STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Post Acute	1090 Rio Lane Sacramento, CA 95822

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48860 Based on interview and record review, the facility failed to ensure an informed consent was obtained (the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention) on the use of psychotropic medication (drugs that affect a person's mental state) for one of 14 sampled residents (Resident 447). This failure decreased the facility's potential to ensure Resident 447 and responsible party (RP) were aware of the risks, benefits, and alternatives of treatment offered to them. Findings: A review of Resident 447's admission records indicated admission to the facility on [DATE], with diagnoses which included dementia (the impaired ability to remember, think, or make decisions), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and schizophrenia (a serious mental health condition that affects how people think, feel, and behave). Resident 447's admission records also indicated a relative was the RP. A review of Resident 447's medical record indicated the following physician's orders: -Risperidone (medication use to treat mental health conditions) 0.5 milligram (mg, a unit of measurement): give 1 tablet via PEG-tube (tube inserted through the wall of the abdomen directly into the stomach) two time a day for bipolar disorder m/b (manifested by) aggression leading towards distress ICO (informed consent obtained), ordered 8/16/24. -Trazodone (medication use to treat depression) 50 mg: give 0.5 tablet via PEG-tube as needed for depression m/b inability to sleep, ordered 8/12/24. A review of Residents 447's Medication Administration Record (MAR) indicated trazodone 0.5 tablet was administered on the following dates: 7/29/24, 7/30/24, and 7/31/24. While risperidone 0.5 mg was administered on 8/16/24, twice on 8/17/24, twice on 8/18/24, twice on 8/19/24, twice on 8/20/24, and on 8/21/24. A review of Residents 447's medical records titled, Informed Consent for Psychoactive Medications for risperidone and trazodone, dated 8/12/24: (continued on next page)

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	--During an interview on 8/21/24 at 3:39 p.m. with LN 3, LN 3 stated staff should ensure that patient has informed consent on file that has been signed by both medical doctor (MD) and representative. LN 3 added that, A nurse can sign a verbal consent from representative as long as the MD will sign it. --During a concurrent interview and record review on 8/21/24 at 1:06 p.m. with DON, Resident 447's informed consents for trazodone and risperidone were reviewed. The records indicated the physician did not provide informed consent to Resident 447. DON confirmed the finding and stated the physician was responsible for obtaining informed consent to a resident prior to initiating a psychotropic medication. During a review of an All Facilities Letter (AFL) 24-07 effective 2/28/24 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 along with, the signature of the health care professional declaring the required material information has been provided. If the resident or resident's representative cannot sign the form, a licensed nurse can sign the form, a licensed nurse can sign the form and document the name of the person who gave consent and the date .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 . During a review of the facility's policy and procedure (P&P) titled, Use of Psychotropic Medications, dated 5/1/23, the P&P indicated, Policy Explanation and Compliance Guidelines: .5. Resident and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48140 Based on observations, interviews and record reviews the facility failed to ensure resident assessments were accurate for one resident (Resident 15) out of nineteen sampled residents. This failure had the potential to establish incorrect baseline data and treatment for Resident 15. Findings: A review Resident 15's Admission Record indicated Resident 15 was admitted to the facility in April 2024 with diagnoses which included metabolic encephalopathy (when problems with metabolism cause brain dysfunction) and generalized weakness. During a concurrent observation and interview on 8/20/24 at 9:10 a.m. in Resident 15's room, Resident 15 was lying in bed. There was no urinary catheter tube (a flexible tube used to empty the bladder) or catheter bag (a bag that collects urine) observed. Resident 15 stated, I can get out of bed myself, I don't use a [urinary] catheter. During a concurrent interview and record review on 8/22/24 at 3:52 p.m., with the Director of Nursing (DON) Resident 15's Order Summary Report (OSR, physician orders), Minimum Data Set (MDS, an assessment tool) dated 5/3/24 and 8/3/24 were reviewed. The DON confirmed Resident 15 did not have a urinary catheter ordered or in use and confirmed the MDS reports were inaccurate. A review of the facility's Policy and Procedure (P&P) titled, Conducting an Accurate Resident Assessment, dated 6/1/23, the P&P stated, The purpose of this policy is to assure that all residents receive and accurate assessment, reflective of the resident's status at the time of the assessment, by qualified staff to assess relevant care areas .Information provided by the initial comprehensive assessment establishes baseline data for the ongoing assessment of resident progress .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34328 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan on the use of a BiPAP (a noninvasive ventilator that helps people breathe by delivering pressurized air into their airways through a face mask) machine for 1 of 19 sampled residents (Resident 10). This failure to develop a care plan on the use of a BiPAP machine had the potential for Resident 10 to received inaccurate and inadequate care. Findings: During a record review of Resident 10's facesheet, the clinical record indicated Resident 10 was admitted with diagnoses of Type 2 Diabetes (a condition of too much sugar in the blood), and Neurocognitive Disorder (a category of mental health disorders that primarily affect cognitive abilities including learning, memory, perception, and problem-solving) with Lewy Bodies (clumps of abnormal protein particles that accumulate in the brain and caused a form of dementia). During the initial pool tour on 8/20/24 at 11 a.m., Resident 10 was observed lying in bed. Resident 10 was was interviewable but confused as to time and place. Resident 10 appeared comfortable. Upon further observation of Resident 10's room, a facemask and tubing connected to a BiPAP machine was found on top of a bedside cabinet. During a record review of Resident 10's physician's order, dated 8/6/24, indicated BiPAP was to be on at bed time and off upon waking. Review of Resident 10's Electronic Health Record (EHR) care plans indicated there were no care plans specific for use of a BiPAP machine. During an interview with the Clinical Reimbursement Director Nurse Consultant (CRD/NC) on 8/21/24 at 9:18 a.m., the CRD/NC was asked to review Resident 10's physician's orders. After reviewing Resident 10's physician's orders she confirmed Resident 10 had orders for BiPAP during bedtime and off when awake. Upon further interview with the CRD/NC, she reviewed Resident 10's care plans using a BiPAP and stated there were no BiPAP care plans in place. She further stated Resident 10 must have a care plan on the use of the BiPAP machine. Review of facility document Comprehensive care plans dated 3/1/23 indicated: .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .3. The comprehensive care plan will describe at a minimum, the following: a. 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 - Many	Ensure services provided by the nursing facility meet professional standards of quality. 48140 Based on observations, interviews and record reviews, the facility failed to assure professional standards of care were followed when: 1. Resident 15, 19, and 29's oxygen tubing (a device that delivers extra oxygen through a tube into your nose) and humidifiers (devices used to humidify supplemental oxygen) were not labeled, dated and changed. 2. Resident 11's physician order for 1:1 (one on one) feeding assistance with meals was not carried out as ordered. 3. Resident 28's physician order for a plate guard (an adaptive device that prevents food from accidentally being pushed off the plate while eating) with all meals was not carried out as ordered. 4. Resident 30's admission medications order for Budesonide inhaler medication to treat a respiratory condition of Chronic Obstructive Pulmonary Disease (COPD) was not entered in the facility's Medication Administration Record and medication was not offered or administered to Resident 30 per physician's order. 5. Licensed Nurse 1 (LN 1) did not observe Resident 27 ingest his afternoon medication. 6. Resident 27's Medication Administration Record (MAR) indicated six doses of intravenous (IV: method of medication administration into a vein) antibiotics (medication to treat bacterial infections) were not documented. 7. Resident 10's BiPAP (a device that helps you breathe) facemask and tubing were not stored in a bag when not in use. These failures resulted in the increased potential for not meeting the resident's therapeutic needs or worsening of their medical conditions. Findings: 1. Review of Resident 15's Admission Record indicated Resident 15 was admitted to the facility in April 2024 with diagnoses which included metabolic encephalopathy (when problems with metabolism cause brain dysfunction) and respiratory failure (not enough oxygen in the tissues in your body). During a concurrent observation and interview on 8/20/24 at 12:53 p.m. with LN 1 in Resident 15's room, Resident 15's oxygen tubing and humidifier were observed labeled with a date of 8/12/24. LN 1 confirmed the date on the humidifier and tubing and stated it should have been changed. LN 1 stated the facility policy is to change the tubing and humidifier weekly and it should have been changed on 8/18/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 15's Order Summary Report (OSR, physician orders) the OSR indicated Resident 15 had an order for oxygen via nasal canula at 2 liters (a unit of measurement) per minute as needed, dated 7/12/24, and an order to change the oxygen tubing (with date labeled on tubing) and humidifier, dated 4/28/24. A review of Resident 19's Admission Record indicated Resident 19 was admitted to the facility in July 2024 with diagnoses including traumatic brain injury (brain dysfunction caused by an outside force) and tachypnea (rapid, shallow breathing). During a concurrent observation and interview of 8/20/24 at 1:10 p.m. in Resident 19's room, with Respiratory Therapist (RT), Resident 19's oxygen tubing and humidifier were observed labeled with a date of 8/12/24. RT confirmed the date on the humidifier and tubing and stated it should be changed every 7 days. During an interview on 08/22/24 at 8:50 a.m. with the Director of Nursing (DON), the DON stated oxygen humidifiers and tubing are to be changed weekly on Sundays and labeled with the date changed. The DON stated changing the humidifiers and tubing regularly decreases the risk for infection. A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 5/1/23, the P&P indicated, Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. 2. Review of Resident 11's Admission Record indicated Resident 11 was admitted to the facility in June 2024 with diagnoses including dysphagia (difficulty swallowing) and cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain). During an observation on 8/21/24 at 12:28 p.m. in Resident 11's room, Resident 11 was observed sitting up in bed, slouched to the right side, with a lunch tray in front of him. Resident 11 was attempting to feed himself with his right hand. During an interview on 8/21/24 at 12:44 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 had picked up Resident 11's lunch tray and stated Resident 11 ate a small percentage of lunch and she was unaware that Resident 11 needed 1:1 assistance with meals. A review of Resident 11's OSR indicated Resident 11 had an order for 1:1 feeding assistance with meals, with a start date of 6/9/24. During a concurrent interview and record review on 8/22/24 at 8:50 a.m. with the DON, Resident 11's OSR was reviewed. The DON acknowledged Resident 11's order for 1:1 feeding assistance with meals and confirmed the order had not been implemented. The DON stated he expected the nursing staff to carry out physician orders when received and to relay this information to the appropriate staff members who were involved in Resident 11's care. 3. Review of Resident 28's Admission Record indicated Resident 28 was admitted to the facility in March 2024 with diagnoses including chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease) and muscle weakness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 28's OSR indicated Resident 28 had an order for a plate guard with all meals, with a start date of 7/26/24. During a concurrent observation and interview on 8/21/24 at 12:22 p.m. with CNA 1, in Resident 28's room, CNA 1 delivered Resident 28's meal tray. CNA 1 confirmed Resident 28 did not have a plate guard on his lunch tray. During an interview on 8/21/24 at 2:19 p.m. with the Certified Dietary Manager (CDM), the CDM stated he was unaware of Resident 28's order for a plate guard. The CDM stated the resident's meal tickets will identify the use of assistive devices, such as a plate guard. During an interview on 8/22/24 at 8:50 a.m. with the DON, the DON indicated he expected the nursing staff to carry out physician orders when received. The DON stated the licensed nurse who received the order is expected to inform kitchen staff, verbally and through written communication, when a new order was received. The DON confirmed the physician order had not been carried out. A review of the facility's P&P titled, Physician Orders, dated 6/15/23, indicated, Enter the order into the medical record manually or electronically as given by the Physician .Follow through with orders by making appropriate contact or notification. 46242 4. The following documents were reviewed in Resident 30's medical records: a. A document titled Admission Record, dated 8/23/24, indicated, Resident 30 was admitted to the facility in July of 2024 with diagnoses which included COPD and Congestive Heart Failure (CHF, a heart condition). b. A hospital discharge document titled Active Medication Interfacility Transfer Report/Physician Orders, dated 7/17/24, indicated the following order budesonide 0.5 mg/2ml [milligrams per 2 milliliter, unit of measurement] . BID NEB -Inhalation Soln [twice a day nebulizer inhalation solution] . c. Medication Administration Record (MAR, a summary document of medications ordered and administered) for July and August of 2024 were reviewed and as of August 23, 2024, did not contain orders for Budesonide inhaler medication and showed no administration record for the medication. d. A Minimum Data Set (MDS, an assessment tool), dated 7/23/24, indicated, Resident 30 was cognitively intact and had a diagnosis of COPD. e. A care plan document indicated care plan titled The resident has COPD, date initiated 7/17/24, included the following interventions, Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. f. A document titled Consultant Pharmacist's Medication Regimen Review (MRR, a document detailing pharmacist recommendations), dated 7/26/24, contained no recommendations addressing Budesonide inhaler medication order for Resident 30. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 8/20/24 at 10:57 a.m. Resident 30 stated that he has COPD and his breathing was getting worse. He also added that he used to get an inhaler that he doesn't get anymore. During a concurrent interview and record review on 8/22/24 at 11:11 a.m. with a Licensed Nurse (LN 5), Resident 30's medications orders were reviewed and LN 5 confirmed that budesonide inhaler medication order was indicated on hospital discharge orders, but she was not able to find the corresponding order in the facility's MAR for Resident 30. In an interview on 8/23/24 at 7:57 a.m. with the Director of Nursing (DON), DON confirmed that hospital discharge order for Budesonide inhaler for Resident 30 did not get transferred to the facility's MAR, and as consequence, medication was not offered or administered to the Resident. DON confirmed that the order was not cancelled on admission to the facility, and medication should have been provided as ordered. A review of facility's policy and procedure (P&P) titled Physician Orders, dated 6/15/23, indicated, .Each medication order should be entered into the electronic medical record .Transcribe newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR . Written Transfer Orders (sent with a resident by a hospital or other health care facility) - Implement a transfer order without further validation, if it is signed and dated by the resident's current attending physician . 47563 5. A review of Resident 27's admission record indicated Resident 27 was admitted to the facility in June of 2024 with diagnoses that included chronic pain (pain that persists beyond the usual recovery period). During a concurrent observation and interview on 8/20/24 at 12:23 p.m., Resident 27 was in his room sitting up in bed with a small plastic cup that contained a yellow pill in his hands. Resident 27 stated a nurse had given him the pill in the cup and left the room without asking Resident 27 to take the pill. During a concurrent observation and interview on 8/20/24 at 12:25 p.m., in Resident 27's room, LN 1 confirmed Resident 27 had a gabapentin pill in a small plastic cup and alleged Resident 27 had put the medication in his mouth while LN 1 was in the room and spit the pill out and into the cup when LN 1 had left the room. Resident 27 said no but LN 1 repeated that Resident 27 had removed the pill from his mouth and put it back in the cup. An interview on 8/20/24 at 12:27 p.m., Resident 27 denied LN 1 had asked him to take the medication and denied that the pill had been in his mouth. An interview on 8/21/24 at 12:33 p.m., LN 3 Stated it is the nurse's responsibility to ensure residents get their medications as ordered. An interview on 8/23/24 at 9:51 a.m., the Clinical Reimbursement Director/ Nurse consultant (CRD/NC) stated when administering medication, she expected the nurse to stay with the resident and make sure the resident took the medication given. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 8/23/24 at 10:26 a.m., the DON stated no residents in the facility were approved to administer medication by themselves and the DON expected nurses stay to ensure the resident took the medication given. A review of Resident 27's OSR, dated 8/22/24, indicated an active order for gabapentin 300 milligram (mg: a unit of measure) to be given by mouth three times a day for pain. A review of the facility's P&P titled, medication administration, dated 3/1/23, indicated, .medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .observe resident consumption of medication . 6. A review of Resident 27's admission record indicated Resident 27 was admitted to the facility in June of 2024 with diagnoses that included extradural and subdural abscess (pocket of pus that forms between the brain and the tissues that cover the brain) and methicillin resistant staphylococcus aureus infection (MRSA: a type of bacterial infection that does not get better with the type of antibiotics that usually cure staphylococcus infections). An interview on 8/21/24 at 12:33 p.m., LN 3 stated only registered nurses are allowed to administer IV medications and when an IV medication is scheduled, she will inform the DON to ensure the DON or another registered nurse is available to give the medication. LN 3 explained, anytime a medication is administered it is expected to be documented as administered in the resident's MAR and if a medication is not documented as administered on the MAR, it means it was not given. LN 3 added, if the scheduled medication was not given nurses are expected to write a progress note indicating why the medication was not given and the resident's doctor (MD) was notified. During a concurrent interview and record review on 8/21/24 at 12:42 p.m. with the DON, Resident 27's August 2024 MAR and August 2024 progress notes were reviewed. The DON stated when medications are administered, he expected the MAR to reflect the medication was given. The DON added, if a medication is not administered as ordered, he expected the MAR would indicate the medication was not given and he expected a progress note, documenting why the medication was not given and the resident's MD was notified. The DON confirmed Resident 27's MAR indicated Resident 27 was ordered Vancomycin (an antibiotic medication) 1 gram (g: a unit of measure) to be administered via IV twice a day from 7/31/24 through 8/15/24 and the MAR indicated no administrations documentation for the 11:50 a.m. scheduled doses on 8/2/24, 8/6/24, 8/7/24, 8/13/24, 8/14/24, and 8/15/24. The DON also confirmed there was no presence of progress notes on those dates indicating the Vancomycin had not been given. The DON stated he had been working those dates, he had given the IV Vancomycin as ordered, and had not documented the administrations on the MAR. An interview on 8/23/24 at 9:33 a.m., LN 4 stated nurses are expected to document all medications given on the resident's MAR and added if an administration was not documented it could lead staff to believe the medication had not been given. An interview on 8/23/24 at 9:51 a.m., the CRD/NC stated it is the expectation that when a medication is administered it is documented in the resident's MAR. The CRD/NC added if the MAR did not indicate a medication was given, a nurse who didn't know the medication was given could possibly give more medication with the potential of a resident receiving too much medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's P&P titled, medication administration, dated 3/1/23, indicated, .medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .Sign MAR after administered .+ During a Record Review of Resident 10's facesheet, Resident 10 was admitted with diagnoses of Type 2 Diabetes (a condition of too much sugar in the blood). Neurocognitive Disorder (a category of mental health disorders that primarily affect cognitive abilities including learning, memory, perception, and problem-solving) with Lewy Bodies (clumps of abnormal protein particles that accumulate in the brain. These deposits cause a form of dementia). During the initial pool tour on 8/20/24 at 11 a.m. Resident 10 was observed lying in bed. Resident 10 was was interviewable but confused as to time and place. Resident 10 appeared comfortable. Further observation of Resident 10's room, on top of the cabinet was observed a facemask and tubing connected to a BiPAP machine (a noninvasive ventilator that helps people breathe by delivering pressurized air into their airways through a face mask). The face mask and tubing were not stored away in a bag to protect from dust, contamination, and a possible source of infection. Review of Physician's order dated 8/6/24 indicated BiPAP was to be on at bed time and off upon waking. On 8/20/24 at 11:30 a.m. accompanied by the Director of Nursing (DON), the DON confirmed Resident 10 received BiPAP treatment at bedtime. The DON confirmed the BiPAP facemask and tubing were left exposed and unprotected from dust and contamination. The mask and tubing must be kept in a clean bag. The DON stated he will provide a clean bag to store the BiPAP equipment. Review of facility policy and procedure CPAP (Continuous Positive Airway Pressure) / BiPAP cleaning dated 6/1/2023 indicated: .2. Respiratory equipment can become colonized with infectious organisms and serve as a source of respiratory infections .6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry Well. Cover with plastic bag or completely enclosed in a machine storage bag when not in use. During a record review of Resident 29's facesheet indicated she was admitted into the facility with diagnoses of Chronic Kidney Disease Stage 4 (severe), Acute Respiratory Failure with Hypoxia (low level of oxygen in the blood). On 8/20/24 11:24 a.m. Resident 29 was observed in his room during the initial pool tour of the facility. Resident 29 was receiving Oxygen at two (2) Liters Per Minute (LPM, the amount of oxygen delivered per minute) via nasal cannula (a device that delivers extra oxygen through a tube and into your nostril). Further observation of the nasal cannula indicated a date was written on the cannula which indicated a date of 7/15/24. During a record review of Resident 29's Physician's Order Summary Report (POSR) indicated the physician ordered on 6/15/24: .Administer O2 (oxygen) at 2 l/min (Liters per minute) via NC (nasal cannula) at HS (Hour of sleep) and naps. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Post Acute	1090 Rio Lane Sacramento, CA 95822

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/20/24 11:35 a.m. accompanied by the DON, the DON confirmed the observation of the date on Resident 29's oxygen cannula was 7/15/24. The DON stated the date represented the last time the oxygen cannula was changed. The DON stated the nasal cannula must be changed once a week or more frequently if dirty or soiled. The DON stated Resident 29 nasal cannula will be replaced. Review of a facility policy dated 5/1/23 Oxygen Administration indicated: .5. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. 34328

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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. 46242 48860 Based on observation, interview, and record review, the facility failed to: 1. Ensure accurate accountability and effective storage of controlled medications (those with high potential for abuse or addiction) when random controlled medication audits of the Medication Administration Record (MAR) and Controlled Drug Record (CDR) for three residents (Residents 9, Resident 28, and Resident 296) did not reconcile to indicate they were given to the residents. 2. Implement a system to accurately document and secure emergency medications (E-Kit). These failures resulted in the facility not having accurate accountability of controlled medications and potential for abuse or misuse of these medications, the potential for emergency medications to be unavailable when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions. Finding: 1. Resident 9 had a physician's order of oxycodone (a medication to treat moderate to severe pain) 5 milligrams (mg, a unit of measurement) , one tablet by mouth every six hours if needed, ordered 8/16/24. The CDR indicated one tablet was signed out on 7/11/24 at 4:39 p.m. and on 7/15/24 at 1:19 p.m. The MAR did not indicate oxycodone was administered to Resident 9 on these dates and times. Resident 28 had a physician's order of hydrocodone/APAP 10-325 mg , one tablet by mouth every four hours as needed for pain, ordered 4/23/24. The CDR indicated one tablet was signed out on 8/4/24 at 9:20 p.m. The MAR did not indicate hydrocodone/APAP was administered to Resident 28 on this date and time. Resident 296 had a physician's order of oxycodone 5 mg, one tablet by mouth every eight hours as needed for moderate to severe pain. The CDR indicated one tablet was signed out on following dates: 7/27/24 at 8:30 p.m., 7/31/24 at 11:36 p.m., 8/1/24 at 12:21 p.m., 8/3/24 at 8 p.m., and 8/9/24 at 3 a.m. The MAR did not indicate Oxycodone was administered to Resident 296 on those dates and times. During an interview on 8/20/24 at 4:03 p.m. with Licensed Nurse 3 (LN 3), LN 3 stated whenever a controlled medication was administered to a resident, it was to be documented on the resident's MAR, progress notes, and CDR. LN 3 stated, It is important to document on both [the CDR and MAR], so that the time can be accurate, and it tells me the last dose of when it was given. During an interview on 8/21/24 at 10:16 a.m. with the Director of Nursing (DON), DON stated staff are expected to sign out the controlled drugs on the CDR and MAR. DON stated it was important for documentation to be complete in the MAR and CDR for controlled drug accountability. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Controlled Substance Administration & Accountability, dated 5/1/23, the P&P indicated, Policy Explanation and Compliance Guidelines . f. All controlled substances (Schedule II, III, IV, V) are accounted for in one of the following ways . ii. All controlled substances obtained from a non - automated medication card or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided . g. In all cases, the doses noted on the usage form or entered in the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in patients' medical record. 2. During a concurrent inspection and interview of the Medication Storage Room on 8/20/24 at 10:05 a.m. with the DON, one of the two E-kits containing controlled medications was inside an unlocked drawer. It was also identified that an opened and used oral E-kit and an opened and unused Intramuscular (IM) E-kit were stored under the countertop. The DON confirmed that there were two oral E-kits and stated E-kits should be exchanged with pharmacy during pick up. The DON stated controlled E-kits should be securely stored behind locked drawer or locked refrigerator. The DON's expectation for staff was to secure the E-kits with zip ties (type of fastener for holding items together), and that E-kits should be reordered once it was opened regardless if medications were used or not. A review of the facility's Policy and Procedures (P&P) titled, Emergency Medication Policy, dated 5/1/23, the P&P indicated, Policy Interpretation and Implementation . 9. Medications and supplies used from emergency medications kit must be replaced upon the next routine drug order. During a review of facility's P&P titled, Medication Storage, dated 3/1/23 the P&P indicated, Policy Explanation and Compliance Guidelines . 2. Narcotics and Controlled Substances . a. Schedule II drugs and back up stock of Schedule III, IV, and V medications are stored under double-lock key. b. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same are, such as in refrigerator.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48860 Based on observation, interview, and record review, the facility had a 12.82% error rate when five medication errors out of 39 opportunities were observed during a medication pass for three of six sampled Residents (Residents 9, 21, and 30). This failure resulted in medications not given in accordance with the prescriber's orders and potential to affect the residents' clinical conditions. Findings: 1.During a medication observation on 8/20/24 at 8:30 a.m., with Licensed Nurse 2 (LN 2), LN 2 was observed preparing 11 medications including losartan (a medication to treat high blood pressure) and B Complex with vitamin C for Resident 9. A review of Resident 9's medical record indicated the following physician's orders: - Losartan 25 milligrams (mg, a unit of measurement): Give 1 tablet by mouth one time a day for hypertension with a meal/ food. Hold for SBP (systolic blood pressure, the maximum pressure in the heart when it pushes blood out to the body) is less than 110 or pulse is less than 60; 1 tablet by mouth every evening with meal, ordered 8/17/24. -Nephplex Rx (use to treat or prevent vitamin B deficiency) Oral Tablet (B-Complex with Vitamin C - Zinc and Folic Acid): 1 tablet by mouth one time a day for supplement, ordered 8/17/24. During a concurrent interview and record review on 8/20/24 at 1:53 p.m. with LN 2, Resident's 9 discharge orders were reviewed. The discharge orders indicated, Losartan (COZAAR, brand for losartan) 25 mg Tablet: Take 1 tablet by mouth every evening with a meal. LN 2 confirmed Losartan should have been administered in the evening. LN 2 reviewed the order for Nephplex Rx Oral Tablet and confirmed the order did not match what she had administered. During an interview on 8/21/24 at 10:08 a.m. with the Director of Nursing (DON), the DON stated, Staff need to follow orders from the hospital. 2. During a medication pass observation on 8/20/24 at 9:10 a.m. with LN 2, LN 2 was observed preparing 12 medications for Resident 30. LN 2 looked in the medication cart and could not locate Resident 30's Brovana (a medication used to treat breathing issues) and stated she would not be able to administer it as scheduled for that morning. A review of Resident 30's medical record indicated the following physician's order: - Brovana Inhalation Nebulization Solution 15 micrograms /2 milliliters (mcg/ml, a unit of measurement) : Inhale one vial orally via nebulizer (a device used to administer medication into the lungs) two times a day for CHF (congestive heart failure, a serious condition that occurs when the heart cannot pump enough blood to meet the body's needs), ordered 7/17/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and inspection of medication refrigerator on 8/21/24 on 9:30 a.m. with the DON, DON confirmed Resident 30's Brovana was inside the medication storage room refrigerator and nursing staff had failed to look there. During an interview on 8/21/24 on 10:08 a.m. with the DON, DON stated missed administration of Resident 30's Brovana could have lead to worsening of his clinical condition. 3. During a medication pass observation on 8/20/24 at 11:56 a.m. with LN 1, LN 1 prepared Resident 21's three medications which included, insulin aspart (medication use to treat diabetes) prefilled pen, ondansetron (a medication to treat nausea and vomiting) ODT (orally disintegrating tablet, a dosage form that dissolves on the tongue) 8 mg, and Thermotabs (a mineral supplement). LN 1 dialed the insulin aspart prefilled pen to 3 units and administered it into Resident 21's left lower quadrant and removed it after approximately two seconds. Resident 21 then took the ondansetron and Thermotab together and swallowed them with sips of water. A review of Resident 21's medical record indicated the following physician's order: - Insulin Aspart 100 units/mL: inject 3 units subcutaneously (under the skin) in the morning for diabetes before breakfast and inject 3 unit subcutaneously one time a day for diabetes before lunch and inject 5 unit subcutaneously one time a day for diabetes before dinner, ordered 8/18/24 - Ondansetron Oral Tablet Disintegrating 8 mg: Give 1 tablet by mouth three times a day for nausea, ordered 8/17/24 During an interview on 8/20/24 at 1:43 p.m. with LN 1, LN 1 confirmed he did not prime (a process to remove air bubbles from the needle and ensure the pen is working properly) the prefilled pen injectors. He stated prefilled pen injectors should be held under the skin for about 10 to 15 seconds and stated the full dose may not be administered if the insulin pen was not primed or held under skin long enough. LN 1 stated ODT tablets were to be administered under the tongue, not swallowed, separately from other medications. During an interview on 8/21/24 on 10:08 a.m. with the DON, DON agreed that residents would not receive the correct dose of insulin if prefilled injector pens were not primed and held long enough under the skin. The DON added that he expected the staff to administer ondansetron ODT separately from other medications. According to UpToDate [NAME]-Drugs, the labeling for administration indicated, For prefilled pen injectors, prime the needle before each injection with 2 units of insulin. Once injected, hold the needle in the skin for at least 6 seconds after the dose dial has returned to 0 units before the needle is removed to ensure the full dose has been administered. During a review of UpToDate [NAME]-Drugs, administration of ondasetron ODT indicated, Using dry hands, place tablet on tongue and allow to dissolve. Swallow with saliva (no need to administer with liquids). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P [NAME], Medication Administration dated March 1, 2023, the P&P indicated, Medication Administration, dated 3/1/23, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Administer medication as ordered in accordance with manufacturer specifications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 48860 Based on observation, interview, and record review, the facility failed to ensure one of 14 sampled residents (Resident 30) was free of a significant medication error when Resident 30 missed 25 doses of Brovana (generic name aformoterol tartrate, a medication to treat breathing problems) when nursing staff did not know to check for it in the medication storage room refrigerator. This deficient practice had the potential to result in breathing complications and worsening of Resident 30's clinical condition. Findings: During a medication pass observation on 8/20/24 at 9:10 a.m. with Licensed Nurse (LN) 2, LN 2 was observed preparing 12 medications for Resident 30. LN 2 looked in the medication cart and could not locate Resident 30's Brovana (a medication used to treat breathing issues) and stated she would not be able to administer it as scheduled for that morning. A review of Resident 30's medical record indicated that the following physician's order: - Brovana Inhalation Nebulization Solution 15 micrograms /2 milliliters (mcg/ml, a unit of measurement): Inhale one vial orally via nebulizer (a device used to administer medication into the lungs) two times a day for CHF (congestive heart failure, a serious condition that occurs when the heart cannot pump enough blood to meet the body's needs), ordered 7/17/24. A review of Residents 30's medication administration record (MAR), dated July 2024, indicated Resident 30 was not administered Brovana as ordered : on the following days (for a total of 8 doses): 7/17/24, 7/18/24, 7/21/24, 7/22/24, 7/23/24, and 7/24/24. A review of Resident 30's MAR, dated August 2024, indicated Resident 30 was not administered Brovana as ordered on the following days (for a total of 17 doses): 8/5/24,8/6/24, 8/7/24, 8/8/24, 8/9/24, 8/12/24, 8/13/24, 8/14/24, 8/15/24, 8/17/24, 8/18/24, and 8/20/24. During an interview on 8/20/24 at 4:24 p.m. with Resident 30, Resident 30 stated that he had notified nursing staff he needed his Brovana breathing treatments. He stated he felt short of breath since not receiving his medication routinely as ordered by the physician. During a concurrent interview and inspection of the medication storage room refrigerator on 8/21/24 at 9:30 a.m. with the Director of Nursing (DON), multiple orders of Resident 30's Brovana (dated 7/13/24, 7/17/24, and 8/20) were identified inside. DON confirmed the finding. During a concurrent interview and inspection of medication refrigerator on 8/21/24 on 9:30 a.m. with the DON, DON confirmed Resident 30's Brovana was inside the medication storage room refrigerator and nursing failed to look there. He stated he expected the MAR to indicate, Keep med in fridge, in order for nursing staff to know to look there. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Medication Administration, dated 3/1/23, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . and 20. Correct any discrepancies and report to nurse manager, MD, and /or DON.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47563 Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly for a census of 51 residents, when a medication cart (a lockable cabinet on wheels that stores drugs and supplies) and a treatment cart (a lockable cabinet on wheels that stores drugs and supplies) were unlocked and unattended. These failures had the potential for drug diversion and drug misuse. Findings: During a concurrent observation and interview on 8/20/24 at 8:22 a.m. with the Activities Director (AD) in the walkway in front of the nursing station, the AD confirmed a treatment cart was observed to be unlocked with keys hanging from the lock cylinder while no staff were present at the cart. The AD confirmed the cart stored drugs and should have been locked. During a concurrent observation and interview on 8/20/24 at 8:27 a.m. with Licensed Nurse 1 (LN 1), in the walkway in front of the nursing station, medication cart A was observed to be unlocked while no staff was present at the cart. The LN 1 confirmed the cart was unlocked while he was at the nursing station, the cart stored drugs, and should have been locked to prevent an unauthorized persons to access and possibly ingest the drugs. An interview on 8/23/24 at 9:33 a.m., LN 4 stated medication and treatment carts should be locked when staff are not attending the carts to prevent unauthorized persons from accessing and taking drugs that could cause a bad reaction. LN 4 added, the treatment cart also stores sharp objects that could be dangerous for unauthorized persons to obtain. An interview on 8/23/24 at 10:51 a.m., the Clinical Reimbursement Director/ Nurse consultant (CRD/NC) stated it was important to ensure treatment and medication carts are locked when staff are not right in front of the carts. The CRD/NC clarified, she expected staff to lock the medication cart to prevent unauthorized access even when a nurse is behind the nursing station and the medication cart is in front of the nursing station. The CRD/NC added, the carts needed to be locked for safety and to prevent someone taking medications they should not take. An interview on 8/23/24 at 10:26 a.m., the Director of Nursing (DON) stated he expected the treatment and medication carts to be locked when the nurse steps away from them. The DON clarified, he expected the medication cart to be locked even if the nurse was just a steps away at the nursing station and the medication cart was left in front of the nursing station. A review of facility policy and procedure (P&P) titled, Medication Storage, dated 3/1/23, indicated, . it is the policy of this facility to ensure all medications house on our premises will be stored . to ensure proper . security . all drugs and biologicals will be stored in locked compartments . only authorized personnel will have access to the keys to locked compartments .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41838 Based on observation, interview and record review, kitchen staff failed to demonstrate appropriate competencies to carry out kitchen sanitation when: 1. Staff were unable to show the correct procedure for testing of sanitation solution buckets, and 2. Staff did not test dishwashing sanitation at the plate level, which was necessary to ensure adequate sanitation had occurred. These failures had the potential of leading to food borne illness for the 49 residents eating facility prepared food. Findings: 1. During the initial kitchen tour on [DATE] at 9:24 a.m., dietary aide 1 (DA1) was asked to show how the red sanitation buckets were tested to ensure the proper concentration of sanitizer. DA1 threw out the solution in the bucket and refilled from the dispenser on the wall. Another red bucket was in the sink, DA1 was asked to test the existing bucket. DA 1 took a test strip and held in in the solution for 10 seconds (directions on bottle stated to hold in solution for 5 seconds). Upon taking the strip out of the solution, he compared that the test strip to the color coding on the strip bottle and stated that it was in the correct range. DA1 was asked to test the bucket a second time, again leaving the strip in the bucket for 10 seconds. Upon taking out the strip, he compared that the test strip to the color coding on the test strip bottle and stated that it was in the correct range. During a return visit to the kitchen on [DATE] at 4:04 p.m., DA 2 was preparing peanut butter and jelly sandwiches. When asked to demonstrate the red bucket sanitizer procedure, DA2 responded that I'm new here, I wasn't trained. When ask how long he had worked at the facility, DA2 stated 2 months. Subsequently, [NAME] 1 was working on the dinner meal and stated, They check the [red] buckets with strips. When asked to show us he stated, I don't do that and pointed to the dietary aide. During a review of the facility provided policy titled Routine Cleaning and Disinfection (Dated [DATE]) it indicated It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infection to the extent possible . 'Disinfection' refers to . chemical destruction of pathogenic and other types of microorganisms. Under the procedures it listed the following: 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Disinfectant solution will be prepared fresh daily and changed frequently in order to ensure effectiveness. a. Follow manufacturer recommendations for dilution and frequency of changing of disinfectant solution. b. Follow manufacturer recommendations regarding appropriate contact time to ensure adequate disinfection. 2. During a kitchen observation on [DATE] at 1:17 p.m., dishwashing of the lunch meal was taking place. DA1 was sending the dirty dishes through the dish washer while DA2 was removing the clean dishes from the dish washer for drying and putting away. After a few racks of dishes had been run through the dish washer, DA2 was asked to demonstrate how the sanitizing solution was checked to ensure it was at an effective concentration level. DA2 took a test strip and started to place it into the liquid collected at the bottom of the machine. DA2 was asked to retest at the plate level of the dish racks since this was the area that sanitation was needed. DA2 performed test strips on 3 separate wash loads without the concentration meeting the desired level. The Certified Dietary Manager (CDM) then changed out the bottle of sanitizing solution. The CDM had more dishes washed and tested again, but the concentration did not meet the desired concentration level. The test strip bottle was reviewed and showed the test strips had not expired, but a new bottle of test strips was trialed and again did not meet the concentration level. During a kitchen observation on [DATE] at 2:30 p.m., the sanitation supply company checked out the dishwasher. The company found that the facility had been using the wrong strips for their product even though the company had been under contract since February 2024. During an interview on [DATE] at 4:24 p.m. with the CDM, the CDM stated that the problem with sanitation not being done correctly could leave bacteria on dishes and lead to cross contamination. During a review of facility provide policy titled Dishwasher Policy (undated), it indicated that It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions . Bullet 5. further indicated that Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift . During a review of the Food and Drug (FDA) 2022 Food Code section ,d+[DATE].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. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The FDA Food Code further explained in section ,d+[DATE].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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 41838 Based on observation, interview and record review the facility failed to provide a resident (296) the appropriate nutritive profile matching the physician prescribed renal diet when potatoes were served. This failure had to potential to lead to confusion regarding diet restrictions for the resident, as well as lead to heart issues due to the high potassium content from the meal provided. Findings: During an observation of the lunch meal on 8/20/24 at 12:50 p.m., Resident 296 was in his bed eating his lunch. The meal plate contained turkey, 2 scoops of mashed potatoes, and broccoli. Resident 296 points to the potatoes and stated that those aren't allowed on the renal diet. Resident 296's tray ticket showed that a renal diet had been ordered, and potatoes were listed as a dislike. During an interview on 8/20/24 at 3:45 p.m. with the Certified Dietary Manager (CDM), the CDM confirmed that renal diet restrictions were listed in the dislike column of the meal tray tickets to provide another cue to food servers of what they should not serve. In reviewing resident 296's tray ticket, the CDM noted that he was on a renal diet and that potatoes were included on the dislike list. The CDM confirmed that Resident 296 should not have received mashed potatoes. During an interview on 8/22/24 at 11:25 a.m. with the Registered Dietitian (RD), the RD stated that the renal diet limits the amount of phosphorus and potassium provided daily. She further stated that she expected the kitchen to follow the menu which would not have included potatoes, beans, tomatoes or other potassium rich foods. She went on to state that The problem with potassium for those with renal disease is that it can lead to heart arrhythmias and heart palpitations. Review of the facility provided Nutrition Manual (Healthcare Menus Direct, LLC. 2023) indicated that the renal diet is used for the resident with renal insufficiency or for residents with renal failure not on dialysis. This diet regulates the dietary intake of sodium, potassium, and protein to lighten the work of the diseased kidney.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49849 Based on observation, interview, and record review, the facility failed to ensure food storage, preparation and cleaning areas were in accordance with professional standards for food service safety when: 1) Foods that had been opened previously were not tightly closed, 2) A dirty fan was turned on and blowing onto clean plate guards, 3) Dishwash sanitizer solution test strips were not correct for solution type (to ensure sanitation occurred), 4) Resident refrigerator/freezer containing food for residents had food products marked with a room number but missing resident name. This failure had the potential to cause food borne illness in 49 of the 51 facility residents that received facility prepared foods. Findings: 1. During a concurrent observation and interview during the initial kitchen tour on [DATE] at 8:40 a.m., with Certified Dietary Manager (CDM), a bag of previously opened shredded cheddar cheese was found unsealed. The CDM verified that the bag of previously opened shredded cheese was not properly sealed. The CDM stated he would want to make sure that this gets sealed so that nothing could get inside the bag. During a follow-up interview on [DATE] at 4:24 p.m., the CDM stated an unsealed bag of food is an issue because things could get into the bag of food, causing bacteria to grow. A review of the facility's policy and procedure (P&P) titled; Food Safety Requirements dated [DATE] indicated, . Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: .Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section [DATE]. 15, titled Package Integrity [DATE] version, indicated FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants. 2. During the initial kitchen tour on [DATE] at 9:04 a.m., with the CDM, a dirty fan was observed, turned on and blowing onto clean plate guards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 4:37 p.m., on a follow-up visit to the kitchen, the CDM confirmed the build-up of dirt on a fan facing clean plate covers. The CDM confirmed that this was an issue because the dirt could get on the clean plate covers. A review of the facility's P&P titled; Routine Cleaning and Disinfection, dated [DATE] indicated, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section ,d+[DATE]. 11, titled Cleaning of Equipment and Utensils [DATE] version, indicated NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 3. During a follow-up kitchen observation on [DATE] at 1:28 p.m., the Dietary Aide 1 (DA1) and DA2 were washing dishes from the lunch meal service. DA2 was asked to demonstrate how to check for effective sanitation concentration level, using test strips for the dishwasher. After 3 attempts, the test strips showed that the sanitation concentration was not meeting the requirement, as evidence by comparing the test strip to the color coding on the test strip bottle. The CDM changed out the sanitizer solution. The dishwasher was restarted with the new solution; however, testing did not show the correct level of effective concentration. A review of the test strip bottle showed the test strips had not expired. The CDM acquired a new bottle of test strips. The new test strips also did not show that it met the effective concentration level. The sanitation company was contacted to come to the facility. The sanitation supply company came to the facility on [DATE] at 2:30 p.m. to assess the dishwasher. The sanitation company found that the facility had been using the wrong test strips for their product, even though the company had been under contract for 6 months. The correct test strips were provided by the company at this time. During a follow-up interview on [DATE] at 4:24 p.m., with the CDM, the CDM acknowledged the incorrect dishwasher sanitation test strips were switched out and the correct test strips were provided by the sanitation company. The CDM acknowledge the staff were using the wrong test strips. The CDM stated it was necessary to ensure the correct test strips were utilized to make sure everything is sanitized. The CDM acknowledged this can cause a problem with confirming sanitation of dishes and could cause cross-contamination. A review of the facility's P&P titled; Routine Cleaning and Disinfection, dated [DATE] indicated, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. 4. During an observation of the Resident refrigerator in the break room on [DATE] at 9:18 a.m., the freezer stored an ice cream container with a label containing only the room number. The ice cream container was not labeled with a resident name or the date that it was brought in. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON), the DON acknowledged that the facility has a policy that outside food can be brought into the facility, but must be labeled with room number, date, and name of resident. The DON stated that missing information on resident food could pose a problem as the wrong resident could get the wrong food and this could cause a possible allergic reaction, and/or the texture could be a choking hazard. A review of the facility's P&P titled; Use and Storage of Food Brought in by Family or Visitors, dated [DATE] indicated, It is the right of the residents of this facility to have food brought in by family or visitors, however, the food must be handled in a way to ensure the safety of the resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34328 Based on observation, interview and record review, the facility failed to store and kept confidential multiple residents medical records. This failure had the potential to exposed multiple residents health information by persons not involved in the residents care, for a facility census of 51. Findings: On 8/20/24 at 1:54 p.m. a large open cardboard box was found underneath one of the desk in the Physical Therapy Department (PTD). The open box was observed to contain multiple residents confidential health information records of residents receiving Physical Therapy and Occupational Therapy (OT). The open and unsecured cardboard box was located near the doorway where other residents and visitors come and go outside to access the patio area. There was a potential for unauthorized access into the cardboard box and unauthorized persons not involved with patient care. During an additional observation of the Physical Therapy Department (PTD) there were no confidential records bins located in the PTD. The nearest accessible confidential records bin were 2 large bins observed located outside the main entrance door of the PTD about 10 to 12 feet away were the cardboard box was found. During an interview with the Physical Therapist (PT) on 8/20/24 at 2 p.m., the PT was shown the open cardboard box stored underneath the desk. She confirmed that the box contained the residents' treatment records and reports. The treatment records and reports, after the therapist had documented and reported in the resident's Electronic Health Records, were stored in the box. The PT stated there is a PT technician who collects the contents of the box at the end of the day and disposed of the contents of the box daily into the confidential records bin for destruction. A random sampling of the contents of the cardboard box were reviewed and indicated there were multiple resident health records of seven (7) discharged residents who were discharged on ,d+[DATE], 7/20, 7/22, 7/26, 7/31, 8/5. and 8/19/24 were available for review. These seven (7) discharged residents records indicated they received Physical Therapy and Occupational Therapies. These seven (7) residents records were not disposed of daily by disposing the residents confidential records into the confidential records bin for destruction. A random sampling of the contents of the cardboard box were reviewed and indicated there were 16 residents currently in house that received Occupational Therapy (OT) services on 6/12, 6/15, 7/11, and 7/14/24. These 16 resident records were not disposed of daily by tossing the residents confidential records into the confidential records bin for destruction. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A random sampling of the contents of the cardboard box were reviewed and found to contain 22 multiple residents health records who were provided Physical Therapy services on the following dates 7/11, 7/12, 7/15, 7/18, 7/22, 8/14, and 8/15/24. These 22 multiple resident records were not disposed of daily by tossing the residents confidential records into the confidential records bin for destruction During an interview with Administrator 1 (ADM 1) on 8/20/24 at 3:16 p.m., the ADM 1 was shown the contents of an opened box stored underneath the desk in the Physical Therapy Department. The ADM 1 confirmed that the box contained confidential residents records. The confidential papers should have been thrown into the confidential paper boxes for shredding. It should not have been stored in an unsecured open cardboard box. The ADM 1 after reviewing the random records picked up for review, stated the documents found in the box were from the months of June, July, and August. This indicated the box was not emptied at the end of the daily workday. The ADM 1 further stated the expectation, once the staff were done working with the records and assignment sheets, was disposal into the confidential records bin for shredding. The presence of multiple resident records kept in the box indicated the residents' confidential records were not disposed of daily into the confidential records bin. Further interview with the ADM 1 he confirmed the daily assignments documents printed by the PT and the OT therapists had at the bottom of the page which indicated . This document contains Protected Health Information (PHI) and therefore must be disposed of properly . CONFIDENTIAL. The paper documents should have been disposed of in the confidential records bin for destruction. Review of facility policy Confidentiality of Personal And Medical Records dated 7/1/2023 indicated: .Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons. These paper notes and reminders will be disposed of in a way that will not compromise resident's personal or medical information .8. Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons. These paper notes and reminders will be disposed of in a way that will not compromise resident's personal or medical information . 9. Documents including resident's protected health information needing to be discarded will be placed in a secure location until destroyed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47563 Based on observation, interview and record review, the facility failed to ensure the infection prevention and control program guidelines and practices were maintained for a census of 51, when Certified Nursing Assistant 5 (CNA 5) was observed taking trash from one resident room to another and allowed trash bags to rest against her clothing. This failure had the potential to result in transmission and spread of infection for a vulnerable population. Findings: During a concurrent observation and interview on 8/22/24 at 8:15 a.m. with CNA 5 in the hallway outside of room [ROOM NUMBER], CNA 5 was observed removing and carrying two bags from room [ROOM NUMBER] and then entered room [ROOM NUMBER] with the two bags, and then CNA 5 exited room [ROOM NUMBER] with the two bags. CNA 5 stopped to speak with the Department and was observed resting the two bags against her leg, making direct contact with her pants. CNA 5 stated the two bags contained trash from room [ROOM NUMBER] and she had taken the two bags of trash towards room [ROOM NUMBER] but denied entering room [ROOM NUMBER] despite being observed entering room [ROOM NUMBER]. CNA 5 confirmed the bags of trash were resting against her and touching her pants. CNA 5 acknowledged, to prevent spread of germs and infections, staff should not take trash from one resident room to another or allow bags of trash to touch their body or uniform. An interview on 8/22/24 at 3:18 p.m., the Infection Preventionist (IP: a healthcare worker with specialty training and oversight in preventing infections among residents and staff) stated it was forbidden to take trash from one resident room into another resident's room. The IP added, staff were expected to hold trash away from their body and clothing to prevent the spread of germs that could cause infections in the facility. An interview on 8/23/24 at 9:33 a.m., Licensed Nurse 4 (LN 4) stated infection control is important to follow and added, when staff are handling trash, she expected them hold bags away from their body and clothing. LN 4 stated she would be concerned about the potential for the spread of germs if trash was taken from one resident room into another resident's room. An interview on 8/23/24 at 9:45 a.m., CNA 4 stated to prevent the spread of germs while handling trash, staff are expected to ensure the trash is carried away from their body and clothing. CNA 4 confirmed staff are not allowed to take trash from one resident room into another resident room. An interview on 8/23/24 at 10:26 a.m., the Director of Nursing (DON) stated when staff handle trash, he expected staff to follow infection prevention practices by taking trash directly to the trash disposal area and staff should hold the trash bags away from their body and uniforms. An interview on 8/23/24 at 12:48 p.m., The Clinical Reimbursement Director/ Nurse consultant (CRD/NC) stated the facility was unable to provide a trash handling policy and procedure (P&P) that had been requested. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, infection prevention and control program, dated 7/1/23, indicated, . infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections .all staff are responsible for following all policies and procedures related to the program .all staff shall demonstrate competence in relevant infection control practices . During a record review of Resident 10's facesheet, Resident 10 was admitted with diagnoses of Type 2 Diabetes (a condition of too much sugar in the blood). Neurocognitive Disorder (a category of mental health disorders that primarily affect cognitive abilities including learning, memory, perception, and problem-solving) with Lewy Bodies (clumps of abnormal protein particles that, accumulate in the brain, these deposits cause a form of dementia). During the initial pool tour on 8/20/24 at 11 a.m. Resident 10 was observed lying in bed. Resident 10 was was interviewable but confused as to time and place. Resident 10 appeared comfortable. Further observation of Resident 10's room, on top of the cabinet was observed a facemask and tubing connected to a BiPAP machine (a noninvasive ventilator that helps people breathe by delivering pressurized air into their airways through a face mask). The face mask and tubing were observed and found not stored away in a bag to protect from possible dust contamination and possible source of infection. Review of Physician's order dated 8/6/24 indicated Resident 10 was to be on BiPAP at bed time and off upon waking. On 8/20/24 at 11:30 a.m. accompanied by the Director of Nursing (DON), the DON confirmed Resident 10 was on BiPAP at bedtime. The DON confirmed the BiPAP mask and tubing were stored exposed and unprotected from dust and contamination. The DON stated the facemask and tubing must be stored in a clean bag. The DON stated he will provide a clean bag to store Resident 10's BiPAP equipment. Review of facility policy and procedure CPAP (Continuous Positive Airway Pressure) / BiPAP cleaning dated 6/1/2023 indicated: .2. Respiratory equipment can become colonized with infectious organisms and serve as a source of respiratory infections .6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry Well. Cover with plastic bag or completely enclosed in a machine storage bag when not in use. 34328

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47563 Based on interview and record review, the facility failed to administer a pneumococcal vaccine (immunization [process of becoming protected against a disease through vaccination] against pneumonia [an inflammatory condition of the lung]) for one of 19 sampled residents (Resident 15). This failure placed Resident 15 at an increased risk for illness that the vaccine could have prevented or decreased the severity of symptoms. Findings: A review of Resident 15's admission record, indicated Resident 15 was admitted to the facility in April of 2024 with diagnoses that included a history of having a tumor in the lungs and respiratory failure (not enough oxygen passes from the lungs to the blood). A review of Resident 15's Pneumococcal Vaccine Informed Consent, dated 4/27/24, indicated Resident 15 marked the option I hereby GIVE the facility permission to administer a pneumococcal vaccination . to the best of my knowledge, I have not received a pneumococcal vaccination in the past five years . A review of Resident 15's Minimum Data Set (MDS: an assessment tool), dated 8/3/24, indicated Resident 15 was offered and declined a pneumococcal vaccine. An interview on 8/22/24 at 1:23 p.m., the Infection Preventionist (IP: a healthcare worker with specialty training and oversight in preventing infections among residents and staff) confirmed Resident 15 did consent to receive the pneumococcal vaccine, Resident 15's health record was accidentally updated to indicate she had declined the pneumococcal vaccine, and Resident 15 had not received the pneumococcal vaccine. The IP added that she also confirmed through the California Immunization Registry (CAIR2: a data base with immunization history and recommendations) that Resident 15 did not have a history of being vaccinated with any pneumococcal vaccine previously, was eligible to receive the pneumococcal vaccine, and facility should have given the vaccine. A review of Resident 15's IP progress notes, dated 8/22/24, indicated, [Resident 15] consented for [type of pneumococcal vaccine] upon admission. Order placed and awaiting pharmacy arrival, MD aware A review of facility policy and procedure (P&P) titled, pneumococcal Vaccine (series), dated 2023, indicated, . it is our policy to offer residents . immunization against pneumococcal disease .each resident will be assessed for pneumococcal immunization .each resident will be offered a pneumococcal immunization unless it is medically contraindicated [harmful] or the resident has already been immunized .

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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. 41838 Based on observation, interview and record review, the facility failed to maintain the reach-in freezer in a safe operating condition when ice build-up was found on the freezer ceiling. This had the potential of leading to food borne illness for the 49 residents receiving facility prepared meals. Findings: During the initial kitchen observation on 8/20/24 at 9:04 a.m., the reach-in freezer was opened to reveal circles of ice crystals (approximately 1/2 inch in diameter) on the freezer ceiling. The freezer door gasket appeared misshapen in the upper, outer corners. During a concurrent interview with the Certified Dietary Manager (CDM), the CDM confirmed the ice build-up on the freezer ceiling. During a return visit to the kitchen on 8/22/24 at 9:20 a.m., the reach-in freezer was shown to the Maintenance Supervisor (MS). The MS noted the buildup of ice on the freezer ceiling and stated that it may be the result of the freezer door not being closed tightly. During an interview on 8/22/24 at 4:24 p.m. with the CDM, the CDM stated that the problem with ice build-up in the freezer was that it could lead to freezer burn which affects the quality of food, as well it can affect the safety since bacteria can grow when the air is warmed. Review of the Troubleshooting section of the Artic Air commercial freezer manual indicated that It is important to defrost and clean the freezer when 1/4 to 1/2 inch of frost has accumulated. Frost may tend to accumulate faster on upper part of the freezer due to warm, moist air entering the freezer when . opened. Review of the Food and Drug Administration (FDA) 2022 Food Code section 4-501.11 on Good Repair and Proper Adjustment indicated Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could .place the health of the consumer at risk.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 47563 Based on observation, interview, and record review, the facility failed to ensure a call light (a device used by a resident to signal the need for help) was accessible for one of 19 sampled residents (Resident 297), when Resident 297 was not physically able to use the type of call light provided. This failure had the potential to result in unmet resident needs and delayed staff response. Findings: A review of Resident 297's admission record indicated, Resident 297 was admitted in early August of 2024 with diagnoses that included dementia (a loss of memory and problem-solving abilities which interfere with daily life) and anxiety (a feeling of fear, dread, and uneasiness). A review of Resident 297's Minimum Data Set (MDS: an assessment tool), dated 8/12/24, indicated Resident 297 was always incontinent (lacks control) with bowel movements and urination and was dependent on staff to provide toileting hygiene. A review of Resident 297's care plan, dated 8/6/24, indicated, .Resident is at risk for falls and/or injuries . interventions .Keep the call light within reach and encourage resident to use it for assistance, as needed . During a concurrent observation and interview on 8/20/24 at 9:59 a.m., Resident 297 stated he wanted coffee. When asked if he was able to use his call light to ask for the coffee, Resident 297 was able to grab the red string for the call light but was unable to pull the string enough to make the call light turn on. An interview on 8/20/24 at 10:10 a.m., Certified Nursing Assistant 3 (CNA 3) confirmed Resident 297 could not use the call light provided to get staff attention and denied knowing if the resident had been offered a different type of call light that he could use. An interview on 8/20/24 at 4:05 p.m., CNA 3 stated since Resident 297 was unable to use the pull string call light, the facility provided Resident 297 with a push button call light that he could use. During a concurrent observation and interview on 8/20/24 at 4:11 p.m. in Resident 297's room, Resident 297 was sitting up in his bed with a call light clipped to his bed. When asked if he received a new call light, Resident 297 picked up his new call light device and pushed the button on the call light and stated he will push the button when he needs help. An interview on 8/23/24 at 9:33 a.m., LN 4 Stated it is unsafe if a resident has a call light they cannot use because the resident would not be able to get the attention of staff when needed. An interview on 8/23/24 at 10:10 a.m., CNA 4 stated if a resident had a call light they could not use, staff would provide a different type of call light device the resident could use and gave examples of a call light that alerts with a soft touch or a bell the resident could ring for assistance. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Post Acute	1090 Rio Lane Sacramento, CA 95822

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/23/24 at 10:51 a.m., The Clinical Reimbursement Director/ Nurse consultant (CRD/NC) stated if a resident cannot use a type of call light, she expected there to be in a progress note to make staff aware the resident required an alternative call light device. The CRD/NC added, if the resident is not able to use any type of call light, she expected it should be reflected on the resident's care plan. An interview on 8/23/24 at 10:26 a.m., the Director of Nursing (DON) stated if a resident cannot use a call light provided, he expected staff to look for an alternative call light, such as a soft touch or a bell. The DON added, if a resident cannot use a call light at all, it should be documented in the care plan. A review of the facility's policy and procedure titled, call lights: accessibility, dated 3/1/23, indicated, . The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside . to allow residents to call for assistance . All residents will be educated on how to call for help by using the resident call system . Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) . A review of Resident 297's progress notes and care plans did not produce any documentation indicating Resident 297 was not able to use a call light or needed any special accommodation for a call light.