STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055304	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	1221 Rosemarie Lane Stockton, CA 95207

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43943 Based on observation, interview, and record review, the facility failed to ensure 2 of 27 sampled residents (Resident 66 and Resident 87) were provided a home-like environment when: 1. Resident 66's bed mattress had tears in the plastic barrier and the bed sloped to the left side; and, 2. Resident 87's bathroom had stool and urine on the toilet seat, toilet paper on the bathroom floor, and a non-operational soap dispenser in the bathroom. These failures led to an uncomfortable sleeping environment for Resident 66 and Resident 87's bathroom was not clean enough to utilize. Findings: 1. During a review of Resident 66's clinical record titled, ADMISSION RECORD, indicated Resident 66's diagnosis included pain in his left knee. During a concurrent observation and interview on 1/28/25, at 9:35 a.m., with Resident 66, Resident 66 stated he had been at the facility for approximately two and half months. Resident 66 stated he would like a new bed because it felt like there was a sinkhole in the middle of the bed and at night, he was afraid he would fall out of bed. Resident 66's bed was noted to be tilting to the left side. Resident 66 stated the bed was very uncomfortable. During a concurrent observation and interview on 1/28/25, at 9:40 a.m., with Licensed Nurse (LN) 1, LN 1 took all the bedding off Resident 66's bed mattress. The blue plastic barrier on the foam mattress was peeling off of 3/4 (unit of measurement) of the mattress. There were liquid stains on the exposed mattress foam. LN 1 stated the mattress could not be properly cleaned because of the large amount of missing plastic on top of the foam. LN 1 acknowledged the bed sloped to the left side. LN 1 stated the bed was not home-like and she would not want to sleep on Resident 66's bed mattress. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/28/25, at 9:45 a.m., with the Maintenance Supervisor (MS), the MS stated he had not received a work order to replace Resident 66's bed mattress. The MS observed the condition of Resident 66's mattress and stated it needed to be replaced because there was not an effective way to clean the mattress, and the mattresses could have harbored bacteria. The MS stated the mattress was not home-like and he would not want to sleep on a mattress that looked like the one Resident 66 was sleeping on. During a concurrent observation and interview on 1/28/25, at 9:50 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated she had noticed Resident 66's mattress had broken down about a month ago. CNA 5 stated she informed the MS verbally. CNA 5 stated she should have put in an electronic work order that would have gone directly to the MS. CNA 5 stated the mattress had tears on the blue plastic barrier of the mattress which allowed fluid to seep into the foam mattress. CNA 5 stated the bed mattress did not provide a home-like environment. During an interview on 1/28/24, at 10 a.m., with the Housekeeping (HK), the HK acknowledged it was impossible to properly clean a mattress that had large rips and missing plastic on the mattress. The HK stated she should have reported the issue to a supervisor and had the mattress replaced. During an interview on 1/29/25, at 1:33 p.m., with the Infection Preventionist (IP), the IP stated Resident 66's mattress was not in good repair, did not provide a home-like environment, and should be replaced. A review of undated facility document titled, [FACILITY NAME] Housekeeper, indicated housekeeping staff's daily activity chart indicated housekeeping staff started deep cleaning at 9:30 a.m. (one per day) and cleaned all the rooms at 10:45 a.m., The document further indicated it was not a comprehensive inventory of duties and responsibilities. A review of the facility's document titled, Environmental Service Housekeeper Job Description, dated 2020, indicated, .Ensures the provision of a clean environment for our residents .providing high quality services and high standards of cleanliness, ensuring complaint with infection control procedures .ensures that daily and deep cleaning schedules are adhered to .adheres to infection control policies at all times . During a concurrent interview and record review on 1/30/25, at 4:04 p.m., with the Administrator (ADM) and the Director of Nursing (DON), the Policy and Procedure (P&P) titled, Resident Rights, dated 2024, was reviewed. The P&P indicated, .8. Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment . The ADM and the DON stated Resident 66's mattress should have been replaced and the condition of the mattress did not lend to a home-like environment. The ADM and the DON acknowledged the P&P was not followed. 2. During a review of Resident 87's clinical record titled, ADMISSION RECORD, indicated Resident 87's diagnosis included depression (a mood disorder that causes persistent feeling of sadness). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 87's clinical record titled, Progress Notes, dated 1/28/25, at 12:21 p.m., by LN 1, indicated at approximately 8:15 a.m., Resident 87 came out of his room while he was still on isolation precautions (a set of practices that help prevent the spread of germs in healthcare and residential settings). LN 1 instructed Resident 87 to return to his room and use the bathroom in his room. Resident 87 stated his bathroom was dirty and told LN 1 she should use it because he was not going to use a dirty bathroom. Resident 87 used the (communal) bathroom by the showers. During an observation on 1/28/25, at 9:03 a.m., Resident 87 walked toward the bathroom by the shower room with a toilet paper roll in his hand. The Infection Preventionist (IP) instructed him to use the bathroom in his room because he was on droplet isolation precautions (a set of precautions used to prevent the spread of infections that are transmitted through respiratory droplets. These precautions are used when a patient is known or suspected to have an infection that could be spread through coughing, sneezing, or talking). Resident 87 refused to use the bathroom in his room because it was dirty. During a concurrent observation and interview on 1/28/25, at 10:05 a.m., with Resident 87, Resident 87's bathroom toilet was noted to have stool and urine on the toilet seat rim, toilet paper that had overflowed from the toilet on the floor, and there was a non-operational soap dispenser by the sink. Resident 87 stated he was on isolation precautions because the facility staff thought he had mumps (contagious viral infection). Resident 87 stated he had used the bathroom by the shower room because the toilet in his private room had overflowed yesterday and there was urine and stool on the toilet seat. Resident 87 stated and it had been in that condition for over a day. Resident 87 stated the bathroom in his room was, very dirty and gross. During a concurrent observation and interview on 1/28/25, at 10:08 a.m., with the Maintenance Supervisor (MS), the MS stated Resident 87's bathroom should have been cleaned to ensure that while Resident 87 was in isolation, he could have safely used his own bathroom. The MS acknowledged Resident 87's bathroom had urine and stool on the toilet, toilet paper on the floor, and a non-operational soap dispenser by the sink. During a concurrent observation and interview on 1/28/25, at 10:13 a.m., with LN 1, LN 1 stated Resident 87 had informed her on 1/28/25, at 8:50 a.m., that his bathroom was dirty. LN 1 stated she called housekeeping to clean the room. LN 1 acknowledged the bathroom was still dirty with urine and stool on the toilet seat rim, toilet paper on the floor, and a non-operational soap dispenser next to the bathroom sink. LN 1 stated the condition of the bathroom did not lend to a home-like environment. During a concurrent observation and interview on 1/28/25, at 10:15 a.m., with the housekeeper (HK), the HK acknowledged there was urine and stool on the toilet seat rim, toilet paper on the floor of the bathroom, and a non-operational soap dispenser. The HK stated Resident 87's toilet was clogged yesterday and overflowed. The HK stated Resident 87's bathroom was supposed to be cleaned once a day and as needed. The HK stated Resident 87's bathroom was not home-like. During an interview on 1/30/25, at 9:12 a.m., with the Housekeeping/Laundry Supervisor (HLS), the HLS stated she was aware Resident 87's toilet in his room was clogged on 1/27/25. The HLS stated she instructed housekeeping staff to clean the bathroom. The HLS stated the bathroom was not clean and was not up to acceptable standards. The HLS stated Resident 87 should not have had to leave his room to find a clean bathroom to use. The HLS acknowledged Resident 87's bathroom was not home-like. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an undated facility document titled, [FACILITY NAME] Housekeeper, indicated housekeeping staff's daily activity chart had housekeeping staff start deep cleaning at 9:30 a.m. (one per day) and cleaned all the rooms at 10:45 a.m. The document further indicated it was not a comprehensive inventory list of duties and responsibilities. A review of the facility's document titled, Environmental Service Housekeeper Job Description, dated 2020, indicated, .Ensures the provision of a clean environment for our residents .providing high quality services and high standards of cleanliness, ensuring complaint with infection control procedures .ensures that daily and deep cleaning schedules are adhered to .adheres to infection control policies at all times . During a concurrent interview and record review on 1/30/25, at 4:04 p.m., with the ADM and the DON, the P&P titled, Resident Rights, dated 2024, was reviewed. The P&P indicated, .8. Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment . The ADM and the DON stated Resident 87's bathroom should have been clean, and he should not have had to leave his room to find a clean bathroom. The ADM and the DON acknowledged the P&P was not followed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50161 Based on observation, interview, and record review, the facility failed to report an allegation of stolen property when Resident 40 reported his suspicion that 2 facility staff members had stolen his money. These failures resulted in a delay of the state survey agency investigating the allegations of abuse, which had the potential to put residents' psychosocial and physical health and safety at risk. Findings: Review of Resident 40's electronic medical record titled, ADMISSION RECORD, indicated, Resident 40 was admitted into the facility with a diagnoses including but not limited to depression (affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and anxiety (excessive fear or worry about a specific situation). Review of Resident 40's facility document titled, Property Loss Report, dated 8/9/24, indicated, Resident 40 reported to the facility staff that two CNAs (Certified Nurse Assistants) took his $2400 cash kept in his zip-lock bag on 8/9/24. The report also indicated that the facility decided not to reimburse the missing cash as Money that was Reported missing did not equal amount that was released to the Resident. Review of Resident 40's Social Services Progress Note, dated 8/29/24, written by the SSD 1, indicated, Resident approached SS [Social Services] in regards to the money that the resident claims have been missing. Facility launched an investigation getting statements from each party. After careful consideration and reviewing all facts, facility will not be reimbursing residentmoney [sic] due to the fact that the resident had signed off on retrieving money from BOM [business office manager] stating that he is responsible for the money which he had also signed for in front of witnesses (SSD, BOM [Business Office Manager], BOMA [Business Office Manager Assistant]). SS to follow up on any orders as needed . During a concurrent observation and interview on 1/28/25, at 10:47 a.m., Resident 40 stated he was missing approximately $2600. Resident 40 stated his money was taken by two CNAs which he identified by name (name redacted, CNA 6 and CNA 7). Resident 40 explained the money was contained in an envelope and wrapped in a towel and stated he kept it tucked into his bedding. Resident 40 stated after the incident he told his nurse his money was gone. Resident 40 stated it was all the money he had and stated it was the last of his savings which he had earned while working before coming to live at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/31/25, 1:18 p.m., the Social Services Director (SSD) 1 stated Resident 40 had cash in his possession in the amount of $1088.00 prior to his allegation missing money in August (2024). SSD 1 provided and reviewed Resident 40's Theft and Loss Report dated 8/9/24, and stated at the time of the incident Resident 40 had called wanting to speak with him (SSD 1) and Resident 40 told him two CNAs took his money when they were changing his bed linens in his room. SSD 1 stated because Resident 40 signed a paper releasing Resident 40's money to him that the facility had held for him in the facility safe on 4/9/24, Resident 40 had assumed the risk and would not be reimbursed. During an interview and record review on 1/31/25, at 2:05 p.m., the ADM reviewed Resident 40's Theft Loss Report provided by SSD 1 and stated he was not aware Resident 40 had taken cash out of the safe earlier in the year. The ADM stated he did not think Resident 40 had any money in his possession and stated looking at the bigger picture he would have followed a different path knowing Resident 40 took out his money in April (2024). The ADM confirmed the incident should have been reported to the Department as abuse due to Resident 40's reporting of two specific CNA's taking his money. The ADM stated the facility was still supposed to help safeguard Resident 40's possessions and stated he would have done something sooner had he known Resident 40 had money in his possession. During a phone interview on 2/3/25, at 9:16 a.m., the Ombudsman (OMB, long term care ombudsman are advocates and can assist residents to obtain quality care) 2 stated she was familiar with Resident 40, and he came to the Resident Council Meeting (meeting held at long-term care centers for residents, as a group, to influence the quality of their care) held at the facility on 8/22/24. The OMB 2 stated Resident 40 brought up the issue with his money at the meeting and afterward she met with him privately. The OMB stated Resident 40 seemed very upset over the incident and spoke with the ADM regarding the issue. Review of a facility Policy and Procedure (P&P) titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 2024, indicated, .It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator at the facility and to other appropriate agencies in accordance with current state and federal regulations with prescribed timeframe .The Administrator or designee will .Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident .

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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. 43943 Based on observation, interview, and record review, the facility failed to ensure 1 of 27 sampled residents' (Resident 48) assessment was completed accurately to identify her hearing and speech disability. This failure could have resulted in Resident 48 not receiving the needed services and communication aids to effectively make her needs known and could have resulted in a decrease in quality of life. Findings: During a review of Resident 48's clinical record titled, ADMISSION RECORD, indicated Resident 48's diagnosis included hearing loss. During a concurrent observation and interview on 1/28/25, at 8:39 AM, with Licensed Nurse (LN) 8, Resident 48 was in her room and there was a whiteboard (writing board) on her nightstand approximately three feet (unit of measurement) from her bed and not within reaching distance. There was no whiteboard marker in the room. LN 8 stated Resident 8 was deaf (unable to hear) and mute (unable to speak); however, Resident 48 pointed and wrote her needs on the whiteboard. During a concurrent observation and interview on 1/30/25, at 12:11 p.m., with Certified Nursing Assistant (CNA) 10, Resident 48 was in her wheelchair, in the dining room, and was ready to eat lunch. CNA 10 stated Resident 48 did not have her whiteboard with her in the dining room and stated it had been left in Resident 48's room. CNA 10 stated Resident 48 communicated by pointing. During a concurrent observation and interview on 1/30/25, at 12:14 p.m., with CNA 11, CNA 11 went to retrieve Resident 48's whiteboard and then wrote, [Resident 48], do you want water [Resident 48]. Resident 48 was unable to write a response on the white board and stared at CNA 11. CNA 11 stated there should have been a better way to communicate with Resident 48 such as a communication board that integrated pictures of different actions and objects. A review of Resident 48's clinical record titled, Discharge Summary, dated 11/15/24, indicated, .unable to obtain history from the patient since patient is deaf and mute . A review of Resident 48's clinical record titled, Interfacility Transfer Report, dated 11/15/24, indicated Resident 48 had poor hearing and speech. A review of Resident 48's clinical record titled Progress Note, dated 1/3/25, by the Assistant Director of Nursing (ADON), indicated Resident 48 was deaf and mute but alert and responsive with the aid of a communication board tool. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/25, at 11:51 a.m., with the MDS Nurse (MDSN, MDS- a standardized evaluation of a nursing home resident's health and functional capabilities), Resident 48's clinical record titled, Section B - Hearing, Speech, and Vision (a section of a comprehensive assessment), dated 11/22/24, by the MDSN, was reviewed. The record indicated, Resident 48 had adequate hearing and clear speech. The MDSN stated the MDS assessment was not completed correctly because Resident 48 was deaf and mute. The MDSN stated the importance of having the assessment done correctly was to ensure Resident 48 received the needed communication devices or services to communicate effectively with healthcare providers. The MDSN stated Resident 48 could have become very frustrated by not having the needed communication tools to accommodate her hearing and speech deficits. A review of Resident 48's clinical record titled, Care Plan (a document that indicated Resident 48's problems, goals, and interventions), indicated Resident 48 had a communication problem related to a hearing deficit. The interventions included an alternative communication tool. A review of an undated facility document titled, MDS Coordinator: Job Description, indicated, .The MDS Coordinator coordinates and assists with completion and submission of accurate and timely interdisciplinary MDS Assessments . A review of the facility's document titled, Non-Discrimination-Effective Communication and Modifications for Disabilities, dated 2024, indicated, .1. The facility will identify the disability needs of an individual during the pre-screening, admission process, and ongoing as needs arise .Definitions: 'Disability' means .a physical or mental impairment that substantially limits one or more major life activities . During a concurrent interview and record review on 1/30/25, at 4:14 p.m., with the Administrator (ADM) and the Director of Nursing (DON), the Policy and Procedure (P&P) titled, Conducting an Accurate Resident Assessment, dated 1/16/25, was reviewed. The P&P indicated, .The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment .3. The .qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities and psychosocial status .5. Information provided by the initial comprehensive assessment establishes baseline data for the ongoing assessment of resident progress. 6. The .condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists .and other professionals .Involvement of other disciplines is dependent upon individual resident status and needs . The ADM and the DON acknowledged Resident 48's MDS assessment was not coded correctly, and this error could have affected Resident 48's services she received. The DON and the ADM stated the P&P was not followed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 51584 Based on observation, interview, and record review, the facility failed to develop or revise a comprehensive care plan for 3 of 27 sampled residents (Resident 7, Resident 48, and Resident 40) when: 1. Resident 7's care plan for contact isolation precaution (steps taken to stop the spread of germs by limiting contact with residents who have contagious illnesses) was not revised, 2. Resident 48's care plan was not implemented when communication aids were not readily available to accommodate her hearing and speech disability; and, 3. Resident 40 reported to the Social Service Director (SSD) in 8/2024 his suspicion that staff took his money, and the facility failed to revise his previous care plan related to his missing items dated 3/2/23. These deficient practices had the potential for not receiving necessary services which could impact quality of care and quality of life for Resident 7, Resident 48 and Resident 40. Findings: 1. A review of Resident 7's ADMISSION RECORD, indicated Resident 7 was admitted to the facility with multiple diagnoses including a stroke (medical condition that occurs when blood flow to the brain is interrupted)affecting the left side and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 7's physician order dated 1/8/25, indicated contact isolation precautions for possible scabies (a contagious skin infestation caused by mites). Review of Resident 7's care plan dated 1/8/25, indicated contact/isolation precautions related to possible scabies exposure. During an observation on 1/30/25, at 8:36 AM, outside Resident 7's room, there was no signage indicating that the resident was on contact isolation precautions. During a concurrent interview and record review on 1/30/25, at 8:55 AM, with Licensed Nurse (LN) 3, LN 3 stated Resident 7 was not currently on contact isolation precaution. LN 3 stated Resident 7 was on contact isolation precautions for scabies 3 weeks ago. LN 3 further stated Resident 7 received the treatment and the doctor cleared him. LN 3 stated care plan was updated/revised whenever there was a change in resident's condition and when a doctor updated an order. LN 3 verified that Resident 7's order and care plan for contact isolation precaution was not revised. LN 3 added Resident 7's order and care plan for contact isolation precaution should have been revised after Resident 7 was cleared by the doctor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/25, at 9:15 AM, with the Infection Preventionist (IP), the IP stated that Resident 7 was placed on contact isolation precaution due to scabies exposure. The IP stated Resident 7 completed the treatment and was cleared by the medical director. The IP confirmed that Resident 7's order and care plan was not revised. The IP further stated the LN should have discontinued Resident 7's care plan and order when Resident 7 was cleared by the doctor. During an interview on 1/31/25, at 2:11 PM, with the Director of Nursing (DON), the DON stated, .a resident's status and condition is ever changing therefore the care plans and orders should be modified basing on their conditions. The DON validated that Resident 7's contact isolation precaution order and care plan were not revised. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered ., revised March 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change . 43943 2. During a review of Resident 48's clinical record titled, ADMISSION RECORD, indicated Resident 48's diagnosis included hearing loss. During a concurrent observation and interview on 1/28/25, at 8:39 AM, with LN 8, Resident 48 was in her room and there was a whiteboard (writing board) on her nightstand approximately three feet from her bed and not within reaching distance. There was no whiteboard marker in the room. LN 8 stated Resident 48 was deaf (unable to hear) and mute (unable to speak); however, Resident 48 pointed at objects and wrote on her whiteboard in order to make her needs known. LN 8 stated he thought Resident 48 had a marker at her bedside and left the room and retrieved a whiteboard marker. Resident 48 wrote a sentence on the white board, but the handwriting was not discernable. During a concurrent observation and interview on 1/30/25, at 12:11 p.m., with the Certified Nursing Assistant (CNA) 10, Resident 48 was in her wheelchair, in the dining room, and was ready to eat lunch. CNA 10 stated Resident 48 did not have her whiteboard with her in the dining room and stated it had been left in Resident 48's room. CNA 10 stated Resident 48 communicated by pointing. During a concurrent observation and interview on 1/30/25, at 12:14 p.m., with CNA 11, CNA 11 went to retrieve Resident 48's white board and then wrote, [Resident 48], do you want water. Resident 48 was unable to write a response on the whiteboard and stared at CNA 11. CNA 11 stated there should have been a better way to communicate with Resident 48 such as a communication board that integrated pictures of different actions and objects. A review of Resident 48's clinical record titled, Discharge Summary, dated 11/15/24, indicated, .unable to obtain history from the patient since patient is deaf and mute . A review of Resident 48's clinical record titled, Interfacility Transfer Report, dated 11/15/24, indicated Resident 48 had poor hearing and speech. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 48's clinical record titled, Section C - Cognitive Pattern, (a portion of a comprehensive assessment) indicated, Resident 48's Brief Interview form Mental Status (BIMS - an assessment of cognitive function), dated 11/22/24, indicated Resident 48's score was 13 (13-15: no impairment; 8-12: Moderate cognitive impairment; 0-7: Severe cognitive impairment). A review of Resident 48's clinical record titled, Progress Note, dated 1/3/25, by the Assistant Director of Nursing (ADON), indicated Resident 48 was deaf and mute but alert and responsive with the aid of a communication board tool. A review of Resident 48's clinical record titled, Care Plan, (a document that indicated Resident 48's problems, goals, and interventions) indicated Resident 48 had a communication problem related to a hearing deficit. The interventions included an alternative communication tool. During a concurrent interview and record review on 1/30/25, at 4:14 p.m., with the Administrator (ADM) and the DON, the Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/22, was reviewed. The P&P indicated, A .person-centered care plan that includes measurable objectives and timetables to meet .functional needs is developed and implemented for each resident .7. The .care plan b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The ADM and the DON stated the whiteboard, and marker should have been with Resident 48 at all times, however; the ADM and the DON stated a better communication tool should have been used to accommodate Resident 48's hearing loss and inability to speak. The ADM and DON acknowledged the P&P was not followed. 50161 3. Review of Resident 40's electronic medical record titled, ADMISSION RECORD, indicated, Resident 40 was admitted into the facility with diagnoses including but not limited to depression (affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and anxiety (excessive fear or worry about a specific situation). Review of Resident 40's Social Service Progress Note, dated 3/2/2023, written by Social Service Director (SSD) 2, indicated, .On 2/28/23, I, along with the administrator met with [name redacted, Resident 40] and confirmed with him that part of the cash he had in his possession upon admission is in fact missing. We agreed to reimburse [name redacted, Resident 40] in the amount of $1800.00 in the form of a check. The cash will be placed in a safe located in our facility and given to [name redacted, Resident 40] upon discharge . Review of Resident 40's Care Plan, dated 3/2/23 and last revision on 4/5/23, indicated, .Resident is at risk for emotional distress r/t [related to] personal items missing such as cash/jewelry .Interventions . Administration to f/u [follow up] for reimbursement or replacement .Encourage resident to express their feelings and concerns .Social services to offer psychosocial support to check on well-being . Review of Resident 40's facility document titled, Business Office Request, dated 4/9/24, indicated, .I [name redacted, Resident 40] received 1,088.00 [dollars] from the business office upon request. I understand that the money in my possession is solely my responsibility after receiving and signing agreement . The document indicated signatures of Resident 40, two witnesses' [including SSD 1's signature], and the administrator. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 40's facility document titled, Property Loss Report, dated 8/9/24, indicated, .Person reporting loss [Resident 40] .Item(s) reported as lost/missing $2400.00 cash/ID CARD/Insurance Card . Description of item(s) $2400.00 in cash .IDENTIFICATION CARD .medi-cal [public health insurance program] Insurance card .Name of owner [Resident 40] .Estimated Value $2400.00 .When loss discovered 8/2/24 .Suspected date of loss .8/2/24 .Action taken by management .Result of Action Facility searched for missing items, nothing was found. Money that was Reported missing did not equal amount that was released to the Resident. Facility will not Reimburse missing items . Further review of the document indicated signature of the Administrator (ADM) and the SSD 1, the section titled Reviewed with Owner both the signature and date was blank. Review of the document titled, ACTION TAKEN BY MANAGEMENT, indicated, .Resident [40] noted that two CNA's [certified nursing assistant] left his zip-lock bag in the barrel of linen and walked off, with items that are listed above . During a concurrent observation and interview on 1/28/25, at 10:47 a.m., Resident 40 stated he was missing money, and when asked how much money, he stated it was approximately $2600. Resident 40 stated his money was taken by two CNA's which he identified by name (CNA 6 and CNA 7). Resident 40 explained the money was contained in an envelope and wrapped in a towel and stated he kept it tucked into his bedding. Resident 40 stated after the incident he told a nurse his money was gone. Resident 40 stated it was all the money he had and stated it was the last of his savings which he had earned while working prior to living at the facility. Resident 40 stated he now had no more money. During a concurrent observation and record review on 1/31/25, 1:18 p.m., the SSD 1 stated Resident 40 had cash in his possession in the amount of $1088.00 prior to his allegation in August (2024) of his money being taken by two CNAs. The SSD stated when he told Resident 40 the facility would not be refunding his money Resident 40 was not happy and did not agree with his money not being reimbursed. Through record review, the SSD confirmed he could not locate a care plan pertaining to Resident 40's theft allegation in August (2024). The SSD stated the care plan would have been important to give staff direction regarding the incident and to help Resident 40 clear confusion over the incident and stated there should have been a care plan created for him. During a concurrent interview and record review on 1/31/25, at 2:05 p.m., the ADM reviewed Resident 40's Theft Loss Report, provided by the SSD 1 and stated he was not aware Resident 40 had taken cash out of the safe earlier in the year. The ADM stated he did not think Resident 40 had any money in his possession and stated looking at the bigger picture he would have followed a different path knowing Resident 40 took out his money in April (2024). The ADM stated it would have been important to care plan the incident, to include progress notes, and better documentation. The ADM stated this would have helped give a more accurate picture of what was going on with Resident 40's missing money. During a concurrent interview and record review on 1/31/25, at 3:33 p.m., the Assistant Director of Nurses (ADON) stated if a resident makes accusations regarding staff taking their possession's including their money, it was important to create a care plan for the incident. Through record review of Resident 40's care plans the ADON confirmed he did not have a care plan regarding the incident that took place in August (2024). The ADON stated the care plan could help with emotion regulation for Resident 40. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 2/3/25, at 9:16 a.m., the Ombudsman (OMB, long term care ombudsman are advocates and can assist residents to obtain quality care) 2 stated she was familiar with Resident 40, and he came to the Resident Council Meeting (meeting held at long-term care centers for residents, as a group, to influence the quality of their care) held at the facility on 8/22/24. The OMB stated Resident 40 brought up his stolen money at the meeting and afterward she met with him privately. The OMB stated Resident 40 seemed very upset over the incident. A review of the facility's Policy and Procedure (P&P) titled, Accommodation of Needs, dated 8/24, indicated, . 4. Based on individual needs ., the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40903 Based on observation, interview, and record review, the facility failed to ensure safe cleaning and sanitization of shared glucometer (a device used to measure blood sugar) in-between resident care on one out of six residents (Resident 30) observed for medication administration based on the facility's policy and manufacturer specifications. This failure had potential to spread infection among residents and compromise resident's well-being. Findings: During a medication administration observation with Licensed Nurse 9 (LN 9), at East Short hallway, on 1/28/25, at 9:28 AM, LN 9 with gloved hand took the glucometer and supplies inside a basket, into the Resident 30's room to measure the blood sugar. LN 9 then poked Resident 30's right middle finger with lancet (small, sharp needles used to obtain a small amount of blood from the finger for blood sugar testing) to get the blood and soaked the test strip (a plastic strip contains chemicals to help with blood sugar measurement) with blood to measure the blood sugar. LN 9 used one Sani-Cloth-Bleach wipe (brand name for a wipe with chemicals to disinfect and kill germs on the surfaces) and wrapped the glucometer with the wipe without wiping to clean and sanitize. LN 9 proceeded to put the wrapped glucometer inside the cart where it was stored. During a concurrent interview with LN 9, at East Nursing Station, and review of Sani-Cloth Bleach wipe labeling, on 1/28/25, at 3:30 PM, LN 9 stated her understanding was to wait 5 minutes after wrapping the glucometer before it could be used on the next resident. LN 9 acknowledged use of one wipe to wrap the glucometer and did not follow the two-step process of using one wipe to clean and the second wipe to sanitized with required 4 minutes time to keep the outer surface wet. During an interview with Infection prevention (IP) nurse, in her office, on 1/29/25, at 11:50 AM, the IP stated each medication cart stored two glucometer devices for the nurses to alternate use if needed. The IP stated the time to keep the glucometer wet was 4 minutes for Sani-Cloth Bleach wipe and 2 minutes for another wipe called purple top Sani-Cloth Wipe. The IP stated the nursing staff were instructed to use cups and wrap the glucometer by placing them in the cup. IP at the end of interview stated the staff should follow the two-step cleaning and sanitizing process. During an interview with Director of Nursing (DON), in her office, on 1/29/25, at 12:27 PM, the DON stated the nursing staff should follow the policy on cleaning and sanitizing shared glucometers. The DON stated the cleaning process was necessary to remove germs and other infectious materials not seen by eyes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the manufacturer of Assure Platinum glucometer (a brand name by ARKRAY, the manufacturer of glucometer used by the facility), titled ARKRAY Technical Brief: Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System , dated 9/2024, the documents under Cleaning and Disinfecting FAQ (Frequently Asked Questions) indicated Can cleaning and disinfecting be accomplished with one wipe? No, Each time the cleaning and disinfecting procedure is performed, two wipes are needed. One wipe to clean the meter and the second wipe to disinfect the meter. What will happen if a blood glucose meter is not clean and disinfected after use? . It is important that long term care facility establish a program for infection control . Program include addressing the cleaning and disinfecting of blood glucose meters along with other equipment and environmental surfaces . It is also important to provide education on infection control and the proper use of products. A review of the Center for Disease Control (A federal agency responsible for the health and safety of people) guideline titled, Considerations for Blood Glucose Monitoring and Insulin Administration, last accessed on 2/3/25 via https://www.cdc.gov/injection-safety/hcp/infection-control/index.html, the guideline indicated, Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place. The guideline further indicated Dedicated meters should be cleaned and disinfected per the manufacturer's instructions and, at a minimum, anytime the device is reassigned to a different person . If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared. Review of the facility's policy titled, Glucometer Disinfection, dated 2023, indicated .This facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instruction for multi resident use . The policy under the Procedure section indicated, .i. Retrieve 2 (two) disinfectant wipes from container. J. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of glucometer. k. After cleaning, used second wife to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instruction .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 40911 Based on observation, interview, and record review, the facility failed to provide an ongoing activity program that was resident centered for 2 of 27 sampled residents (Resident 23 and Resident 54) when: 1. Person-centered activities were not provided for Resident 23 while on contact precautions (set of steps to prevent the spread of illnesses that can be transmitted by direct or indirect contact) isolation; and, 2. Person-centered activities were not provided for Resident 54 who preferred to remain in his room. These failures had the potential to negatively impact Resident 23's and Resident 54's physical, mental, and psychosocial well-being. Findings: 1. Review of Resident 23's ADMISSION RECORD, indicated Resident 23 was admitted to the facility in the beginning of 2025 with diagnoses which included osteomyelitis (bone infection), MRSA (Methicillin Resistant Staphylococcus Aureus) infection, and a pressure ulcer to right heel. During a review of Resident 23's Skin Care Plan, dated 1/10/25, the care plan indicated, .Resident will be compliant with contact/isolation (help prevent the spread of germs from one patient to others) precautions by remaining in the room . During an interview on 1/29/25, at 9:04 a.m., with Resident 23, Resident 23 stated he had been in his room and had been in bed most of the time. During an interview on 1/30/25, at 11:55 a.m., with the Activity Director (AD), the AD explained residents on isolation were given an activity packet, composition book, and were provided with a one-on-one room visit at least twice a week to do activities of choice. During a concurrent interview and record review on 1/30/25, at 11:58 a.m. with the AD, Resident 23's activity documentation was reviewed. The AD confirmed there was no documentation to reflect the one-on-one room visits. The AD stated she had not had any room visits activity done for at least twice a week while resident was on contact isolation. The AD further stated she should have scheduled room visits as required. 2. Review of Resident 54's ADMISSION RECORD, indicated Resident 54 was admitted to the facility with diagnoses including heart disease and cerebral infarction (a medical condition when blood flow to the brain is disrupted). During a review of Resident 54's Mobility Care Plan, dated 1/24/22, indicated, Resident 54 had difficulty walking and to anticipate and meet needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/25, at 9:15 a.m., with Resident 54, Resident 54 stated he had not been out from his room and had not attended any group activities. Resident 54 also stated he was not able to walk and mostly in bed. During a concurrent interview and record review on 1/30/25, at 12:16 p.m., with the AD, Resident 54's activity documentation was reviewed. The AD explained residents who preferred to remain in their rooms for activities were also provided with activity packets, puzzles, any choice of activities that met their interests, and provided one-on-one visits at least twice a week. The AD confirmed there was no documentation to reflect one-on-one room visits at least twice a week. The AD also confirmed the last Activities-Participation Review was done on 7/6/23. The AD stated room visits should had been completed as scheduled and the type of activity done during the room visits should had been documented. During an interview on 1/31/25, at 11:15 a.m. with the Administrator (ADM), the ADM stated he would have expected one-on-one room visits for residents on isolation and residents who preferred to stay in their rooms should have been provided as appropriate. The ADM also stated he would have expected services rendered to be documented to show more involvement during the room visits. Review of the facility's undated policy and procedure titled, Activities indicated, .Provide an on-going program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences .activities will be designed to meet the interests of each resident .as well as support their physical, mental, and psychosocial well-being .Activities may be conducted in different ways: One-to-One Programs .Activities will include individual, small and large group activities as well as: In-Room Activities .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50161 Based on observation, interview, and record review, the facility failed to provide quality care for 1 of 27 residents (Resident 56) when Resident 56's physician orders for cardiology (medical specialty that focuses on the heart), urology (medical specialty that focuses on urinary tract or organs that produce urine), psychiatry consults, and neurology (medical specialty that focuses on conditions of the brain, spine and nerves) referral were not addressed. These failures could contribute to health concerns not being addressed and could lead to adverse events for Resident 56. Findings: Review of Resident 56's electronic medical record titled ADMISSION RECORD, indicated, Resident 56 was admitted to the facility during February of 2022, with a diagnosis including but not limited to paraplegia (inability to voluntarily move the lower parts of the body), spina bifida (birth defect that occurs when the spinal cord and spine do not develop normally), post-traumatic stress disorder (PTSD, a mental health condition that is caused by an extremely stressful or terrifying event), anxiety disorder (excessive fear or worry about a specific situation), major depressive disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems), and insomnia (inability to sleep). During a concurrent observation and interview on 1/28/25, at 11:33 a.m., with Resident 56, in his room, Resident 56 stated he was supposed to have medical appointments scheduled for a neurologist (brain doctor) and urologist (doctor that specializes on the urinary tract), and they had not scheduled them. Resident 56 stated they (facility) told him they could not find a doctor. Resident 56 stated he was born with spina bifida and had a shunt (a surgically placed tube that drains excess fluid from brain or spine and redirects it to another part of the body) and had seen his prior neurologist regularly. Resident 56 stated he wanted to see a urologist due to frequent infections, and he uses a straight catheter (a thin hollow tube that drains urine from the bladder) to empty his urine. Resident 56 stated he requested psychiatric (mental health provider) help and needed to see a mental health female doctor in person, and he did not approve of the telehealth mental health services through video calls he had received. Resident 56 stated he had spoken to his nurse, the Medical Doctor (MD) 1, and the Social Service Director (SSD) 1 regarding his requested consultations. Review of Resident 56's Order Details, dated 9/30/23, ordered by MD 2, indicated, .May refer to neurologist due to multiple syncopal [fainting] episodes . Review of Resident 56's Nurses Notes, dated 1/4/24, indicated, .Spoke with [name redacted, Hospital B] from neurology. Referral status denied. [Hospital B] has no availability . Review of Resident 56's Nurses Notes, dated 1/8/24, indicated, .Will endorse to MD [medical doctor] in regards to neuro [neurology] appointment . Request of Resident 56's Order Summary Report, to include all orders, including discontinued orders, were made on 1/31/25; discontinued orders for Resident 56 were not provided by the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 56's Order Summary Report, indicated active orders as of 1/31/25 were as follows: Psychiatry Consult .Order Date .1/13/2025 Urology Consult .Order Date .1/13/2025 Cardio [cardiac] Consult .Order Date .1/13/2025 During an interview on 1/30/25, 11:02 a.m., with Licensed Nurse (LN) 3, LN 3 stated Resident 56 uses a straight catheter through belly button to access his bladder and he likes to be independent in his care and performs the procedure himself. LN 3 stated Resident 56 has a shunt in his brain. LN 3 stated Resident takes medication for his anxiety. LN 3 stated she could not recall a mental health provider visiting with Resident 56 and she did not arrange the appointments for him and the SSD would arrange these. During a concurrent interview and record review on 1/31/25, 10:10 a.m., with the SSD (1), SSD 1 stated Resident 56 had a traumatic past and receives mental health services through a telehealth provider every month. SSD 1 stated he was responsible for scheduling appointments for residents regarding medical and psychiatric consults and was aware Resident 56 had a brain stent. SSD 1 stated he was aware of Resident 56's neurology, cardiac and psychiatry consults ordered on 1/13/25. SSD 1 stated he has attempted to schedule Resident 56's neurology appointment and was not successful. Through record review of Resident 56's clinical notes, SSD 1 confirmed he had not placed any notes regarding the scheduling of the urology, cardiac, and psychiatry consults. SSD 1 stated he was not aware of Resident 56's social service notes regarding scheduling of neurology appointments written on 1/4/24 and 1/8/24. SSD 1 stated it was important to follow-up on scheduling of consults due to clinical concerns for residents. During a concurrent interview and record review on 1/31/25, at 11:15 a.m., with the Director of Nurses (DON), the DON stated ancillary services provides psychiatric services for residents through telehealth consultations. The DON confirmed Resident 56 had orders for psychiatry, urology, cardiac consults. The DON stated the SSD was responsible for scheduling of consult appointments including medical consults. Through record review of Resident 56's clinical record, the DON confirmed there were no progress notes regarding appointment scheduling. The DON stated the time frame for scheduling a consult was within the week of receiving the order. The DON stated the reasons for consults was better assessment and to evaluate any medical needs. The DON stated the consults were important due to Resident 56's spina bifida diagnosis and to address the proper management, medical interventions, and routine care and healing. During an interview and record review on 1/31/25, at 12:50 p.m., with the SSD 1, SSD 1 reviewed Resident 56 clinical record and confirmed he had a neurology consult order which was never scheduled. SSD 1 stated in terms of referral if it was denied he would still go through process of calling for an appointment. SSD 1 stated this was important for residents' health and to follow medical orders. SSD 1 stated the timeline of scheduling was a few days to a week and it was important to get accomplished within short time frame. SSD 1 stated if consults were not scheduled timely there could be negative changes in a resident's condition. SSD 1 stated Resident 56, and his nurses had come to him requesting the appointments and when he attempted to call there was a 20-minute wait time and the appointments were not made. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 1/31/25, at 2:40 p.m., with the Medical Doctor (MD) 1, MD 1 stated he was familiar with Resident 56 and just recently became his patient. MD 1 stated his expectation was there was follow-up with staff on scheduling Resident 56's ordered consults. MD 1 stated consults should be scheduled within a week of the resident receiving the physician order. In regard to Resident 56's prior neurology consult, MD 1 stated his expectation was the appointment was made and the resident was seen. MD 1 stated clinical staff must work as a team for better outcomes for residents. Review of facility policy and procedure (P&P) titled Referrals, Social Service, revised 12/2008, indicated, . Social services shall coordinate most resident referrals. Exceptions might include emergency or specialized services that are arranged directly by a physician or the nursing staff .Referrals for medical services must be based on physician evaluation of resident need and a related physician order .Social Services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician .Social services will document the referral in the resident's medical record .Social services and administration will maintain a listing of referral agencies that may provide assistance or therapy to residents with special problems and/or needs .Social services will help arrange transportation to outside agencies, clinic appointments, ect., as appropriate . Review of a facility policy and procedure (P&P) titled, Behavioral Health Services, dated 2024, indicated, .It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychological functioning .The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrist, or neurologists (brain doctor) .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43943 Based on observation, interview, and record review, the facility failed to ensure residents were free from accidents and hazards when: 1. One of two sampled residents (Resident 43) who were at risk for elopement (leave the facility or a safe area without the facility's knowledge and supervision), did not have an effective plan of care was in place to protect Resident 43 from elopement, 2. The facility did not ensure the lint traps were clean in 2 out of 2 dryers; and, 3. The facility did not ensure 1 of 27 sampled residents (Resident 45)'s sliding door was operational. These failures could have resulted in injury such as falls, burns, or inability to exit a room. Findings: 1. During a review of Resident 43's clinical record titled, ADMISSION RECORD, indicated Resident 43's diagnosis included schizoaffective disorder (a mental condition that includes seeing and hearing things that are not real). A review of Resident 43's clinical record titled, IDT - Interdisciplinary Post Event Note, dated 12/11/24, on 12/10/24, at 5:41 p.m., by the Assistant Director of Nursing (ADON), indicated Resident 43 wandered (to move around without purpose) out of the facility at around 7:55 p.m. A Certified Nursing Assistant (CNA-unnamed) thought she saw Resident 43 passing by the nurse's station while she was documenting. Nursing staff immediately looked for Resident 43 outside. At around 8:05 p.m., the licensed nurse received a call from 711 (convenient store) identifying Resident 43. The nursing staff was told Resident 43 was approximately 60 meters (unit of measurement) away from the facility. A bystander claimed Resident 43 fell twice and called 911 for assistance. The LN noticed Resident 43 was confused but without obvious injuries. The ambulance brought Resident 43 to [ACUTE CARE HOSPITAL NAME] for further evaluation. A review of Resident 43's clinical record titled, Nursing Notes, dated 12/11/24 at 5:56 a.m., by the Licensed Nurse (LN 10), indicated Resident 43 returned from [ACUTE CARE HOSPITAL NAME] on 12/11/24 at 5:30 a.m. A review of Resident 43's clinical record titled, Nursing-Elopement Evaluation, dated 6/25/24, indicated Resident 43 was a high risk for elopement. A review of Resident 43's clinical record titled, Care Plan, (a record of Resident 43's specific goals, problems, and interventions) dated 6/28/24, indicated Resident 43 had behavior of wandering. An intervention was Resident 43 had 1:1 monitoring (one nurse watched one resident). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 43's clinical record titled, Monitor Resident Risk For Elopement Every 30 minutes Visual Check Whereabouts, dated 12/15/24 through 1/30/25, indicated the following monitoring times were not completed: -12/16/24 at 6:30 a.m., 3:00 p.m., 10 p.m., 10:30 p.m. -12/18/24 at 1:00 a.m., 6:30 a.m. -12/21/24 at 6:30 a.m. -12/22/24 at 2:30 p.m., 10:00 p.m., 10:30 p.m. -12/23/24 at 6:30 a.m., 3:00 p.m., 10:00 p.m., 10:30 p.m. -12/24/24 at 3:00 p.m., 10:00 p.m., 10:30 p.m. -12/25/24 at 2:30 p.m., 3:00 p.m., 6:30 p.m., 7:30 p.m., 9:30 p.m., 10:30 p.m. -12/26/24 at 11:00 a.m., 11:30 a.m., 10:30 p.m. -12/27/24 at 12:00 p.m. -12/28/24 at 6:30 a.m. -12/29/24 at 2:30 p.m., 4:30 p.m. -12/30/24 at 2:30 p.m., 15:00 p.m. -12/31/24 at 2:30 p.m., 3:00 p.m. -1/1/25 at 6:30 a.m. -1/3/25 at 6:30 am -1/4/25 at 3:00 p.m. -1/6/25 at 6:30 a.m. -1/9/25 at 6:30 a.m., 2:30 p.m. -1/10/25 at 6:30 a.m., 2:30 p.m., 3:00 p.m. -1/14/25 at 6:30 a.m. -1/16/25 at 3:00 p.m., 10:30 p.m. -1/18/25 at 6:30 a.m. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/20/25 at 6:30 a.m., 9:30 pm, 11:30 p.m. -1/22/25 at 2:30 p.m. -1/25/25 at 6:30 a.m.10:00 p.m., 10:30 p.m. -1/26/25 at 6:30 a.m. -1/27/25 at 6:00 a.m., 6:30 a.m. -1/30/25 at 1:30 p.m., 2:00 p.m., 2:30 p.m. During a concurrent observation and interview on 1/30/25, at 2:46 p.m., with Resident 43, Resident 43 stated she did not recall leaving the facility on 12/10/24. Resident 43 was in her bed with no staff present in the room or directly outside the room. During an interview on 1/30/25, at 2:47 p.m., with Licensed Nurse (LN 11), LN 11 stated Resident 43 was an elopement risk and the interventions to keep her safe was to have a CNA with Resident 43 at all times as a (1:1) and have Resident 43's whereabouts monitored every 30 minutes. LN 11 acknowledged the CNA was not in Resident 43's room and the expectation was that there would be a nurse with Resident 43's at all times. LN 11 stated Resident 43 walked on her own, did not use assistive devices (walker or wheelchair), and was at risk for leaving the facility. During an interview on 1/30/25, at 2:59 p.m., with CNA 9, CNA 9 stated the CNAs rotated turns every hour and provided Resident 43 with 1:1 supervision. CNA 9 stated he had left Resident 43's room and went to the bathroom. CNA 9 stated he should have asked another nurse to watch Resident 43 while he used the bathroom. CNA 9 stated Resident 43 was on 1:1 supervision because she was at risk for elopement. During an interview on 1/30/25, at 3:11 p.m., with the Director of Nursing (DON), the DON stated there was not a physician's order for monitoring Resident 43's whereabouts every 30 minutes, but the monitoring was listed in Resident 43's care plan. During a joint interview and records review on 1/30/25, at 3:36 p.m., with the DON and the Administrator (ADM), the facility's document titled, Monitor Resident Risk For Elopement Every 30 minutes Visual Check Whereabouts, dated 12/15/24 through 1/30/25, and the Policy and Procedure (P&P) titled, Wandering and Elopements, dated 3/19, were reviewed. The P&P indicated, .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment of residents .1. 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety . The ADM and the DON acknowledged there were multiple missing monitoring times between 12/15/24 through 1/30/25 and the facility failed to follow the P&P. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 1/29/25, at 10:49 a.m., with the Housekeeping/Laundry Supervisor (HLS), the lint traps in two out of two dryers were full of lint and looked like blankets over the lint traps. The HLS stated the lint traps needed to be cleaned every two to three hours to prevent fires and ensure the dryers were running efficiently. The HLS stated the dryer lint traps were not cleaned to her expectations and that she was not happy to see the condition of the lint traps. The HLS acknowledged the lint traps had not been cleaned within two to three hours and posed a fire risk. During an interview on 1/29/25, at 10:54 a.m., with the Housekeeping Assistant (HKA), the HKA stated the dryer lint traps were supposed to be cleaned every two hours. The HKA stated he had last cleaned the dryer lint traps on 1/29/25, at 5 a.m. The HKA stated he had missed at least two lint cleaning times on 1/29/25. The HKA stated it was important to clean the lint traps to prevent a fire. During a joint interview on 1/29/25, at 11:49 a.m., with the HLS and the Maintenance Supervisor (MS), the HLS and the MS acknowledged the dryer lint traps had not been cleaned within the two-to-three-hour timeframe. During a review of an undated facility document titled, [FACILITY NAME] Laundry Aid 5:40 a.m. through 2:00 p.m., indicated the laundry lint traps were supposed to be cleaned at 5:30 a.m., 8:30 a.m., 11:30 a.m., 1:30 p. m. During a review of the facility's document titled, Direct Supply TELS, (work order) dated 12/12/24, by the MS, indicated, .Confirm that the lint is removed from the stack and inside the dryer. It is a fire hazard and a code violation if this is not maintained .Lint Catch/Screens - lint catchers should be cleaned AFTER EACH LOAD . A review of the facility's document titled, Environmental Service Laundry Worker Job Description, dated 2022, indicated, .Ensures the provision of the day-to-day activities of the Laundry Department .ensures that daily work/cleaning schedules are followed . During a concurrent interview and review of policies and procedures (P&Ps) on 1/30/25, at 4:06 p.m., with the Administrator (ADM) and the Director of Nursing (DON), the P&Ps titled, Accidents and Supervision, dated 2024, and Emergency Preparedness Plan, dated 2024, were reviewed. The P&P titled, Accidents and Supervision indicated, .'Hazards' refers to elements of the resident environment that have the potential to cause injury .'risk' refers to any external factor, facility characteristic (e.g physical environment) .that influences the likelihood of an accident . The P&P titled, Emergency Preparedness Plan, dated 2024, indicated, .3. The plan will consider particular hazards most likely to occur in the surrounding area including . ii. Equipment .failures . The ADM and the DON stated the lint traps were not cleaned to the standards held by the facility and posed a fire hazard risk. The ADM and the DON acknowledged the P&Ps were not followed. 50161 3. Review of Resident 45's electronic medical record, titled ADMISSION RECORD, indicated Resident 45 was admitted to the facility during November of 2024, with a diagnosis including but not limited to major depressive disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and spinal stenosis (space inside the backbone is too small and can cause back or neck pain). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/28/25, at 12 a.m., Resident 45 was observed in his room, sitting in his wheelchair next to his bed, and behind him was a glass sliding door that led to an outside area. Resident 45 stated the sliding door in his room does not open. Resident 45 was observed making multiple attempts to open the sliding door not open and appeared to be stuck. Resident 45 stated he cannot get the sliding door to open and stated he had informed maintenance staff and the Director of Nurses (DON) of the issue. Resident 45 stated not being able to open the door to go outside made him feel stuck in his room and anxious. Resident 45 stated the fresh air helped to relieve some of his anxiety and stated he needed to be able to get fresh air and go outside. Resident 45 stated he physically could not open the door and stated he was concerned about his health and safety. During a concurrent observation and interview on 1/28/25, at 12:14 p.m., CNA 8 in Resident 45's room, was observed attempting to open the sliding glass door in the room. CNA 8 stated the sliding glass door was hard to open and stated it seemed like it was stuck. CNA 8 stated the other sliding doors in other resident's rooms were easier to open. CNA 8 stated it would be hard for Resident 45 to open due to his limited mobility and stated Resident 45's room sliding door should not be like this. During a concurrent observation and interview on 1/28/25, at 12:18 p.m., LN 4 stated residents could go outside through slider door in their room for fresh air and they could sit on the porch. LN 4 confirmed Resident 45's sliding door was not able to open. LN 4 explained if the sliding door was difficult to open this could limit Resident 45's mobility and he could end up falling and hurting himself. LN 4 explained the sliding door required to much force and she could open it. During a concurrent observation and interview on 1/28/25, at 12:24 p.m., in Resident 45's room, the MS confirmed there was no wheels on the track of the rooms sliding door. The MS stated the door should smoothly open with little force. The MS stated the sliding door was a safety hazard and could be used as a fire exit. The MS stated the opening of the door allowed for fresh air to enter the room. The MS stated he was informed yesterday that the sliding glass door was not working and stated he will order the wheels now. During an interview and record review on 1/31/25, at 2:10 p.m., the ADM stated regarding Resident 45's sliding glass door in his room, the ADM stated Resident 45 used his sliding door to go outside to the patio a lot. The ADM stated they (facility) did order the sliding glass door parts to fix the door. Review of a facility policy and procedure (P&P) titled, Accidents and Supervision, dated 2024, indicated, .The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive to prevent accidents. This includes .Identifying hazard (s) and risk (s) . Evaluating and analyzing hazard (s) and risk (s) .Implementing interventions to reduce hazard (s) and risk (s) .Monitoring for effectiveness and modifying interventions when necessary .Hazards .refers to elements of the resident environment that have the potential to cause injury or illness .Identification of Hazards and Risks . the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident .All staff (e.g. [for example], professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident .the facility should make a reasonable effort to identify the hazards and risk factor for each resident. These sources include . environmental rounds . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of a facility P&P titled, Safe and Homelike Environment, dated 2024, indicated, .In accordance with the residents' rights, the facility will provide a safe, clean, comfortable and home like environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk .Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas . Housekeeping and maintenance services will be provided as necessary to maintain sanitary, orderly and comfortable environments .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 40911 Based on observation, interview, and record review, the facility failed to ensure one of seven residents (Resident 76) was provided with appropriate care and services with enteral feeding (also referred to as G-Tube feeding-gastrostomy tube feeding, the delivery of food and nutrients through a feeding tube directly into the stomach or part of the intestines) when: 1. The enteral feeding formula container did not have a stop time and a re-start time labeled on the bottle; and, 2. The water flush bag was not labeled with Resident 76's name, room number, date, time started and stopped, the administration rate, and initials of the nurse. These failures had the potential for Resident 76 to not receive adequate enteral nutrition and proper hydration and to not receive the correct water flush bag. Findings: During a review of Resident 76's ADMISSION RECORD, indicated resident was admitted to the facility in the middle of 2024 with diagnoses which included dysphagia (inability to swallow). The Minimum Data Set (MDS, an assessment tool) dated 12/19/24, indicated Resident 76 was receiving nutrition through feeding tube while being a resident of this facility. A review of Resident 76's G-Tube Feeding Care Plan, dated 6/14/24, indicated, .The resident needs assistance with tube feeding and water flushes. See MD [Medical Doctor] orders for current feeding orders . 1. A review of Resident 76's Order Summary Report, dated 10/17/24, indicated, .one time a day [Brand name] enteral feed order @ 80ml/hr x 18hrs. This will provide 2160 kcal. per pump . (at 80 milliliters per hour for 18 hours-unit of measurement. This will provide 2160 kilocalories-unit of measurement). During an observation on 1/30/25, at 4:45 p.m., in Resident 76's room, the enteral feeding bottle was delivering the formula at 80 ml/hr via a feeding pump. The start time showed the feeding started at 6 a.m. However, the bottle was still full at this time it was noted. There was no indication the time the feeding was stopped nor the time the feeding was re-started. During an interview on 1/30/25, at 4:55 p.m. ,with Licensed Nurse (LN) 12, LN 12 stated she just re-started the enteral feeding bottle at 4 p.m. and did not write the start time. LN 12 confirmed there was no stop time when it was started at 6 a.m. and continued to use the same bottle because it was still full. LN 12 further stated the feeding bottle should have a stop time and a start time to know how long the bottle had been in use. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/25, at 8:36 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the enteral feeding formula should have an end time and a start time to be able to calculate the correct amount of nutrients received or delivered. During an interview on 1/31/25, at 10:09 a.m., with the Director of Nursing (DON), the DON stated the date together with the start and end time were important information to know because enteral feedings were perishable food and had a high chance of getting spoiled once spiked (opened). A review of Resident 76's Order Details, dated 10/17/24, indicated, .All enteral feed schedules in this order use the same start date and end date . 2. A review of Resident 76's Order Summary Report, dated 10/17/24, indicated, .every shift Water flush 40ml per hour x 18 hrs per pump . During an observation on 1/30/25, at 4:44 p.m., in Resident 76's room, a water flush bag was hanging and did not have a label that indicated the resident's name, room, number, administration rate, the date and time the bag was hung and started or stopped, and the initials of the nurse. During an interview on 1/30/25, at 4:55 p.m., with LN 12, LN 12 confirmed the water flush bag did not have the label. LN 12 stated the water flush bag should have the label written on the bag to indicate who the bag belonged to and how long the bag was hanging. LN 12 further stated without the label she would not know if the water flush bag would still be good to use. During an interview on 1/31/25, at 8:36 a.m., with the ADON, the ADON stated the water flush bag should have been labeled appropriately. The ADON further stated labeling any bag hung was the proper nursing practice. During an interview on 1/31/25, at 10:09 a.m., with the DON, the DON stated the water flushing bag should have been labeled accordingly and expected the nursing staff to have followed proper labeling facility policy. During a review of the facility's undated policy and procedure titled, Care and Treatment of Feeding Tubes, indicated, .It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .Feeding tubes will be utilized according to physician orders .the kind of feeding and it's caloric value, volume, duration, mechanism of administration, and frequency of flush .Frequency of and volume used for flushing .Ensuring that the product has not exceeded the expiration date .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	1221 Rosemarie Lane Stockton, CA 95207

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 50598 Based on observation, interview, and record review, the facility failed to ensure direct care staffing information was posted as required for a census of 92. This failure prevented the residents and visitors from viewing the hours and number of direct care staff providing care to the residents of the facility daily. Findings: During a concurrent interview and record review on 1/30/25, at 4:35 PM, with the Director of Staff Development (DSD), while reviewing a document titled, The PPD (Per Patient Day) Spreadsheet, The DSD stated, the spreadsheet was in his binder and the binder was used to calculate the PPD daily. The DSD further stated the PPD Spreadsheet was also used when admissions and discharges were expected. During a concurrent observation, interview, and record review, on 1/31/25 at 10:50 AM, with the Director of Nursing (DON), the DON stated when determining the daily schedule for staff they used the PPD that was current at the time and included consideration of the acuity of the residents. The DON stated when needed they would adjust the PPD. When asked where the PPD was located the DON stated, the PPD was in the DSD office and once it was calculated for that day it would be given to the Administrator (ADM). During an interview on 1/31/25 at 1:33 PM, with the DON, the DON stated, when she arrived at this facility the document that was previously being used as the nursing schedule was the same document that was being used during the observation. The DON stated the facility reviewed document titled, BROOKSIDE CARE .Nursing Daily Assignment contained the following information, the staff member names, titles, work location, lunch times, and room assignment. The DON confirmed the document was missing the facility's census and hours scheduled and actual hours worked by licensed and non-licensed staff that's responsible for the resident's care. The DON further stated the PPD and the census were just not posted. A review of a facility provided document titled, Posting Direct Care Daily Staffing Numbers, dated August 2022, indicated, Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to: assisting with activities of daily living (ADLs) .The information recorded on the form shall include the following: a. The name of the facility .c. The resident census at the beginning of the shift for which the information is posted .g. the actual time worked during that shift for each category and type of nursing staff .

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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. 50778 Based on observation, interview, and record review, the facility failed to ensure safe and timely medication acquisition, handling, use, and disposition (destruction of unused medications) with a resident census of 92 when: 1. Non-controlled prescription medication (medications prescribed by a doctor and not an opioid) destruction logs were either not signed or not co-signed by licensed nurses in the destruction medication binder in one of two nurse's stations (East nurse station); and, 2. Resident 45's and Resident 83's prescribed medications were not available and not refilled (process of obtaining additional medication) in a timely manner leading to missed doses. These failed practices led to the residents not receiving prescribed medications as a result of unavailability and delay in the refill process, and potential for medication diversion. Findings: 1. During a concurrent interview with Licensed Nurse (LN) 2 and record review of a binder of the facility's documents titled MEDICATION DISPOSITION SHEET on 01/28/25, at 4:50 PM, the medication destruction logs were missing either one signature of a witness or missing both required co-signatures as follows: 12/28/24 and 1/8/25 (on the same page) one signature listed; 12/22/24 one signature listed; 12/1/24 and 12/14/24 (on the same page) one signature listed; 11/16/24, 11/17/24, and 11/24/24 (on the same page) one signature listed; 11/2/24 and 11/9/24 (on the same page) one signature listed; Two undated pages with no signatures; and 3/17/24 no signature listed. LN 2 acknowledged the findings listed above. During an interview on 1/29/25, at 12:27 PM, with the Director of Nursing (DON), the DON was shown pictures of Medication Disposition Sheets that were either unsigned or without a co-signature and confirmed the staff should have signed and obtained a witness signature on each of the pages when destroying discontinued prescription medication per facility policy. The DON stated the risk of not following established facility policy increases the chance of drug diversion (prescription drugs taken for personal use). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy titled, Discarding and Destroying Medications, revised 11/2022, indicated, .Medications that cannot be returned to the dispensing pharmacy .are disposed of in accordance with federal, state and local regulations .Non-controlled and Schedule V (non-hazardous) controlled substances [something is not dangerous or harmful to people or the environment] .are disposed of in accordance with state regulations .Medication disposition records contain, as a minimum .signature of witnesses . 2a. During a medication administration observation on 1/28/25, at 9:10 AM, accompanied by LN 1 in the [NAME] Long Hall, LN 1 administered a total of seven medications to Resident 83 and stated she did not have a medication called Eliquis (also called apixaban, a medication that thins the blood). LN 1 stated Eliquis needed to be reordered. During a concurrent interview with LN 5 and review of Resident 83's electronic medical record on 1/28/25 at 4:10 PM, LN 5 stated Eliquis had not been reordered and was still not available in the medication cart. LN 5 then proceeded to reorder the medication via the computer. During a concurrent interview with LN 1 and a review of Resident 83's medical records on 1/31/25, at 11:58 AM, LN 1 stated the process for reordering medication was to use the computer or to call the provider pharmacy when a medication was at a low level and a few days before it would run out. LN 1 stated she did not know Resident 83 missed one full day of Eliquis and that the pills did not arrive until the following day. During an interview on 1/29/25, at 1:10 PM, with the DON in the DON's office, the DON stated the provider pharmacy delivered medication multiple times per day and the nurses could have made a phone call or informed the management to expedite the delivery of medication. The DON stated Eliquis was not contained in the facility's EKit (emergency medication kit). The DON stated the risk of not having prescribed blood thinners for residents would be increased chance of stroke and blood clot formation. A review of the facility's policy and procedure titled, Medication Administration General Guidelines, dated 09/18, indicated, .Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices .Medications are administered in accordance with written orders of the prescriber . A review of the facility's policy titled, Pharmacy Services Overview, revised 4/19, indicated, .Pharmaceutical services consists of .the process of receiving and interpreting prescriber's orders .Pharmacy services are available to residents 24 hours a day, seven days a week .residents have a sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner . Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available to administration . 50161 2b. Review of Resident 45's electronic medical record titled ADMISSION RECORD, indicated Resident 45 was admitted to the facility with a diagnoses including but not limited to major depressive disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and spinal stenosis (occurs when the space inside the backbone is too small and can cause back or neck pain). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 45's electronic medical record titled Medication Administration Record (or MAR, where nurses document what and when ordered medications were administered), dated 1/2025, the record indicated the following orders for mind altering medication as follows: traZODone HCL Oral Tablet 150 MG (antidepressant, and used to treat depression and anxiety, MG is milligram, a unit of measure) by mouth at bedtime for Depression m/b [manifested by] inability to sleep .Start Date 9/14/23 . The record indicated the medication was not administered for the dates of 1/13/25, 1/14/25, and 1/15/25. Zolpidem Tartrate [brand name Ambien, a sedative and is used for the short-term treatment of insomnia by helping you fall asleep] Oral Tablet 10 MG (Zolpidem Tartrate) Give 1 tablet by mouth at bedtime related to INSOMNIA .M/B [manifested by] inability to sleep .Start Date .11/26/24 . The record indicated the medication was not administered on 1/23/25, 1/24/25, 1/25, 1/26/25, and 1/27/25. Gabapentin Oral Capsule 300 MG (an anti-seizure medication and used to treat nerve pain); Give 1 capsule by mouth two times a day for Neuropathic Pain .Start Date 1/5/2024 .End Date 1/29/25 . The record indicated the medication was not administered for the dates of 1/27/25 (5 p.m. dose,), 1/28/25 (9 a.m. dose), and 1/29/25 (9 a.m. dose). Gabapentin Oral Capsule 300 MG (an anti-seizure medication and used to treat nerve pain); Give 2 capsule by mouth at bedtime for Neuropathic Pain .Start Date 1/4/2024 . The record indicated the medication was not administered for the date of 1/27/25 and 1/28/25 (9:00 p.m. dose). This order was discontinued 1/29/25, after the missing doses was questioned by the Department. Gabapentin Oral Capsule 300 MG (an anti-seizure medication and used to treat nerve pain); Give 300 mg by mouth two times a day for Neuropathic pain related to SPINAL STENOSIS, LUMBAR [lower back] REGION WITH NEUROGENIC CLAUDICATION [condition characterized by pain, numbness, or weakness in the legs that occurs during physical activity or walking] .Start Date 1/30/2025 . The record indicated the medication was not administered for the date of 1/30 (9 a.m. dose). During a concurrent observation and interview on 1/28/25, at 12 a.m., Resident 45 was observed in his room, sitting in his wheelchair next to his bed, and stated two weeks ago the facility ran out of his medications over the weekend. Resident 45 stated due to a back surgery, he was in constant pain. Resident 45 stated his medications were often missing and there were delays in getting his pain related medications. Resident 45 stated as of right now the facility was out of his gabapentin and two other medications for the last three days. Resident 45 stated they (facility) should not be out of his medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25, at 11:10 a.m., LN 3 stated sometimes the pharmacy was late in delivering Resident 45's medications. LN 3 stated Resident 45 had been getting upset when he was informed of delay in his medication availability. LN 3 stated she had been reordering the medication up to seven days out from the medication pack being empty. LN 3 stated it took the pharmacy two to three days to deliver the medication. LN 3 stated Resident 45's medication refills were not automatic and confirmed he was out of a few medications today, including his gabapentin, which was used for his nerve pain, and explained this was due to delay in reordering the medication. LN 3 stated Resident 45's pain could get worse if he missed his doses. LN 3 confirmed Resident 45 missed trazadone doses for three consecutive days. LN 3 stated Resident 45 missed trazadone doses could worsen his anxiety, depression, sleep issues, and contribute to his agitation. LN 3 stated she did not notify the medical doctor for Resident 45's missed doses of medications. Through record review, LN 3 confirmed Resident 45 did not receive his ordered zolpidem for five consecutive days on 1/23/25, 1/24/25, 1/25/25, 1/26/25, and 1/27/25. LN 3 stated Resident 45 needed the zolpidem to help him sleep every night. Further review of Resident 45's MAR with LN 3 confirmed he did not receive his scheduled daily gabapentin from 1/27/25 through 1/30/25 and stated they were currently out of the medication. During an interview on 1/30/25, 12:20 p.m., the Assistant Director of Nurses (ADON), the ADON confirmed Resident 45's missed doses of medications over three to four consecutive days. The ADON stated the missed doses could contribute to resident's pain level, quality of life, and could experience a rebound effect (symptoms can come back or worsen) for whatever the medication was treating. The ADON stated the nursing staff should have reordered the medications well in advance and notify management if not delivered to the facility. The ADON stated it was important for the LN to notify the MD so they were aware of the possible withdrawal symptoms the resident could experience and the MD can place new orders for the resident if needed. During a phone interview on 1/31/25, at 2:56 p.m., the MD 1 stated he had spoken to Resident 45 the day before and confirmed Resident 45 did not receive or had access to his trazadone for a few days recently. MD 1 stated Resident 45 used the trazadone for his anxiety and to help with his sleep. MD 1 stated it was his expectation for the nurses to refill a resident's medication timely. MD 1 stated all medications have risks if they are suddenly stopped and stated the patient could experience worsening of their anxiety and could experience side effects such as increase in seizures (uncontrolled brain activity leading to harmful body contractions). MD 1 stated the missed doses of sleep medications would put residents at risk of sudden withdrawal symptoms. A review of the facility's policy and procedure titled, Medication Administration General Guidelines, dated 09/18, indicated, .Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices .Medications are administered in accordance with written orders of the prescriber . A review of the facility's policy titled, Pharmacy Services Overview, revised 4/19, indicated, .Pharmaceutical services consists of .the process of receiving and interpreting prescriber's orders .Pharmacy services are available to residents 24 hours a day, seven days a week .residents have a sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner . Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available to administration .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40903 Based on interview, and record review, the facility failed to ensure safe use of psychotropic medications (mind altering drugs used to control behavior or thought process) in 4 out of 27 sampled residents (Resident 11, Resident 43, Resident 23, and Resident 56) when: 1. Resident 11 and Resident 43's psychotropic PRN (as needed) medication use was not re-assessed for lorazepam (or Ativan, drug used to treat anxiety) continued use, 2. Resident 11 and Resident 23's documented diagnosis for psychotropic medications did not have a specific mental health diagnosis in the medical records and/or by medical doctor caring for the resident; and, 3. Resident 56's mental health consult notes and medication recommendations via telehealth care (use of technology, video, or phone to provide long distance mental health care) were not communicated to medical doctor (MD) 1 and the licensed nursing (LN) staff. These failed practices could contribute to unsafe medication use and adversely affect residents' mental health treatment. Findings: 1a. During review of Resident 11's electronic medical record titled, Medical Diagnosis, on 1/30/25, the record indicated Resident 11 was admitted to the facility in August of 2024 with diagnosis including, heart disease, breathing issues, depression, dementia (forgetfulness), and psychotic disorder (Psychotic disorders described as a group of mental disorders that cause abnormal thinking and perceptions). During review of Resident 11's electronic medical record titled, Medication Administration Record, dated 1/2025, the MAR record indicated Resident 11 was ordered a drug called lorazepam to help with agitation and shortness of breath as follows: Lorazepam Concentrate 2 MG/ML (MG/ML is milligram in each Milliliter, a measure of dose and strength): Give 0.5 ml by mouth every 4 hours as needed for agitation/sob (SOB is Shortness of Breath)-Start Date-1/30/25 The PRN (as needed) lorazepam order did not have a duration of use. During a concurrent interview and record review of the Resident 11's electronic medical record, with the Assistant Director of Nursing (ADON), on 1/31/25, at 11:20 AM, the ADON confirmed the PRN (as needed) lorazepam did not have a duration of use. The ADON stated the order for routine and PRN lorazepam were combined and this perhaps resulted in not addressing the duration of use for PRN lorazepam order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of nursing (DON), in her office, on 1/31/25, at 2:40 PM, the DON stated she expected the staff to make sure the regulatory requirements were followed because the drug use needed to be re-assessed for effectiveness if used on as needed basis. 1b. During review of Resident 43's electronic medical record titled, Medical Diagnosis, on 1/30/25, the record indicated Resident 43 was admitted to the facility in June of 2024 with diagnosis including, high blood pressure, diabetes (blood sugar disease), and Schizoaffective disorder (a mental health condition that combines symptoms including delusion [false beliefs], hallucination [hearing or seeing unreal things] or depression). During review of Resident 43's electronic medical record titled, Medication Administration Record, dated 1/2025, the MAR record indicated Resident 43 was ordered lorazepam as follows: Lorazepam oral tablet 0.5 mg (or Ativan, mg is milligram, a unit of measure); Give 1 tablet by mouth every 4 hours as needed for anxiety; Start Date: 1/4/25 Lorazepam Injection Solution 2 MG/ML (Ativan); Inject 0.25 mL Intramuscularly (or IM, shot into the muscle) every 2 hours as needed for anxiety M/B (manifested By): Violence/aggression toward staff .Max (maximum) 2 doses per day. Give if unable to give po (orally)- Start date: 6/26/24. The PRN lorazepam orders did not have a duration and re-assessment period to address use and effectiveness. During a concurrent interview and record review of the Resident 43's electronic medical record, with the Assistant Director of Nursing (ADON) on 1/30/25, at 4:36 PM, the ADON confirmed the PRN (as needed) lorazepam did not have a duration of use. The ADON stated the order for PRN use of IM and PO (oral pill) lorazepam were combined and this perhaps resulted in not addressing the duration of use for PRN lorazepam order. The ADON stated it was not a safe practice not addressing the duration of use. The ADON stated the PRN use should have been reviewed by facility's team of doctors, nurses, pharmacists and social workers that monitor the resident. During an interview with the Director of Nursing (DON), in her office, on 1/31/25, at 2:40 PM, the DON stated she expected the staff to make sure the regulatory requirements were followed because the drug use needed to be re-assessed for effectiveness if used on as needed basis. 2a. During review of Resident 11's electronic medical record titled, Medical Diagnosis, on 1/30/25, the record indicated Resident 11 was admitted to the facility in August of 2024 with diagnosis including, heart disease, breathing issues, depression, dementia (forgetfulness), and psychotic disorder with delusion (delusion same as false beliefs, psychotic disorders described as a group of mental disorders that cause abnormal thinking and perceptions). During review of Resident 11's electronic medical record, titled Medication Administration Record, dated 1/2025, the MAR record indicated Resident 11 was ordered a drug called Seroquel (or quetiapine, a mind-altering drug used for mental health) and Depakote (drug used for mood swings or brain seizure[unusual activity in brain]) as follows: Seroquel Oral Tablet 50 MG (Quetiapine .); Give 3 tablet by mouth at bedtime related to PSYCHOTIC DISORDER WITH DELUSIONS [false beliefs] .M/B (manifested By): Yelling -Start Date- 11/26/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Depakote Tablet Delayed Release (Divalproex Sodium); Give 500 mg by mouth two times a day for Mood disorder M/B yelling . -Start Date- 12/10/24. The documented diagnosis of psychotic disorder was not specific to the condition and behavior. Review of the facility's documented MDS (Minimum Data Set, a report sent to federal government by the facility and included resident diagnosis) for Resident 11, dated 11/27/24, the record under psychiatric/Mood disorder indicated diagnosis of depression and psychotic disorder (other than Schizophrenia- a mental health disease). During a concurrent interview and review of Resident 11's electronic medical record with the ADON, on 1/31/25, at 11:20 AM, the ADON confirmed the diagnosis listed in the medical records for use psychotropic medications. The ADON stated the facility copied what was recorded in the previous nursing home. The ADON stated there was no psychiatric consult (mental health doctor evaluation) found in the medical record. 2b. During review of Resident 23's electronic medical record, titled Medical Diagnosis, on 1/30/25, the record indicated Resident 23 was admitted to the facility in January of 2025 with diagnosis including, heart disease with heart Rhythm issues, breathing issues, depression, diabetes (blood sugar disease) and bone infections among other. The record did not indicate any diagnosis for anxiety. During review of Resident 23's electronic medical record titled, Medication Administration Record, dated 1/2025, the MAR record indicated Resident 23 was ordered a drug called Buspar (or buspirone, anti-anxiety drug) that was indicated for anxiety as follows: busPIRone (or Buspar) Oral Tablet 5 MG .Give 1 tablet by mouth two times a day for anxiety- Start Date: 1/10/25 Further review of the MAR indicated the facility was monitoring anxiety as manifested by inability to relax. During a concurrent interview and review of Resident 23's electronic medical record with the ADON, on 1/30/25, at 4:17 PM, the ADON confirmed there was no documented diagnosis in the medical record for anxiety and use of Buspar. The ADON could not find the electronic copy of the admission History and Physical (or H&P, a record that summarized residents past medical history and plan of medical care in the facility) from Medical Doctor 1 (MD 1) who cared for Resident 23. The ADON stated the H&P should have been done within 72 hours of admission. The ADON later brought a paper version of the H&P dated 1/24/25 that she received from the medical record department. The paper version of MD 1's H&P did not include anxiety as a diagnosis for use of Buspar. During an interview with the Director of nursing (DON), in her office, on 1/31/25, at 2:40 PM, the DON stated she expected the staff to make sure the regulatory requirements were followed because every drug use should have had a medically documented diagnosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, titled Use of psychotropic Medications, dated 2024, the policy indicated Residents are not given psychotropic drug unless the medication is necessary to treat specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to medications. The policy on section 4 indicated The indication for use of any psychotropic drug will be documented in the medical record. The Policy on section 9 indicated PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration of. PRN use . 50161 3. Review of Resident 56's electronic medical record titled, ADMISSION RECORD, indicated, Resident 56 was admitted to the facility during February of 2022, with a diagnoses including but not limited to post-traumatic stress disorder (PTSD, when a person's past experience cause emotional problems on their daily life), anxiety disorder (excessive fear or worry about a specific situation), major depressive disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems), and insomnia (inability to sleep) among others. During a concurrent observation and interview with Resident 56, in his room, on 1/28/25, at 11:33 a.m., Resident 56 stated he requested psychiatric (mental health provider) help and needed to see a mental health female doctor in person and he did not approve of the telehealth mental health services through video calls he had received. Review of Resident 56's electronic medical record, titled Medication Administration Record (or MAR, where nurses document what and when ordered medications were administered), dated 5/2024, indicated the following orders for mind altering medication as follows: Lorazepam Oral Tablet 0.5 MG (or Ativan, anti-anxiety medication, MG is milligram, a unit of measure) Give 0.5 mg by mouth every 12 hours as needed for anxious/restlessness; Start date 3/24/2024. Lexapro Tablet (a drug used to treat depression); Give 10 mg by mouth one time a day for Depression M/B [manifested by]; Start Date 11/04/2023 Review of Resident 56's name redacted, Psychiatric Visit Progress Report, dated 5/6/24, indicated the recommendations to reduce lorazepam dosage and increase Lexapro dosage. Review of the Resident 56's electronic medical records and notes did not reflect the recommendations were communicated with the medical doctor or the nurse. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Social Service Director (SSD), on 1/31/25, 10:10 a.m., the SSD stated Resident 56 had been receiving telehealth mental health services. The SSD confirmed Resident 56 received telehealth mental health services in May of 2024. The SSD stated the mental health consult records of service were emailed to him and he printed them out and gave them to medical record staff. The SSD stated he stopped printing and providing them to medical records in August of 2024 due to things piling on. The SSD reviewed his incoming emails for Resident 56 from the telehealth services and found clinical progress notes for: 5/6/24, 6/28/24, 7/26/24, 8/7/24, 10/1/24, and 11/22/24. The SSD stated he never emailed the mental health consult via telehealth notes to the Resident 56's medical care provider. The SSD stated he assumed somehow the medical doctor would receive them from someone else other then him. The SSD stated he did not provide the telehealth consult notes to the front-line nursing staff and he assumed the medical doctor would take care of it. Through further record review of Resident 56's telehealth consult and medication order recommendation dated on 5/6/24, the SSD confirmed the recommendation for lorazepam and Lexapro were not addressed by the medical doctor and the nursing staff. The SSD stated there a break in the communication and he was not sure of his role in the process of follow-up with the clinical team. During a concurrent interview and record review with the Director of Nurses (DON), on 1/31/25 at 11:15 a.m., the DON confirmed that she had been receiving telehealth consult notes via email for over thirty residents approximately once a month since July 2024. The DON stated she was not sure what the SSD receives via email from the telehealth company. The DON acknowledged there had been communication issues and there were challenges with medical records uploading documents into resident charts. The DON stated the process needed to be fixed and the attending doctor and nursing staff. The DON stated her expectation was all resident consult notes to be uploaded and available in the clinical record for nursing staff to review and provide care. The DON stated if the recommendations from mental health provider were not addressed in a timely manner it might affect the residents physical and mental well-being and continuity of care. During a phone interview with the Medical Doctor (MD) 1, 1/31/25, 2:40 p.m., MD 1 stated he was familiar with Resident 56 and was not yet sure of the communication process with the telehealth mental health services in the facility. MD 1 stated there should be a process for communication of consult notes, new medication orders, and recommendations from the mental health consults to the medical doctor and the process should not be delayed. MD 1 stated clinical staff must work as a team for better outcomes for residents. Review of facility policy and procedure (P&P) titled Use of Psychotropic Medications, dated 12/16/24, indicated, .The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team . Review of facility P&P titled Behavioral Health Services, dated 2024, indicated, .It is the policy of this facility to ensure all residents receive necessary behavioural health services to assist them in reaching and maintaining their highest level of mental and psychological functioning .The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facilty and outside sources such as physician, psychiatrist, or neurologists (brain doctor).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50778 Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when the medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with a resident census of 92. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of five errors out of 35 opportunities which resulted in a facility wide medication error rate of 14.29% in 3 out of 6 residents (Resident 17, Resident 5, and Resident 76) were observed for medication administration. These failures may result in unsafe medications use affecting residents' health and well-being. Findings: 1a. During a medication administration observation, accompanied by Licensed Nurse 1 (LN 1), on 1/28/25, at 8:40 AM, in the [NAME] Long hallway, LN 1 administered a total of 10 medications to Resident 17. The medications included an inhaler called Breo Ellipta (an inhaled medication containing two medications in one; used to treat breathing issues) and a blood pressure medication called amlodipine as follows: Breo Ellipta Inhalation Aerosol . (Fluticasone/Vilanterol; names two medications in the inhaler); 1 puff inhale orally (by mouth) one time a day for shortness of breath; Rinse mouth with water and spit out after each use. Amlodipine . oral tablet .; give 1 tablet by mouth one time a day for HTN (hypertension, or high blood pressure) if SBP (Systolic Blood Pressure- pressure in arteries when heart beats, representing the top number in a blood pressure reading) below 100 and PR (Pulse Rate or heart rate) below 60- Start date- 11/6/24. The LN 1 did not offer or help Resident 17 to rinse his mouth after the Breo Ellipta use. LN 1 did not hold the blood pressure medicine when the Resident 17's heart rate was 59. During a concurrent interview with LN 1, and record review of Resident 17, at the [NAME] nursing station, on 1/31/25, at 11:59 AM, LN 1 stated she should have held the blood pressure medication, amlodipine. LN 1 stated Medication Administration Record (MAR) order for heart rate hold parameter should have been clarified with the doctor if it was indicated for this drug. LN 1 stated the resident drank water after Breo inhaler use and LN 1 agreed it was not same as rinsing mouth and spitting the rinse. LN 1 stated this practice was to prevent oral thrush (a type of fungal/yeast infection) infection caused by the drug remaining the mouth. In an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), in their office, on 1/31/25, at 2:40 PM, the DON stated the staff should follow medication administration instruction. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy titled, Vital Signs, the policy indicated, .Vital signs will be obtained by the nurse .when administering certain medications .certain cardiac drugs [drugs that treat heart conditions, such as high blood pressure] are given only when a resident's pulse or blood pressure is within a certain range . 1b. During a medication pass observation, accompanied by LN 4, on 1/28/25, at 10:01 AM in the Long East Hall, LN 4 administered a total of five medications to Resident 5 and did not measure blood pressure or pulse prior to medication administration. LN 4 crushed four of the medications and mixed them with applesauce including two medications used to treat high blood pressure as follows: Losartan Potassium Tablet 25 MG [milligram, a unit of measurement of mass in the metric system commonly used in medication dosing; medication to treat high blood pressure], give 0.5 tablet by mouth one time a day . hold for SBP less than 100 . Metoprolol Succinate ER Extended-Release tablet [ER same as a long-acting tablet form of medication used to treat high bleed pressure] Give 1 tablet by mouth one time a day .hold if SBP < [less than] 100 and pulse < 60 . LN 4 crushed Metoprolol ER tablet and should not have. LN 4 did not measure blood pressure or pulse prior to administering the Losartan and Metoprolol medications. During a concurrent interview with LN 4 and review of Resident 5's medical records at the East nursing station on 1/28/25 at 3:01 PM, LN 4 stated you cannot crush ER medications. LN 4 confirmed she crushed Resident 5's Metoprolol Succinate ER tablet. LN 4 acknowledged crushing extended-release medication would result in the entire dose of the drug being given at once, potentially causing dangerous side effects (undesirable effect of a drug) instead of the intended slow-release formulation of the medication over time. During a concurrent interview with LN 4 and review of Resident 5's medical records at the East nursing station on 1/28/25, at 3:22 PM, LN 4 stated she measured Resident 5's blood pressure and pulse and recorded the results on a handwritten piece of paper that she could not locate. LN 4 presented an undated sheet of paper titled, Assignment Sheet/East Long Station, which did not have any vital sign (blood pressure and pulse) results documented next to Resident 5's name. LN 4 stated the vital signs documented for Resident 5 was written on different piece of notepad which she could not locate. LN 4 confirmed the blood pressure and pulse numbers in the MAR were the same numbers as another resident documented on the Assignment Sheet . and was entered in the MAR at 11:12 PM on 1/28/25 when the medication was administered at 10:27 AM. During an interview with the DON and the ADON, in their office, on 1/31/25, at 2:40 PM, the DON stated the staff should follow medication administration instructions. During a review of the facility's undated policy titled, Vital Signs, the policy indicated, .Vital signs will be obtained by the nurse .when administering certain medications .certain cardiac drugs [drugs that treat heart conditions, such as high blood pressure] are given only when a resident's pulse or blood pressure is within a certain range . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Medication Administration General Guidelines, dated 9/2018, the policy indicated, .Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices .Long acting, extended release or enteric-coated dosage forms should generally not be crushed . 1c. During a medication administration observation, with Licensed Nurse 5 (LN 5), in the [NAME] Long Hall, on 1/28/25, at 4:12 PM, LN 5 entered Resident 76's room with medications to be administered via Gastronomy Tube (GT- a surgically inserted tube that provides a direct route to the stomach for nutrition, fluids, and medication). LN 5 administered the first medication dose via a syringe and did not flush 30 mL of water prior to the first medication given. LN 5 proceeded to give the second medication via GT. During a concurrent interview and record review of Resident 76's MAR, on 1/28/25, at 04:35 PM, with LN 5, LN 5 read the MAR order which indicated, .Enteral Feed Order .water flush 30 mL before and after medication administration . LN 5 confirmed he did not flush the GT with 30 mL of water prior to the first medication given. LN 5 stated the reason to flush the line was to clean the line and check for patency (to remain open and free of blockages). During an interview with the DON and the ADON, in their office, on 1/31/25, at 2:40 PM, the DON stated the staff should follow medication administration instructions. During a review of the facility's policy and procedure titled, Medication Administration General Guidelines, dated 9/2018, the policy indicated, .Medications are administered in accordance with written orders of the prescriber . During a review of the facility's policy titled, Medication Administration Enteral Tubes, dated 1/2020, the policy indicated, .Enteral tubes are flushed with at least 15 mL of water before administering any medications and after all medications have been given .

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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** 40911 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and distributed in accordance with professional standards for food service safety for 85 out of a census of 92 residents who ate facility prepared meals when: 1. Several containers of spices had lids left open, 2. Expired food item was not removed from the dry storage area, 3. Kitchen staff did not wear gloves while preparing ready to eat food, 4. Kitchen staff did not perform hand hygiene when moving from dirty to clean surfaces, 5. Appropriate measuring utensil was not used during food distribution; and, 6. Chopping boards were not color-coded to indicate different food items for a specific color. These failures placed residents at risk for foodborne illnesses. Findings: 1. During the initial kitchen tour on [DATE], at 8:27 a.m., with the Certified Dietary Manager (CDM), there were several containers of used spices had their lids left open. These spices were located in an open shelf above the preparation food counter. The CDM confirmed the lids of the spice containers were left open. The CDM stated the spice containers should have the lids closed to prevent from pests entering the containers and to retain the freshness of the spices. A review of the facility's guidelines titled, DRY GOODS STORAGE GUIDELINES, dated 2018, indicated, . Spices, ground .Spices whole .These items are not refrigerated after opening. Keep them dry and tightly covered . 2. During the initial kitchen tour on [DATE], at 8:27 a.m., with the CDM in the dry goods storage area, a bag of tortilla with expired date was in the storage area that was available for resident consumption. The CDM stated this food item should have been removed from the dry storage area and should have been discarded. A review of the facility's policy and procedure titled, STORAGE OF FOOD AND SUPPLIES, dated 2020, indicated, .All food products will be used per the times specified .No food will be kept longer than the expiration date on the product . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a lunch meal preparation observation on [DATE], at 11:05 a.m., with the Dietary [NAME] (DC) 1 in the kitchen by the stove and steam table area, DC 1 took out a pan of rice from the steamer and placed it on the steam table. DC 1 then took a pan of vegetables and poured it into the rice. DC 1 then took a ladle and started mixing the vegetables and the rice together without using food gloves. During an interview on [DATE], at 11:05 a.m., with DC 1, she confirmed she did not use gloves while mixing the rice and the vegetables together. DC 1 stated she should have not used her bare hands during food preparation. DC 1 further stated the importance of food safety and to prevent the risk for food contamination when ready to eat food would be touched with bare hands. During a review of the facility's policy and procedure titled, FOOD HANDLING, dated 2018, indicated, .Food will be prepared and served in a sanitary manner .Employees should never use bare hand contact with any foods, ready to eat or otherwise . 4. During a lunch meal preparation observation on [DATE], at 11:05 a.m. with DC 1 in the kitchen by the stove and steam table area, DC 1 picked up some pieces of rice that fell off from the pan on to the steam table. DC 1 then went to the trash bin and opened the lid of the trash container to throw away the rice she picked from the steam table. DC1 went back to handling ready to eat food that was on the steam table without washing her hands after touching the lid of the trash can. During an interview on [DATE], at 11:05 a.m., with DC 1, DC 1 confirmed she did not wash her hands before handling the ready to eat food and after touching the lid of the trash container. DC 1 stated she should have washed her hands before handling ready to eat food and after touching a dirty surface such as the lid of a trash bin. DC 1 stated she should have washed her hands after touching a dirty surface and before handling ready to eat foods. During a review of the facility's policy and procedure titled, FOOD HANDLING, dated 2018, indicated, .All food & Nutrition service personnel will wash their hands prior to handling all food .Hands should be washed before and after . A review of the FDA Food Code 2022 indicated, The hands are particularly important in transmitting foodborne pathogens .any activity which may contaminate the hands must be followed by thorough handwashing .The hands of employees can be contaminated by touching their nose or other body parts. (on page Chapter ,d+[DATE] in the 2022 FDA guide) 5. During a lunch trayline observation on [DATE], at 12:40 p.m., DC 1 prepared the food items on the steam table for distribution with gray colored handle scoops in each pan which is numbered #12 that corresponds to regular portion equivalent to one-third cup (,d+[DATE] c). There were no other scoops available for meals that called for large portions and small portions. DC 1 used the the same #12 scoops for both large and small portions instead of the #8 which was equivalent to one-half cup (,d+[DATE] c) for large portion or #16 which was equivalent to one-fourth cup (,d+[DATE] c) for small portion. DC 1 did not use appropriate measurement for a large or small meal. (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 on [DATE], at 12:40 p.m., DC 1 confirmed she used one scoop for all meal portions and did not use the corresponding scoops for large or small meal. DC 1 stated she did not have the exact measurements and she should have used the different scoops for different meal portions. DC 1 further stated by not measuring portions accurately may have an effect on residents who were on weight management program. During an interview on [DATE], at 1:30 p.m., with the CDM, the CDM stated she expected the kitchen staff to use proper and accurate scoops for each meal portions and should have the different sizes in the tray and readily accessible when needed. During a review of the facility's policy and procedure titled, PORTION SIZES, dated 2018, indicated, .Various portion sizes of the food served will be available to better meet the needs of the residents .The food server is to give the ,d+[DATE] size portion of the regular diet for the food on the main plate .Regular portions will be given .unless otherwise stated by the Dietitian. An example would be, if the regulars are given a #8 scoop, then use a #16 scoop on the ,d+[DATE] size portion . 6. During a concurrent observation and interview on [DATE], at 4:30 p.m., with the CDM in the facility's kitchen, there were four white chopping boards and there were no other chopping boards of different colors. The CDM stated using one color coded chopping board and staying away from multiple color coded chopping board would avoid confusion. A review of the FDA Food Code 2022 indicated, .Develop and Implement Recipe/Process Instructions . Simple control measures integrated into recipes and processes can improve management control over foodborne illness risk factors. For example: Process instructions that specify using color-coded cutting boards for separating raw animal foods from ready-to-eat products are developed to control the potential for cross contamination . (on page Annex ,d+[DATE] in the 2022 FDA guide)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50778 Based on interview, and record review, the facility failed to maintain accurate medical records for 2 of 27 sampled residents in accordance with accepted professional standards and practices when Protected Health Information (PHI - any information that can be used to identify a person and is related to their health including any information about a person's physical or mental health, treatment, and payment for healthcare) of another resident was found in Resident 40's and Resident 43's Electronic Medical Record. These failures had the potential to violate the safeguarding of residents' health information, privacy, and confidentiality. Findings: 1a. During a record review of Resident 40's electronic medical record, the document under the heading History and Physical (H&P) contained another resident's H&P information. During a concurrent interview with the Assistant Director of Nursing (ADON) and a record review of Resident 40's electronic medical record on 1/30/25, at 5:04 PM, the ADON confirmed the H&P in Resident 40's chart belonged to a different resident who had been discharged . The ADON stated the H&P document was scanned into Resident 40's medical record in error. During a concurrent interview with the Medical Record Lead (MRL) and a review of Resident 40's electronic medical record on 1/31/25, at 2:25 PM, the MRL confirmed the H&P of a different resident was scanned into Resident 40's electronic medical record and should not have been. The MRL stated the facility switched from paper charts to an electronic medical record system where many documents had to be scanned in a short period of time. The MRL acknowledged PHI of residents should have been protected and scanned into the correct electronic medical record. 1b. During a record review of Resident 43's electronic medical record the record under the heading Order Listing Report, (a report containing resident treatment and medication information) contained other resident names and their associated PHI. During a concurrent interview with the ADON and a record review of Resident 43's electronic medical record on 1/30/25, at 5:06 PM, the ADON confirmed an Order Listing Report was uploaded into Resident 43's electronic medical record and displayed the names and PHI of five other residents. The ADON stated the Order Listing Report, should have been redacted (to obscure or remove [text] from a document) before it was scanned into Resident 43's electronic medical record. During a concurrent interview with the Medical Record Lead (MRL) and a review of Resident 40's electronic medical record on 1/31/25, at 2:30 PM, the MRL confirmed an Order Listing Report was uploaded into Resident 43's electronic medical record and displayed the names and PHI of five other residents. The MRL stated the Order Listing Report showing names other than Resident 43 should not have been scanned into Resident 43's electronic medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy titled HIPPA Security Measures, indicated, .It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the residents identifiable information and/or records that are in electronic format .Facility leadership will ensure the implementation of policies and procedures to prevent, detect, contain, and correct any security violations .The facility will implement policies and procedures to address security incidents, including identification and response to suspected or known incidents .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40903 Based on observation, interview, and record review, the facility failed to ensure safe and effective infection prevention practices with a resident census of 92 when: 1. The facility's policy on Enhanced Barriers Precaution (or EBT, an infection control measures used to prevent the spread of disease and required the caregivers wear gowns and gloves during high-contact care activities) and use of protective gown (Protective gear worn to reduce exposure of germs to resident and prevents the spread) was not followed in one out of six residents (Resident 76) observed for medication administration during a high contact (involves significant physical contact) resident care activity when the Feeding Tube (or FT, also known as enteral nutrition, where a tube was inserted into the stomach to provide nourishment, fluids or medications to a patients unable to take by mouth) was accessed to administer medication and nutrition, 2 a. Resident 66's bed mattress had large areas of exposed, stained foam, 2 b. Resident 87's bathroom was dirty, 3. Resident 3 was placed on contact/isolation precautions (or transmission based precautions which are a set of steps to prevent the spread of infection and are used in addition to standard precautions which are used for all resident care) for exposure to scabies (an itchy skin rash caused by a tiny burrowing mite called) on 11/20/24, and Resident 3 completed the ordered prophylactic treatment (a drug or other treatment that is given prophylactically and is intended to help prevent a symptom or condition) on 11/21/24 and 11/25/24, and after 11/23/24, Resident 3 remained on contact/isolation precautions; and, 4. A used Gastronomy Tube dressing (A tube placed directly in the resident's stomach to provide nutrition) was found on Resident 16's beside floor. These failed practices could contribute to spread of infections in the facility and jeopardize resident's safety. Findings: 1. During a medication administration observation, with Licensed Nurse (LN) 5, in [NAME] Long hallway, on 1/28/25, at 4:15 PM, LN 5 without wearing a gown, entered Resident 76 room with medications to be administered after sanitizing the hands. LN 5 placed the individual cups of crushed medications and two cups of water on Resident 76's bedside table. LN 5 with gloved hand set up the feeding pump (a machine that delivered feeding nutrition). LN 5 accessed the tip of the Feeding Tube, located on the Resident 76's stomach area, and used a syringe to check for patency (the state of being open or unobstructed) of feeding tube then administered two medications sequentially. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LN 5, outside of Resident 76's room, on 1/28/25, at 4:30 PM, LN 5 was asked to read the posted sign on the wall next to the room marked as EBP. LN 5 stated he should have put on a gown as listed on the EBP sheet for high contact resident care including accessing Feeding Tube during medication administration. LN 5 stated the gown would have prevented the spread of germs from his outfit to Resident 76 and vice versa it would have prevented spread of germs to the next resident he cared for. During an interview with facility's Infection Preventionist (IP), in her office, on 1/29/25, at 11:41 AM, the IP stated the policy on EBP was clear and during the high contact care the nursing staff should use both gloves and a gown to prevent spread of infection. The IP stated the facility had provided education to nursing staff to follow the facility's policy. Review of the facility's policy titled, Enhanced Barrier Precautions dated 2024, the policy indicated Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistance organisms (bugs that are hard to treat with regular antibiotics) that employs targeted gown, and gloves use during high contact resident care activities. The Policy on section 4 indicated high-contact resident care activities include .Device care or use .Feeding tubes . 43943 2 a. During a review of Resident 66's clinical record titled, ADMISSION RECORD, indicated Resident 66's diagnosis included kidney failure. During a concurrent observation and interview on 1/28/25, at 9:35 a.m., with Resident 66, Resident 66 stated he had been at the facility for approximately two and half months. Resident 66 stated he would have liked a new bed because it felt like there was a sink hole in the middle of the bed and at night, he was afraid he would fall out of bed. [STATE AGENCY] observed Resident 66's bed tilted to the left side. Resident 66 stated the bed was very uncomfortable. During a concurrent observation and interview with LN 1, LN 1 took all the bedding off Resident 66's bed mattress. The blue plastic barrier on the foam mattress was pealing off of 3/4 of the mattress. There was exposed mattress foam visualized with liquid stains on the foam. LN 1 stated the mattress could not be properly cleaned because of all large amount of missing plastic on top of the foam. LN 1 acknowledged the bed sloped to the left side. LN 1 stated she would not want to sleep on Resident 66's bed mattress. During a concurrent observation and interview on 1/28/25, at 9:45 a.m., with the Maintenance Supervisor (MS), the MS stated he had not received a work order to replace Resident 66's bed mattress. The MS observed the condition of Resident 66's mattress and stated it needed to be replaced because there was not an effective way to clean the mattress, and the mattress could have harbored bacteria. The MS stated he would not like to sleep on a mattress that looked like the one Resident 66 was sleeping on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/28/25, at 9:50 a.m., with the Certified Nursing Assistant (CNA) 5, CNA 5 stated she had noticed Resident 66's mattress was broken down about a month ago. CNA 5 stated she informed the MS verbally. CNA 5 stated she should have put in an electronic work order that would have gone directly to the MS. CNA 5 stated the mattress and tares on the blue plastic barrier of the mattress which allowed fluid to seep into the foam mattress. CNA 5 stated this was an infection control concern because the foam could harbor bacteria from urine or stool. During an interview on 1/28/24, at 9:50 a.m., at 10 a.m., with the Housekeeping (HK), the HK acknowledged it was impossible to properly clean Resident 66's mattress which had large rips and missing plastic on the mattress. The HK stated she should have reported the issue to a supervisor and had the mattress replaced. During an interview on 1/29/25, at 1:33 p.m., with the IP, the IP stated Resident 66's mattress was not in proper repair and posed an infection control concern due to the exposed foam on the mattress harboring microorganisms from stool, urine, and/or wound fluids. During a concurrent observation and interview on 1/30/25, at 9:09 a.m., with the Housekeeping/Laundry Supervisor (HLS), the HLS was shown a photo of Resident 66's mattress. The HLS acknowledged Resident 66's mattress was ripped in multiple areas and was missing the protective plastic barrier. The HLS stated there was no way the housekeeping staff was effectively able to clean the mattress, and this was an infection control concern because bodily fluids could seep through the mattress foam. The HLS stated the mattress needed to be replaced. A review of the facility's document tiled, Environmental Service Housekeeper Job Description, dated 2020, indicated .Ensures the provision of a clean environment for our residents .providing high quality services and high standards of cleanliness, ensuring complaint with infection control procedures .ensures that daily and deep cleaning schedules are adhered to .adheres to infection control policies at all times . During a concurrent interview and Policy and Procedure (P&P) review on 1/30/25, at 4:04 p.m., with the Administrator (ADM) and the Director of Nursing (DON), the Policy and Procedure (P&P) titled, Infection Prevention and Control Program, dated 2024, was reviewed. The P&P indicated, .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines 2. All staff are responsible for following all policies and procedures related to the program . The ADM and the DON stated Resident's 66's mattress should have been replaced and it posed an infection control risk to the resident. The ADM and DON acknowledged the P&P was not followed. 2 b. During a review of Resident 87's clinical record titled, Admission Record, indicated Resident 87's diagnosis included sepsis (a serious infection that affected the function of multiple organs in the body). During a review of Resident 87's clinical record titled, Orders, dated 1/26/25, at 9:07 a.m., by LN 2, indicated Resident 87 was placed on isolation precautions (a set of precautions used to prevent the spread of infections) while mumps (a contagious viral infection that can be serious) was ruled out. The order to discontinue isolation precautions was on 9/28/25 at 9:12 a.m. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 87's clinical record titled, Progress Notes, dated 1/28/25, at 12:21 p.m., by LN 1, indicated at approximately 8:15 a.m., Resident 87 came out of his room while he was still on isolation precautions. LN 1 instructed Resident 87 to return to his room and use the bathroom in his room. Resident 87 stated his bathroom was dirty and told LN 1 she should use it because he would not use a dirty bathroom. Resident 87 used the (communal) bathroom by the showers. During an observation on 1/28/25, at 9:03 a.m., Resident 87 walked toward the bathroom by the shower room with a toilet paper roll in his hand. The IP instructed him to use the bathroom in his room because he was on droplet isolation precautions (a set of precautions used to prevent the spread of infections that are transmitted through respiratory droplets. These precautions are used when a patient is known or suspected to have an infection that could be spread through coughing, sneezing, or talking). Resident 87 refused to use the bathroom in his room because it was dirty. A review of Resident 87's clinical record titled, Progress Notes, dated 1/28/24, at 9:08 a.m., by the Assistant Director of Nursing (ADON), indicated Resident 87 was on droplet isolation precautions and left his room because he wanted to take a shower. During a concurrent interview with Resident 87 and observation of his bathroom, on 1/28/25, at 10:05 a.m., Resident 87 stated he was on isolation precautions because the facility thought he had mumps. Resident 87 stated he had used the bathroom by the shower room because the toilet in his private room had overflowed the day before and there was urine and stool on the toilet seat. Resident 87 stated and it had been in that condition for over a day. Resident 87 stated he did not use the bathroom in his room because it was, very dirty and gross. Resident 87's bathroom toilet was noted to have stool and urine on the toilet seat rim, toilet paper that had overflowed from the toilet on the floor, and a non-operational soap dispenser by the sink. During a concurrent observation and interview on 1/28/25, at 10:08 a.m., with the Maintenance Supervisor (MS), the MS stated Resident 87's bathroom should have been cleaned to ensure that while Resident 87 was in isolation, he could safely use his own bathroom. The MS acknowledged Resident 87's bathroom had urine and stool on the toilet, toilet paper on the floor, and a non-operational soap dispenser by the sink. During a concurrent observation and interview on 1/28/25, at 10:13 a.m., with the Licensed Nurse (LN 1), LN 1 stated Resident 87 had informed her on 1/28/25, at 8:50 a.m., that his bathroom was dirty. LN 1 stated she called housekeeping to clean the room. LN 1 acknowledged the bathroom was still dirty with urine and stool on the toilet seat rim, toilet paper on the floor, and a non-operational soap dispenser next to the bathroom sink. LN 1 stated the bathroom was an infection control concern because Resident 87 would not use it and left his isolation room to use other clean bathrooms. During a concurrent interview and observation on 1/28/25, at 10:15 a.m., with the housekeeper (HK), the HK stated resident 87's toilet was clogged on 1/27/25 and overflowed. The HK stated Resident 87's bathroom was supposed to be cleaned once a day and as needed. The HK acknowledged there was urine and stool on the toilet seat rim, toilet paper on the floor of the bathroom, and a non-operational soap dispenser. The HK stated Resident 87 was on isolation precautions and was supposed to use the bathroom in his room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview n 1/28/25, at 12:30 p.m., with the IP, the IP stated Resident 87 was still on droplet isolation precautions when he exited his room and used a common use bathroom by the shower room. The IP stated when Resident 87 broke isolation precautions, this action put other residents in the facility at possible risk of contracting mumps. During an interview with the Housekeeping/Laundry Supervisor (HLS), on 1/30/25, at 9:12 a.m., the HLS stated she was aware Resident 87's toilet in his room was clogged on 1/27/25. The HLS stated she instructed housekeeping staff to clean the bathroom. The HLS stated the bathroom was not clean and was not up to the acceptable standards. The HLS stated Resident 87 should not have had to leave his isolation room to find a clean bathroom to use. A review of an undated facility document titled, [FACILITY NAME] Housekeeper, indicated housekeeping staff's daily activity chart had housekeeping staff started deep cleaning at 9:30 a.m. (one room per day) and cleaned all the rooms at 10:45 a.m., The document further indicated it was not a comprehensive inventory list of duties and responsibilities. A review of the facility's document titled, Environmental Service Housekeeper Job Description, dated 2020, indicated, .Ensures the provision of a clean environment for our residents .providing high quality services and high standards of cleanliness, ensuring complaint with infection control procedures .ensures that daily and deep cleaning schedules are adhered to .adheres to infection control policies at all times . During a joint interview and policy and procedure (P&P) review on 1/30/25, at 4:18 p.m., with the ADM and the Director of Nursing (DON), the P&P titled, Transmission-Based (Isolation) Precautions, dated 5/23, was reviewed. The P&P indicated, .It is our policy to take appropriate precautions to prevent transmission of pathogens .11. Droplet precautions - a. intended to prevent transmission of pathogens spread through . coughing, sneezing, or talking .B. A private room is preferential, but if not available, the resident can be cohorted with a resident with the same infectious agent .Recommendations for Personal Protective Equipment (PPE) . Droplet - gloves, gowns, mask - don a mask upon entry into the patient room . Recommendation for Selected Infections and Conditions .Mumps .until 5 days after the onset of swelling . The ADM and the DON stated Resident 87's bathroom should have been cleaned so Resident 87 would not have sought out a clean bathroom outside of his isolation room. ADM and DON stated Resident 87 was on isolation precautions while mumps was ruled out. ADM and DON stated when Resident 87 left his room, it put other residents at risk for possibly contracting mumps. ADM and DON acknowledged the P&P was not followed. 50161 3. Review of Resident 3's ADMISSION RECORD, indicated Resident 3 was originally admitted to the facility in late 2018, with a diagnosis including but not limited to dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems), dysphagia (difficulty swallowing), and need for assistance with personal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of Resident 3's electronic medical record, titled Medication Administration Record, (or MAR, a document listed medications and treatments to be given to resident based on doctor's order) dated 11/2024, the record indicated Resident 3 received the following scabies treatments: Permethrin Cream 5% for one application on 11/25/24, Ivermectin for a one time dose on 11/20/24, and monitoring for skin rash for five days including: 11/21, 11/22, 11/23, 11/24, 11/24, and 11/25/24. Further review of the record did not indicate further scabies treatment. Review of Resident 3's Nurses Note, dated 11/20/24, indicated .Resident on monitoring for Scabies mites, did not complain of itching or discomfort, refuse all medications including Ivermectin 3 mg, explain purpose of medications, resident stated she won't take it, endorse to upcoming shift, Isolation/Contact precautions in place, all needs met by staff, call light within reach . Review of Resident 3's Nurses Note, dated 11/22/24, indicated, .Resident was on monitoring for scabies exposure, completed the the [sic] prophylaxis with no s/s/ [sign or symptoms] of scabies, continue on monitoring, continue POC [plan of care] . During an observation and interview on 1/28/25, at 12:32 p.m., outside of Resident 3's room, LN 2 stated Resident 3 was on contact/isolation precautions due to suspected scabies. LN 2 stated two weeks ago Resident 3 was transferred from a room on the other side of the facility due to a suspected scabies and she was currently being treated. During a concurrent interview and record review on 1/31/25, at 8:35 a.m., the IP stated back in 11/2024, Resident 3's roommate (Resident 57) was suspected of having scabies due to the roommate (Resident 57) having an itchy, scattered, pinpoint rash. The IP stated the MD orders permethrin and a skin scrape test for residents with symptoms of scabies and the resident remains on isolation until completion of the scabies treatment and the skin scraping shows a negative result. The IP stated this process usually takes a week and when the resident receives a negative scabies test result, they will notify the MD and remove the isolation. Through record review of Resident 3's former roommates medical record, the IP stated the roommate was placed on contact precautions on 11/15/24 and after receiving scabies treatment had a negative skin scrape test on 12/3/24. Through record review of Resident 3's medical record, the IP confirmed Resident 3 remained in the shared room with her roommate, who had signs and symptoms of scabies, and received her ordered prophylactic treatment on 11/23/24 due to potential exposure to scabies from her roommate. The IP stated once Resident 3's prophylactic treatment was completed the expectation was to contact the MD and get an order to discontinue the contact/isolation precautions. The IP stated Resident 3 should have been transferred from her room on 11/23/24 after her treatment was completed but was not. Regarding why Resident 3 was left on contact/isolation precautions and not transferred out of her shared room with a scabies positive roommate, the IP stated she was on leave from facility during this time and through the middle of January (2025) and an interim IP was covering for her. Through record review of Resident 57's clinical record, the IP confirmed Resident 57 had active contact/isolation orders. The IP confirmed even after Resident 3 was treated prophylactically and her roommate (Resident 57) had a negative skin scraping on 12/3/24, neither resident was taken off isolation but should have been. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/31/25, 3:12 p.m., the ADON stated Resident 3 had an initial scabies exposure in 11/2024 after her roommate had signs and symptoms of scabies. The ADON stated after Resident 3 received the ordered scabies prophylactic treatment and skin checks the expectation was, she changes rooms and her order for contact precautions be discontinued. The ADON explained this was to prevent Resident 3's continued scabies exposure from her roommate who was at the time still being treated for signs and symptoms of scabies. The ADON stated a room change was important to prevent Resident 3's exposure and contraction of scabies. The ADON stated the risks for Resident 3 not being removed from contact precautions was continuous isolation which could cause psychosocial harm. Through record review of Resident 3's physician's orders, the ADON confirmed Resident 3's contact isolation orders were placed on 11/20/24 and were still in place currently. During a phone interview on 1/31/25, at 3:01 p.m., the Medial Doctor (MD) 1 stated he was familiar with Resident 3 and acknowledged her contact precautions should have been removed when she had completed her prophylactic scabies treatment back in November of 2024. MD 1 stated if a resident was not showing any signs of scabies such as an acute rash, then the expectation was to wash her clothing and after two or three days of monitoring to move the (symptom free) resident to another room. MD 1 further explained after the resident was moved to a separate room, after another two to three days (of being free of rash), the resident can be mingled with other residents. MD 1 stated the risk of leaving a resident who did not show signs and symptoms of scabies in the same room with a scabies positive resident was the symptom free resident can in fact get scabies. Review of a facility P&P titled, Scabies Identification, Treatment and Environmental Cleaning, dated 2016, indicated, .The purpose of this procedure is to treat residents infected and sensitized to Sarcoptes scabiei [mite or small bug that causes scabies] and to prevent the spread of scabies to other residents and staff . Preparation . Obtain or verify the existence of a physician's order for this procedure .General Guidelines . Affected residents should remain on contact precautions until twenty-four (24) hours after treatment . Environmental Control: Typical Scabies .Place residents with typical scabies on contact precautions during the treatment period: 24 hours after application of 5% permethrin cream or 24 hours after last application of scabicides requiring more than one application . Review of a facility P&P titled, Transmission Based Precautions, dated 2024, indicated, .It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission .Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment . Transmission-based precautions (aka [also known as] Isolation Precautions) refer to the actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne contact and droplet) in order to prevent or control infections .Scabies .Precaution . Contact .Duration .Until 24 hours after initiation of treatment . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility P&P titled, Infection Prevention and Control Program, dated 2024, indicated, .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological [study of cause, occurrence, and distribution of health and disease in populations] investigations of exposures of infectious diseases .All staff are responsible for following all policies and procedures related to the program .Isolation Protocol (Transmission-Based Precautions): A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC [Center for Disease Control, government agency] guidelines. Residents on transmission-based precautions should be placed into a private/single room if available/ appropriate or cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards .Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances . 50598 4. During a concurrent observation and interview with LN 9, on 1/28/25 at 1 PM, a square soiled gauze dressing with a written date of 1/27/25 was found on Resident 16's beside floor. LN 9 stated the dressing was used for Resident 16's Gastronomy Tube dressing change. LN 9 also stated Resident 16 was unable to move his hands this error was on behalf of the facility and the dressing should've been thrown in the trash. LN 9 stated, the dressing posed an infection control risk. During a concurrent observation and interview with the IP on 1/30/25 at 5:17 PM, when shown the image of the dressing on the floor the IP stated, that type of practice did not follow the facility's protocol and did not meet her expectations. The IP stated, the used dressings should be placed in the trash after removal. The IP stated this placed staff, residents, and visitors at risk for cross contamination. During a concurrent observation and interview with the DON on 1/31/25 at 1:37 PM, the DON explained the facility's expectations after removal of a soiled gastronomy tube was to place the dressing in a red biohazard bag and dispose of it properly. The DON stated the dressing on the floor did not meet the facility's expectations, was a violation of the principles of infection control, and policy and procedures. A review of an undated facility provided document titled, Infection Prevention and Control Program, indicated, The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent development and transmission of communicable diseases and infections .a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services . A review of an undated facility provided document titled, Care and Treatment of Feeding Tubes, indicated, .It is a policy of this facility to utilize feeding tube in accordance with current clinical standards of practice .7. Direction for staff on how to provide the following care will be provided .Use of infection control precautions and related techniques to minimize the risk of contamination .