stated, Call lights that aren't working or if the resident doesn't even have one, I should be notified immediately. A review of Resident 38's care plan indicated Resident 38 had a risk for further falls due to poor or no safety awareness and to place the call light within easy reach and to remind [Resident 38] to call for assistance. A review of Resident 30's Admission Record, indicated Resident 30 was initially admitted to the facility in August 2023 with diagnoses which included COPD and diabetes mellitus, type 2 (DM II, a long-term condition in which the body has trouble controlling blood sugar and using it for energy). During a concurrent observation and interview on 9/3/24 at 3:53 p.m., with CNA 5, in Resident 30's room, CNA 5 confirmed Resident 30's call light was broken and inoperable. CNA 5 stated, There's no button, there should be a button. A review of Resident 30's care plan, indicated Resident 30 was found on the floor sitting next to her bed and wheelchair. The nursing staff initiated the following interventions to decrease Resident 30's risk for falls, Encourage to use call for help before attempting to transfer or ambulate .keep call light within reach and answer promptly. A review of Resident 26's Admission Record, indicated Resident 26 was initially admitted to the facility in March 2021 with diagnoses which included Huntington's disease (an inherited condition in which nerve cells in the brain break down over time) and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 9/3/24 at 4:06 p.m. with the MD, in Resident 26's room, the MD confirmed Resident 26's call light was broken and inoperable. The MD stated, These call lights that aren't working should be reported to me immediately .this needs to be fixed immediately. During an interview on 9/5/24 at 4:03 p.m. with the Director of Nursing (DON), the DON stated, Call lights are expected to be close to resident, within easy reach; and the call light needs to be working . without the call light residents would not be able to alert staff for their needs or if there was a safety concern. A review of the facility's policy and procedure (P&P) titled, Call System, Resident, dated September 2022, indicated Each resident is provided with a means to call staff directly for assistance from his/her bed .the resident call system remains functional at all times. A review of the facility's P&P titled, Answering the Call Light, dated September 2022, indicated Be sure that the call light is plugged in and functioning at all times .Ensure that the call light is accessible to the resident when in bed .and from the floor .Report all defective call lights to the nurse supervisor promptly.