STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055303	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Woods	651 Sinex Avenue Pacific Grove, CA 93950

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 44733 Based on interview and record review, the facility failed to provide written notification to the Long-Term Care Ombudsman (person who routinely visits the facility and advocates for the residents) for one of two sample discharged residents (Resident 14) when Resident 14 was transferred to the acute care hospital. This failure had the potential to result in the resident not having an advocate who could inform them of their admission, transfer, and discharge rights and options. Findings: Review of Resident 14 clinical record indicated she was transferred to the acute hospital on 8/17/24. There was no documentation in the clinical record indicating the facility notified the Ombudsman regarding this transfer. During an interview with the social service designee (SSD) on 9/13/24 at 1:43 p.m., she confirmed written notification regarding the above transfer was not sent to the ombudsman. The SSD acknowledged the resident's transfer should have been notified to Ombudsman. During a review of the facility's policy and procedure (P&P) titled Transfer, Evacuation, Relocation or Discharge retrieved 9/2024, the P&P indicated, Notice of transfer or discharge: when the SNF transfers or discharges a resident . the community will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for one of eight sampled residents (Resident 12) when the resident's communication care plan was not person-centered. This failure had the potential for inaccurate development and implementation of person-centered care plans that would address the residents' identified concerns and needs. Findings: Review of Resident 12's clinical records indicated he was admitted on [DATE] with diagnoses including myringotomy tube status (a small tube placed in the ear to treat ear infections and other ear conditions) and bilateral presbycusis (age-related hearing loss). During an interview on 9/09/24 at 10:38 a.m. in his room, he stated he could not hear and needed to use his cellphone, which has a translator function as a communication tool. Review of Resident 12's minimum data set (MDS, an assessment tool) dated 7/15/24 indicated he had a brief interview of mental status (BIMS, a tool used to assess cognition) score of 12 (moderate cognitive impairment). Section B0200 asked to check ability to hear, and code 3. Highly impaired (absence of useful hearing) was checked. Section B0300 asked if a hearing aid or other hearing appliance was used, and code 0. No was checked. Review of Resident 12's care plans indicated he had a communication problem related to hearing deficit. The interventions of the care plan did not indicate his cellphone use as a communication tool. During an interview and record review on 9/11/24 at 2:15 p.m. with minimum data set coordinator (MDSC) A, she verified Resident 12 was using his cellphone as a communication tool. MDSC A reviewed Resident 12's care plans and stated the care plan for the communication problem did not indicate his cellphone use as a communication tool. MDSC A stated the care plan was not person-centered care planning. During a review of the facility's policy and procedure (P&P) titled Care Planning, revised 2/2021, the P&P indicated, An initial care plan will be developed and implemented .and a summary provided to the resident and residents representative if applicable which will include interventions to provide effective, safe and person-centered care that meets professional standards of quality of care based on the residents history.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on observation, interview, and record review, the facility failed to ensure an activity program that met the resident's needs, interests, and preferences was provided to one of eight sampled residents (Resident 11). This failure had the potential to affect the residents' physical, mental, and psychosocial well-being and quality of life. Findings: Review of Resident 11's clinical record indicated she was admitted on [DATE] and had diagnoses including Alzheimer's disease (a progressive brain disorder that destroys memory, thinking skills, and the ability to perform simple tasks) and dementia (a decline in mental capacity affecting daily functioning). Review of Resident 11's minimum data set (MDS, an assessment tool), dated 7/15/24, indicated she was not able to complete the brief interview for mental status. It also indicated Resident 11 felt it was very important to listen to music she liked. During a review of Resident 11's activities care plan, the care plan indicated she has little or no activity involvement related to immobility or physical limitations and enjoys music recitals/performers as well as travel channels. The care plan included interventions to invite the resident to activities of interest or other preferred room activities if unable to attend group activities and to offer daily reading and drawing materials. During an observation from 9/09/24 to 9/11/24 in Resident 11's room, there were no books, magazines, or drawing materials for the resident observed. There was no music or travel channel offered to the resident. During an interview and record review on 9/11/24 at 9:12 a.m. with the activities coordinator (AC), she reviewed Resident 11's activities care plan and stated Resident 11 was doing only social dining because she refused all activities. The AC stated there was no documentation indicating that Resident 11 refused all activities. The AC further verified that the care plan was not updated with social dining activity. During an interview on 9/11/24 at 9/18 a.m. with the AC, she stated she could not locate any documentation indicating that the facility offered room activities when Resident 11 refused to participate in group activities, music or travel channels that the resident enjoyed, or reading or drawing materials as indicated on the activities care plan. During a review of the facility's policy and procedure (P&P) titled Activities, revised 9/2024, the P&P indicated, The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored group and individual activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the facility. The director/coordinator shall at least: c. monitor and evaluate the resident's responses to activities and revise the approaches as appropriate.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview and record review, the facility failed to ensure the interdisciplinary team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents) assessed and discussed the cause of unplanned weight loss, updated the care plan with a measurable goal and interventions, and provided necessary and timely interventions to maintain the acceptable weights of the residents when there was no follow-up by the IDT after the significant weight loss for one of eight sampled residents (Resident 8). This failure had the potential to result in being unable to evaluate the residents' complete nutritional status and provide necessary interventions timely. Findings: Review of Resident 8's medical record indicated she was admitted on [DATE] with diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), hemiplegia (a condition that causes partial or complete immobility on one side of the body), and type 2 diabetes (high blood sugar). Review of Resident 8's minimum data set (MDS, an assessment tool) dated 8/16/24 indicated he had a brief interview of mental status (BIMS, a tool used to assess cognition) score of 15 (cognitively intact). Section K0300 asked if the resident had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, and code 2. Yes, not on physician-prescribed weight-loss regimen was checked. Review of Resident 8's Weights and Vitals Summary indicated her weights were 163 pounds (lbs) on 8/12/24, 158.4 lbs on 8/18/24, 157 lbs on 8/25/24, 154.5 lbs on 9/01/24, and 151.8 lbs on 9/08/24. Review of Resident 8's Nutrition/Dietary Note, dated 8/14/24, indicated the resident had a weight loss during hospitalization , the medical record confirmed the resident had 7.7% weight loss during the last 12 days, and the registered dietitian (RD) would continue to monitor. Review of Resident 8's Nutrition/Dietary Note, dated 9/03/24, indicated monthly weight reveals significant weight loss since admission (-5.2%, -8.5 lbs since 8/12/24), and the RD would continue to monitor and observe the resident at meals this week. Review of Resident 8's Nutrition/Dietary Note, dated 9/11/24, indicated the RD observed the resident to be reluctant to eat due to shakiness/instability, and the RD would continue to encourage the resident to eat and suggest additional feeding support from nursing staff. The note further indicated the resident has been provided with nutrition supplement shakes by family and has these at bedside to drink as needed. Review of Resident 8's physician's order, dated 8/28/24, indicated she had a regular diet and regular texture. There was no physician's order for high- calorie food or supplement. Review of Resident 8's medical record indicated there was no documentation that the IDT meeting was conducted for Resident 8's significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's care plans indicated the care plan for the nutritional/hydration risk did not indicate additional feeding support from nursing staff or the nutrition supplement shakes provided by family. During an interview and record review on 9/12/24 at 1:58 p.m. with the RD, she reviewed Resident 8's medical records and confirmed the above record reviews. During an interview and record review on 9/12/24 at 2:03 p.m. with the RD, she confirmed there was no documentation indicating an IDT meeting regarding Resident 2's significant weight loss was conducted. The RD acknowledged the resident's significant weight loss should have been followed by IDT. During an interview and record review on 9/12/24 at 2:06 p.m. with the RD, she verified that Resident 8's family member brought supplement shakes related to the resident's poor meal consumption. The RD stated there was no documentation indicating the supplement shakes were offered and an amount consumed if the resident consumed any. The RD acknowledged the supplement should have been offered to the resident, and staff should have measured the amount consumed and documented it. During an interview on 9/12/24 at 2:10 p.m. with the RD, she acknowledged that she could have recommend interventions including a fortified diet and a high calorie supplement, which were not implemented. During an interview on 9/12/24 at 2:37 p.m. with the direct of nursing (DON), she stated an IDT meeting should have been conducted for Resident 8's significant weight loss to assess and discuss the cause of unplanned weight loss, update the care plan with a measurable goal and interventions, and provide necessary and timely interventions to maintain the acceptable weights of the residents. The DON stated common interventions for the weight loss would have been a fortified diet and additional supplements, which were not implemented. During a review of the facility's policy and procedure (P&P) titled Interdisciplinary Team Meeting, revised 4/2018, the P&P indicated, Purpose: To identify residents at risk for decline, improve communication between the interdisciplinary team, review resident status and improve resident outcomes. Guidelines for review: 1. Weight Variance will review those residents having a weight change of 3 or more percent in one week, 5# or 5% over a 30 day period . During a review of the facility's policy and procedure (P&P) titled Weight Variance Monitoring, revised 2/2009, the P&P indicated, Residents with weight changes will be reviewed by members of the interdisciplinary team to assure that interventions are in place to ensure nutritional needs are met and undesirable weight changes are prevented. When weight change has been identified a s a problem the resident will be discussed at Risk management. The DTR and/or RD will be notified, and the resident's Plan of Care will be updated as needed. During a review of the facility's policy and procedure (P&P) titled Nutrition Interventions, revised 10/2024, the P&P indicated, The dietitian/qualified nutrition professional recommends interventions to maintain the resident's nutrition status, based on resident preference and tolerance. For residents at nutritional risk: Determine appropriate interventions .Options may include: use fortified food to increase the calorie and/or protein in foods being served, Offer additional food (snacks) between meals, Use a high calorie supplement as a part of the medication pass. Progress updates will be documented in the medical record and care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44733 Based on observation, interview, and record review, the facility failed to follow their bed rails (adjustable rigid bars attached to the side of a bed: side rails, safety rails, and grab/assist bars) policy for one of one sampled resident (Resident 2) when there was no informed consent verification form obtained prior to installing bed rails. This failure had the potential to result in the resident and the resident's responsible parties (RP, individuals designated to make decisions on behalf of the residents) not being fully informed of the use of bed rails. Findings: During an observation on 9/09/24 at 10:13 a.m., the bed of Resident 2 was inspected. The bed had an upper partial bed rail on the left side. During an interview on 9/10/24 at 11:33 a.m., minimum data set coordinator (MDSC) A stated that the facility initiated bed rail for Resident 2 on 7/06/22, removed on 4/25/24, and reinstalled on 5/06/24. Review of Resident 2's physician's order, dated 5/06/24, indicated she use side rails assist bar on the left side of the bed to increase mobility (movement), support self during ADL care, turn or reposition, and provide a feeling of comfort and security. Review of Resident 2's Bed Rail Risk Data Collection Tool, dated 7/07/22, indicated quarter top bed rails were initiated on 7/06/22. Review of Resident 2's clinical record indicated there was no informed consent verification form obtained prior to installing bed rails on 7/06/22. During an interview and record review on 9/10/24 at 2:07 p.m. with MDSC A, she reviewed Resident 2's informed consent verification form for bed rails. MDSC A confirmed that there was no informed consent verification form obtained prior to installing bed rails on 7/06/22. MDSC A acknowledged that the facility should have obtained an informed consent verification form prior to installing bed rails. During a review of the facility's policy and procedure (P&P) titled Side Rails/Assist Bar, dated 4/2017, the P&P indicated, The physician must be notified to give informed consent to the resident or resident representative. The nurse will verify with the resident or resident representative that informed consent has been given and document on the Verification of Informed Consent Form.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44733 Based on interview and record review, the facility failed to document administration of controlled medications (medications controlled by the government because they may be abused or cause addiction) on the controlled medication accountability sheet (count sheet) for one resident (Resident 8). This failure compromised the facility's ability to ensure accurate administration of medications. Findings: During controlled medications accountability check on 9/09/24 at 10:50 a.m. with registered nurse (RN) B, Resident 8's controlled medication accountability sheet indicated the remaining count of lacosamide (an anticonvulsant) 100 milligrams (mg, unit dose of measurement) was 7, but the medication stock count was 6 in a bottle container. RN B stated she counted controlled medications during the shift change this morning but did not open the bottle container to count lacosamide. Review of Resident 8's physician's order, dated 8/12/24, indicated lacosamide 100 mg by mouth two times a day for seizure (abnormal electrical activity in brain). During an interview and record review with registered nurse (RN) B on 9/09/24 at 11:15 a.m., she confirmed the above observation. RN B stated the evening shift nurse did not document when giving one dose of lacosamide 100 mg on 9/08/24 around 5:00 p.m. RN B acknowledged the licensed nurses should have document it when they administered the medications. During an interview with the DON on 9/12/24 at 11:00 a.m., she acknowledged the licensed nurses should have document administration of controlled medications on the controlled medication accountability sheet when the medications are administered. The DON further acknowledged the licensed nurses should have count controlled medications during shift change. During a review of the facility's policy and procedure (P&P) titled Controlled Substance Medication Orders, dated 1/2023, the P&P indicated, Each controlled substance medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the prescription.

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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. 44185 Based on observation, interview and record review, the facility failed to ensure, one of eight sampled residents (Resident 66), was free of significant medication error, when the physician order for the Lasix (a diuretic, used to reduce fluid retention) medication, of Resident 66 was not followed. This failure had the potential to affect the health and general well-being of the resident. Findings: During an observation and interview with Resident 66 on 9/9/24 at 12:35 p.m., Resident 66 was in her bed with the head of her bed elevated at 90 degrees. Resident 66 was eating her lunch. She verbalized that her Lasix medication was wrongly given last week. The nurses gave it to her three times per day instead of three times per week. Review of the admission record (a document that contains important information about a resident's admission to a healthcare facility) of Resident 66 indicated, Resident 66 was readmitted to the skilled nursing facility on 9/3/24 with diagnoses including acute pulmonary edema (a medical emergency that occurs when fluid builds up in the lungs, making it difficult to breathe), chronic diastolic congestive heart failure (a condition that comes on slowly with age, where the left ventricle is not able to fill properly with blood) and type 2 diabetes mellitus (adult onset, high levels of sugar in the blood) without complications. Her brief interview for mental status (BIMS, mandatory tool used to screen and identify the cognitive condition of residents) score was 15 (which suggests that cognition was intact), taken on 9/3/24. Review of the physician orders of Resident 66 indicated, Resident 66 had an order of Lasix 20 milligram (mg, a unit of mass or weight) oral tablet by mouth, one time a day every Monday, Wednesday, and Friday, related to acute pulmonary edema, ordered on 9/3/24. Review of the medication administration record (MAR, used to document medications taken by each resident in a treatment facility) of Resident 66, it was indicated Lasix 20 mg oral tablet by mouth, was given three times a day on 9/4/24, 9/5/24, 9/6/24 and 9/7/24 to Resident 66. During the interview with registered nurse B (RN B) on 9/10/24 at 1:18 p.m., RN B verified the medication error for the Lasix 20 mg oral tablet of Resident 66. RN B acknowledged that the Lasix 20 mg oral tablet of Resident 66 was given three times per day on 9/4/24, 9/5/24, 9/6/24 and 9/7/24 and the Lasix order of Resident 66 was, Lasix 20 mg oral tablet by mouth, one time a day every Monday, Wednesday, and Friday, ordered on 9/3/24. RN B then stated that the physician was already notified of the medication error of Resident 66. During the interview with the minimum data set coordinator A (MDSC A) on 9/12/24 at 2:35 p.m., MDSC A verified the medication error for the Lasix 20 mg oral tablet of Resident 66. MDSC A stated that the Lasix 20 mg oral tablet of Resident 66 was given three times per day on 9/4/24, 9/5/24, 9/6/24 and 9/7/24. MDSC confirmed the physician order was Lasix 20 mg oral tablet by mouth, one time a day every Monday, Wednesday, and Friday. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview with the director of nursing (DON), on 9/13/24 at 11:45 a.m., DON verified the medication error for the Lasix 20 mg oral tablet of Resident 66. DON acknowledged that the Lasix 20 mg oral tablet order of Resident 66 should have been followed by the nurses and she would remind the nurses about following the physician orders. Review of the facility's policy titled, Medication Administration: General Guidelines, dated 1/2023 indicated, Medications are administered in accordance with written orders of the prescriber If necessary, the nurse contacts the prescriber for clarification

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44185 Based on observation, interview and record review, the facility failed to ensure that recipe for making puree was being followed when the executive chef did not follow the recipe for making chicken teriyaki puree. This failure had the potential to result in decreased palatability that could lead to decrease in food intake for the 2 residents with puree diet order out of the skilled nursing facility census of 15. Findings: During the observation of making puree (smooth, crushed, or blended food that has the consistency of a creamy paste or liquid) with executive chef (EC), on 9/11/24 at 11:32 a.m., EC was making chicken teriyaki (grilled or broiled chicken after being soaked in a seasoned soy sauce marinade) puree. EC put 12 ounces (oz, unit of weight) of chicken teriyaki into the robo coupe blender, added 3 oz of milk and then pureed them. EC then checked the consistency of the pureed chicken teriyaki, and added 2 oz more of milk, then pureed them again. EC placed the pureed chicken teriyaki in the steamed table food container after. Review of the facility's undated, Pureed Recipe, indicated, Combine 4 oz of menued protein and 1 oz of milk in robo coupe blender until smooth and pudding consistency. Place in steam table pan and heat to a minimum of 165 degrees Fahrenheit for 15 seconds. Serve per spread sheet. The recipe did not indicate to add 2 more oz of milk after already putting 3 oz of milk for the 12 oz of chicken teriyaki. During a concurrent record review and interview with EC on 9/11/24 at 2:07 p.m., EC verified that the recipe for making chicken teriyaki puree was not followed. EC further verified that the recipe did not mention to add 2 more oz of milk after putting 3 oz of milk already for the 12 oz of chicken teriyaki, to be pureed. During a concurrent record review and interview with the registered dietitian (RD), on 9/12/24 at 11:02 a.m., RD verified that the executive chef should have followed the recipe for making chicken teriyaki puree but it was not followed. RD further verified that the recipe did not mention to add 2 more oz of milk after putting 3 oz of milk already for the 12 oz chicken teriyaki and RD added that she would check on the recipe for making puree meats. Review of the facility's policy titled, Resident Food Services: Modified Texture Foods, revised on 1/2024 indicated, Provide a standardized process for modified texture foods to meet community-approved diet guidelines and to assure palatability, flavor, texture, and nutritional value. Foods requiring modification to a puree texture will have a smooth texture. Foods requiring modification to other levels will be provided per the guidelines established by the community and approved in the diet manual. Food thickening agents will be used when necessary to obtain proper consistency. Follow thickening recipe

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to ensure foods were stored in safe and sanitary manner when: 1. Resident foods and food brought by family or visitor stored in the refrigerator at the facility dining area, were readily accessible to all the residents and; 2. Expired food was kept in the cabinet at the facility dining area. These failures had the potential to access the expired food and the food brought by family or visitor in the refrigerator. Findings: 1. During an observation of the skilled nursing facility dining area on [DATE] at 3:27 p.m., there was a refrigerator for storage of resident foods. The refrigerator had the following unexpired food items: a. 41 small cups of juices; b. 8 cups of snack packs; c. 2 small cups of diced peaches; d. 4 cups of yogurts (food produced by bacterial fermentation of milk); e. 8 small cups of cranberry juices; f. 9 cans of tomato juices; g. 12 small packs of milk; h. 3 packs of thickened dairy (milk-based) beverages; i. 6 cans of vegetable juices and j. 1 opened sauvignon [NAME] (wine known for its crisp acidity and aromatic fruit flavors), half was consumed. During the interview with the director of nursing (DON), on [DATE] at 3:45 p.m., DON acknowledged that the above food items in the refrigerator at the skilled nursing facility dining area should have not readily accessible to the residents of the facility especially those residents that are on special diet and she would inform the kitchen staffs about it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055303	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Woods	651 Sinex Avenue Pacific Grove, CA 93950

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the director of dining services (DDS), on [DATE] at 2:18 p.m., DDS verified that the refrigerator in the facility dining area with resident foods should have not readily accessible to the facility residents especially those residents with restrictions in their diet. DDS further verified she would put refrigerator locks so that the residents could not open the refrigerator. During an interview with the registered dietitian (RD), on [DATE] at 9:07 a.m., RD verified that the refrigerator in the facility dining area with resident foods should have not readily accessible to the facility residents especially those residents with restrictions in their diet. RD further verified she would put refrigerator locks so that the residents could not open the refrigerator. Review of the facility's policy titled, Food and Supply Storage, revised ,d+[DATE] indicated, Restrict access to storage areas to only those associates whose job responsibilities require them to retrieve items from these areas. Review of the facility's policy titled, Resident Food Services: Unit Pantry Stock, revised ,d+[DATE] indicated, Provide a method of communicating appropriateness of the available food items for therapeutic and consistency modified diets 2. During an observation of the facility dining area on [DATE] at 3:27 p.m., there were cabinets above the refrigerator and there was 1 packet of expired eclipse gum that had dark white colored gums that was still stored inside. During the interview with the DON, on [DATE] at 3:40 p.m., DON acknowledged that the expired eclipse gum with dark white colored gums inside should not be kept in the cabinet of the skilled nursing facility dining area and had it removed right away. During the interview with the RD on [DATE] at 9:09 a.m., RD verified that the 1 packet of eclipse gum is expired because of the dark white colored gums inside and should not be placed in the cabinet in the skilled nursing facility dining area. RD further verified that the expired gum should be removed there in the cabinet in the dining area. Review of the facility's policy titled, Resident Food Services: Unit Pantry Stock, revised ,d+[DATE] indicated, Discard outdated items per the food storage policy

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 49345 Based on interview and record review, the facility failed to ensure that one out of five sampled residents (Resident 6), who signed the binding arbitration agreement (BAA, contract between the facility and resident requiring disputes to be resolved by a neutral arbitrator [third party decision-maker] instead of a judge or jury in court) understood the BAA prior to signing. This failure posed the risk for the resident to make uninformed decisions regarding the right to file an appeal if there was any allegations of medical malpractice. Findings: A review of facility-provided document, it indicated there were five residents (Residents 1, 6, 10, 65, and 66) currently residing in the facility who have entered into a binding arbitration agreement on or after 9/16/19. During an interview with Resident 6 on 9/11/24 at 11:09 a.m., Resident 6 stated he was not aware he had a choice not to sign the BAA during admission. Resident 6 stated, I didn't feel pressured, but I felt I had to sign everything. I just want to be here. Resident 6 also stated, During the admission there were a lot of papers, I fell asleep literally. Resident 6 also stated he was not aware he had the right to terminate or withdraw from the agreement within 30 days of signing. When asked if arbitration agreement was explained in a way Resident 6 understood, Resident 6 stated, I don't remember. I don't know if I have a copy of the arbitration agreement. A review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 8/13/24, the MDS indicated Resident 6 had a Brief Interview for Mental Status (BIMS, 13 to 15 points suggests that cognition is intact) score of 15. A review of Resident 6's Binding Arbitration Agreement (BAA) dated 8/12/24, the Binding Arbitration Agreement indicated, Resident 6 and facility representative, Social Services Designee (SSD) D signed the BAA. During an interview and record review with Activities Coordinator (AC) on 9/11/24 at 1:32 p.m., AC confirmed the signature on a BAA for another resident (Resident 10) dated 5/17/24. AC stated that everyone that was admitted was offered a BAA. AC also stated that if a resident was sleepy during the explanation of the BAA, AC would have stop and would not let Resident 6 sign the form. During an interview on 9/11/24 at 1:48 p.m. with Director of Nursing (DON), DON stated BAA was new and recent. DON also stated that DON would not let Resident 6 sign any form if the resident was sleepy. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility Policies and Procedures (P&P) titled SNF Admissions Policies revised November 2023, the P&P indicated 23. Requirements for Pre-Dispute Agreements a. The community must ensure that the agreement is explained to the resident and their representative in a form and manner that they understand, including in a language the resident and their representative understands, and that the resident acknowledges that they understand the agreement.

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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. 44733 Based on observation and interview, the facility failed to implement infection control practices for one of eight sampled residents (Resident 165) when staff did not follow the facility's handwashing/hand hygiene policy. This failure had the potential to spread infection in the facility. Findings: During a medication administration observation on 9/10/24 at 4:09 p.m., Resident 165 tried to walk out from her room when Licensed Vocational Nurse (LVN) B wiped a glucometer (a device to check blood sugar). LVN B went into the room and assisted Resident 165 with her bare hands. During an observation on 9/10/24 at 4:13 p.m., Resident 165 with LVN B's assistance came out of the room. LVN B picked the glucometer, put it in its container, and stored the container in the medication cart without performing hand hygiene. During an interview on 9/10/24 at 4:15 p.m. with LVN B, she confirmed the above observation. LVN B stated she should have performed hand hygiene before and after assisting Resident 165 for infection control. During a review of the facility's policy and procedure (P&P) titled Handwashing/Hand Hygiene, revised 10/2021, the P&P indicated, Hand hygiene is the primary means to prevent the spread of infections. Use an ABHR (alcohol-based hand rub), or alternatively, soap and water for the following situations, even if gloves are used: immediately before touching a resident; after contact with a resident. Single-use disposable gloves should be used: when in contact with a resident.