STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055388	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Jose Healthcare & Wellness Center	75 N. 13th Street San Jose, CA 95112

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to treat the residents with dignity for one of 14 residents (31) when licensed vocational nurse A (LVN A) opened Resident 31's room door without covering her while her back and buttocks were exposed. This failure had the potential to cause embarrassment and feelings of low self-esteem (unhappy and thinking negatively about yourself) for the resident. Findings: Review of Resident 31's Admission Record indicated she was admitted to the facility on [DATE]. During a wound treatment observation, on 3/5/25 at 2:11 p.m., Resident 1 was lying in her bed, the first bed from her room door; the curtain was opened all the way, and the door was closed. LVN A turned Resident 1 to the side. Resident 1's back and buttocks were exposed and facing the room door. LVN A found that Resident 1 had bowel movement. Without covering Resident 1's body, LVN A opened the door and called the certified nursing assistant (CNA) to come to clean Resident 1. During the wound treatment, LVN A needed assistance. Again, without covering Resident 1's body, LVN A opened the door and called for help. During an interview with LVN A, on 3/5/25 at 3:20 p.m., she acknowledged that she should have covered Resident 31's body before she opened the room door to call for assistance. Review of the facility's policy, Resident Rights, dated 1/1/12, indicated Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 49345 Based on interview and record review, the facility failed to properly obtain informed consent (permission granted in the knowledge of the possible consequences) for psychotropic medications (medications capable of affecting the mind, emotions and behavior) for three (Resident 20, Resident 4, and Resident 28) out of 14 residents. This failure had the potential to compromise the right of the residents or responsible parties (persons designated to make decisions of behalf of the residents) to be fully informed regarding care and treatment in order to make health care decisions. Findings: 1. A review of Resident 20's clinical record indicated he had a physician's order for Risperidone (medication used to treat mental illness that causes disturbed or unusual thinking, loss interest in life, and strong or inappropriate emotions) 0.25 milligrams (mg, unit of dose measurement) to be administered at bedtime for one week started on 3/1/25 until 3/8/25. A review of Resident 20's diagnoses included but not limited to unspecified psychosis [refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality] not due to a substance or known physiological condition During a concurrent interview and record review of Resident 20's clinical record with The Director of Nursing (DON) on 3/6/25 at 1:58 p.m., the DON verified the document entitled Informed Consent Documentation dated 12/10/24, signed by Resident 20 and the physician, did not indicate medication name, dose, frequency, indications, side effects and possible adverse reactions. The DON also verified Resident 20's Verification of Informed Consent for Risperidone which did not indicate a date and a nurse's signature. A review of facility's Policy and Procedure (P&P) entitled NP67 Informed Consent dated 1/3/24, the P&P indicated, Except in emergencies, informed consent must be obtained prior to the proposed treatment or procedure. A review of facility's undated Policy and Procedure (P&P) entitled, Behavior/Psychoactive Drug Management, the P&P indicated, .J. When processing a new order or an increase in psychoactive drugs, the Attending Physician/Prescriber must do and as follows: i. Obtain informed consent from resident or responsible party .K. When an order for psychotropic drug is obtained, the Licensed Nurse verifies with the Attending Physician/Prescriber that informed consent has been obtained . 42819 2. A review of Resident 4's clinical record shows diagnoses including Parkinson's Disease (disorder of the nervous system that causes tremors, stiffness, and slow movements), Schizoaffective disorder (a mental health condition including schizophrenia, which affects thinking, emotions, and behavior), mood disorders and, Dementia (a group of thinking and social symptoms that interferes with daily functioning) with agitation. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's physician's order for Valproic Acid (medication used to treat seizures, mood disorders) 250 milligrams/5 milliliter (mg/ml, measurement of solution's concentration) to be given two times a day to manage mood disorder, including angry outburst, throwing things towards patients and aggressive behavior. The medication was started on 6/24/24. During a concurrent interview and record review with the director of nursing (DON) on 3/7/25, at 10:47 a.m., the DON confirmed that Resident 4's clinical record did not contain an Informed Consent for Valproic acid. After further review, the DON found an informed consent for Seroquel (a medication used to treat schizophrenia, bipolar disorder, and severe depression), but acknowledged that an informed consent should also have been obtained for Resident 4's Valproic Acid. 3. A review of Resident 28's clinical record with diagnoses including Encephalopathy (a condition that affects brain function, leading to confusion, memory problems, and difficulty thinking); schizoaffective disorder, bipolar disorder (mood swings between depression and mania). A review of Resident 28's physician's order for Risperidone 0.25 mg, twice a day, to manage Schizoaffective Disorder, Bipolar type manifested by paranoid thoughts, physical aggression. The medication was ordered on 12/4/24. During a concurrent interview and record review with the DON on 3/7/25, at 2:40 p.m., the DON confirmed that the Informed Consent Documentation dated 12/5/24, and signed by Resident 28 and the physician, was incomplete. The document did not include the medication name, dose, frequency, indications, side effects, or possible adverse reactions. The DON also confirmed that Resident 28's Verification of Informed Consent for Risperidone was missing a date and a nurse's signature.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 42819 Based on observation, interview, and record review, the facility failed to ensure medications were not left unattended at the bedside for one of 14 sampled residents (Resident 4). Resident 4 was not approved to self-administer medications. This deficient practice placed Resident 4 and other residents at risk for harm. Findings: A review of Resident 4's clinical record with diagnoses including Parkinson's Disease (disorder of the nervous system that causes tremors, stiffness, and slow movements), schizoaffective disorder (a mental health condition including schizophrenia [mental health illness affects thinking, emotions, and behavior), mood disorders, Dementia (a group of thinking and social symptoms that interferes with daily functioning) with agitation. A review of Resident 4's Self-Administration of Medication Assessment form, dated 1/16/25, indicated that Resident 4 was not a candidate for self-administration of medications. During an observation of Resident 4 in her room on 3/3/25 at 9:01 a.m., the resident was sitting in her wheelchair, and a medication cup with five pills was left on her breakfast tray. In a concurrent interview, Resident 4 stated that staff routinely leave her medications, and she takes them on her own. No licensed staff member was present in the room. During an interview with Registered Nurse E (RN E) on 3/3/25, at 3:19 p.m., RN E confirmed that she gave the pills to Resident 4. However, the resident indicated she would take the medication later. RN E stated she left the medication in the room and did not stay to observe whether Resident 4 took all of the prescribed medications. During an interview with the Director of Nursing (DON) on 3/7/25, at 2:37 p.m., the DON confirmed that Resident 4 is not approved for self-administration of medications. Review of facility's policy, titled, Medication Administration, dated 1/1/12, indicated, Medication will be administered directed by a license nurse and upon the order of a physician or licensed independent practitioner.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure the residents received the necessary care and services for three of 14 residents (3, 21, and 23) when: 1. Resident 3 was not served yogurt, tofu, orange, tangerine with his meals as ordered by the physician; 2. For Resident 21, rolled towels to his bilateral (right and left sides of the body) hands and offloading boots to his bilateral lower extremities were not applied as ordered by the physician; and 3. Certified nursing assistant C (CNA C) did not know about her resident, Resident 23. These failures had the potential to affect the residents' care and could jeopardize their health and well-being. Findings: 1. Review of Resident 3's Admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 3's physician order, dated 1/31/25, indicated he had an order for the facility to provide yogurt, tofu, orange, tangerine with his meals. During an observation, on 3/4/25 at 12:45 p.m., Resident 3 did not have yogurt, tofu, orange, tangerine with his lunch. During an observation and interview with the registered dietician (RD), on 3/5/25 at 12:35 p.m., Resident 3 did not have yogurt, tofu, orange, tangerine with his lunch. The RD reviewed Resident 3's physician order and confirmed Resident 3 had an order for the facility to provide yogurt, tofu, orange, tangerine with his meals. During an interview with Resident 3, on 3/5/25 at 1:25 p.m., he stated he would like to have yogurt, orange, tangerine with his meals. During an interview with the director of nursing (DON), on 3/5/25 at 1:35 p.m., she stated that the physician order should be followed. Review of the facility's policy, Dietary Profile and Resident Preference Interview, dated 4/21/22, indicated Resident preferences will be reflected in the medical record and tray-card and updated in a timely manner. 2. Review of Resident 21's Admission Record indicated he was admitted to the facility on [DATE]. (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 21's physician orders indicated he had orders for the licensed nurse to apply roll towel to his bilateral hand every shift for it helps fingers from rubbing due to closed hand fist, started on 12/10/24; and to apply offloading boot to his bilateral lower extremities every shift for pressure release, started on 11/17/24. During the observations, on 3/4/25 at 11:20 a.m. and on 3/4/25 at 3:40 p.m., Resident 21 did not have rolled towels in his hands and offloading boots on his lower extremities. During an observation and interview with licensed vocational nurse B (LVN B), on 3/5/25 at 11:10 a.m., Resident 21 did not have rolled towels in his hands and offloading boots on his lower extremities. LVN B reviewed Resident 21's clinical record and stated that she would apply rolled towels in Resident 21's hands and offloading boots on Resident 21's lower extremities as ordered by the physician. Review of the facility's undated job description, LVN Staff Nurse, indicated . General Duties and Responsibilities: General: Provides nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, policies, and procedures . 3. Review of Resident 23's Admission Record indicated he was admitted to the facility on [DATE] with dependence on renal dialysis (a type of treatment that helps the body remove extra fluid and waste products from the blood when the kidneys are not able to) diagnosis. Review of Resident 23' s clinical record indicated he had an arteriovenous (AV) shunt (a surgical connection between an artery and a vein) on his right lower arm. During an interview with certified nursing assistant C (CNA C), on 3/5/25 at 1:05 p.m., she stated that she worked with Resident 23. Resident 23 was a dialysis resident. CNA C stated Resident 23's dialysis site was on his chest, and she could take his blood pressure on either his left arm or right arm. Review of the facility's policy, NP37 Dialysis Management, dated 3/27/24, indicated . No blood pressure, phlebotomy (a procedure in which a needle is used to take blood from a vein, usually for laboratory testing), or other pressure inducing procedures on the arm with an AV shunt.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 37409 Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of a bed) for six of 11 residents (31, 33, 35, 37, 42, and 49) when: 1. Residents 31, 33, and 35 did not have care plan for siderails; 2. Residents 42 and 49 did not have a physician's order for the use of siderails and care plan for siderails; and 3. Resident 37 did not have a consent and a physician's order for the use of siderails, and care plan for siderails. These failures had the potential to place the residents at risk of entrapment and injury. Findings: During an observation on 3/4/25 at 11:47 a.m., Residents 31, 33, 35, 37, 42, and 49 had bilateral siderails. Review of Residents 31, 33, and 35's clinical records indicated Residents 31, 33, and 35 did not have care plan for siderails. Review of Residents 42 and 49's clinical records indicated Residents 42 and 49 did not have a physician's order for the use of siderails and care plan for siderails. Review of Resident 37's clinical record indicated Resident 37 did not have a consent and a physician's order for the use of siderails, and care plan for siderails. During an interview with the director of nursing (DON) on 3/7/25 at 11:49 a.m., she reviewed Residents 31, 33, 35, 37, 42, and 49's clinical records, and she confirmed that Residents 31, 33, and 35 did not have care plan for siderails; Residents 42 and 49 did not have a physician's order for the use of siderails and care plan for siderails; and Resident 37 did not have a consent and a physician's order for the use of siderails, and care plan for siderails. The DON stated the residents should have documented consent, physician's order, and care plan for the use of siderails. Review of the facility's policy, NP120 Bed Rails, dated 6/12/24, indicated . 1. Evaluating the Resident's Need for Bed Rails: . d. The ordering physician will obtain informed consent from the resident/resident representative prior to the use of bed rails. e. A care plan will be developed regarding the use of bed rails.

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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. 42819 Based on observation, interview, and record review, the facility failed to ensure that medications were fully administered as prescribed for one of 4 residents (Resident 21) observed during medication pass administration. This failure placed Resident 21 at risk for ineffective treatment and potential health complications. Findings: During a medication pass administration observation on 3/4/25, at 4:10 p.m., Licensed Vocational Nurse D (LVN D) prepared Resident 21's medications for administration via gastrostomy tube (GT, tube inserted through the abdomen to deliver nutrition and medications directly to the stomach). LVN D crushed each medication separately, placed them into individual medicine cups, and added approximately 10 milliliters (ml, unit of measurement) of water per cup. After confirming that Resident 21 had 12 medications, LVN D administered each medication separately, flushing the GT with 10 ml of water between doses. However, medication residue remained in 6 of the 12 medication cups after administration. During a concurrent interview, LVN D confirmed that residue remained in the six medication cups and acknowledged that more water should have been added to ensure all medication was administered. During an interview with the Director of Nursing (DON) on 3/7/25, at 2:35 p.m., the DON acknowledged that Resident 21 did not receive the full prescribed dose because medications remained in the medication cups. Review of Resident 21's physician's order, ordered date 11/16/24, indicated, crush and dilute medications with water prior to administering via TF (tube feeding) as appropriate Review of facility's policy, titled, Medication Administration, dated 1/1/2012, indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42819 Based on observation, interview and record review, the facility failed to store and label medications and biologicals according to manufacturer instructions and facility policy. These failures had the potential for residents to receive incorrect or unsafe medications. Findings: During an observation on 3/4/25, at 3:50 p.m., in Station 2, while inspecting the medication cart with Registered Nurse E (RN E), the following issues were identified: 1. One unopened bottle of Latanoprost eye drops (a medication used to treat glaucoma, which is increased pressure inside the eye) for Resident 3 was found in the top drawer of the medication cart. The pharmacy label indicated that it should be refrigerated until opened, it was not stored in the refrigerator. 2. An inhaler Breo Ellipta (an inhaled medication to treat breathing problems) for Resident 15 was opened but did not have an open date indicated on the label. 3. One unopened Humalog (a fast-acting insulin used to control blood sugar) insulin vial (a small glass or plastic bottles used to store liquids, or powder medication) for Resident 16 was stored in the medication cart. The pharmacy label on the insulin vial indicated that it should be kept in the refrigerator until opened. During a concurrent interview, RN E confirmed that the Latanoprost eye drops, and Humalog insulin vial should have been stored in the refrigerator until opened and that the Breo Ellipta inhaler should have been labeled with an open date upon first use. A review of the facility's policy and procedure titled, Medication Storage in the Facility, dated 4/2008, indicated: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49345 Based on observation, interview, and record review, the facility failed to ensure the kitchen staff competently carried out the functions of the food and nutrition services department according to facility policy and standards of practice when kitchen staff did not correctly demonstrate how to test the dish machine sanitizer. This failure had the potential to place 51 residents who consumed food from the kitchen at risk for exposure to contaminants in food that may lead to food borne illness. Findings: During a kitchen observation and interview on 3/4/25 at 1:09 p.m. with the Registered Dietician (RD), Dietary Manager (DM), and Dietary [NAME] (DC), DC tested the sanitizer of the facility dish machine. DC took a test strip and dipped it in the water that came out of the dish machine after a cycle. The test strip turned purple and DC compared it to the test strip container. The RD and DM stated this was how they test the sanitizer. During an interview on 3/5/25 at 10:41 a.m. with dish machine vendor technician specialist (TS), TS stated, the correct way to test the dish machine sanitizer was either to take a cleaned plate out of a dish machine, flip the plate upside down, and put the test strip on the bottom of the plate or let the test strip touch the inside walls of the dish machine and then compare the strip with the test strip container. TS also stated, that test strip should not be dipped directly in the water from the dish machine. TS stated that kitchen staff were trained about this technique. Dish machine procedure manual/manufacturer guidelines was requested but was not provided. Based on dish machine vendor's Proper Testing Procedure for the low temperature dish machine, When testing for sanitizer, we need to test the items that are actually being washed .a good example is coffee cups . coffee cups have a concave bottom that will hold a little bit of final rinse water .as soon as the rack comes out of the machine, take the test strip, wipe it on the bottom of the coffee cup . (https://diversey.com/en/video-hub/chlorine-sanitizer-testing) A review of facility's policy and procedure (P&P) entitled Dish Machine Operation and Cleaning revised 10/1/2014, the P&P indicated, .The dietary staff will use the dish machine according to the manufacturer's guidelines A review of facility's policy and procedure (P&P) entitled, Dietary Department-General revised 6/1/2014, the P&P indicated, .I. The primary objectives of the dietary department include: .B. Maintenance of standards for sanitation and safety

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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. 49345 Based on observation, interview and record review, the facility failed to ensure safe and sanitary conditions were maintained in the kitchen for food preparation equipment and food storage methods, according to standards of practice and facility policy when: 1. Foods were stored unlabeled and/or past used-by date; and 2. Sink drainage pipe with buildup within the inner lining. These failures had the potential for food contamination, resulting in food borne illnesses for 51 residents who consume food from the kitchen. Findings: 1. During the initial kitchen tour observation and interview on 3/3/25 at 8:51 a.m., with the Registered Dietician (RD), the sink faucet was dripping and drainage pipe with an air gap was dirty with accumulation of whitish to yellowish build up around the inner lining. The outer part of the pipe had whitish substance in drip patterns. During an observation and interview in the kitchen on 3/4/25 at 1:00 p.m. with the Dietary Manager (DM), the DM confirmed the state of the dirty sink drainage pipe and stated that the DM is the cleaner for the drainage pipe, but it was not in the schedule. DM confirmed the sink faucet cannot be turned off completely for one or two weeks and a work order was requested. During a concurrent interview and record review on 3/6/25 at 9:40 a.m. with the Regional Registered Dietician (RRD), the RRD stated, The drainage pipe could have been cleaner. The RRD also verified the facility kitchen's Food and Nutrition: Cleaning Log dated 12/30/24 to 3/6/25 did not include the sink and drainage pipe on the list of areas/equipment to be cleaned. The RRD stated that it will be recommended to add the sink on the cleaning log. A review of facility's policy and procedure (P&P) entitled, Dietary Department-General revised 6/1/2014, the P&P indicated, .I. The primary objectives of the dietary department include: .B. Maintenance of standards for sanitation and safety A review of facility's policy and procedure (P&P) entitled, Cleaning Schedule revised 10/1/2014, the P&P indicated, The dietary staff will maintain a sanitary environment in the dietary department by complying with the routine cleaning schedule developed by the Dietary Manager .II. The Dietary Manager monitors the cleaning schedule to ensure compliance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During the initial kitchen tour observation and interview on 3/3/25 at 9:11 a.m., with the Registered Dietician (RD), RD verified a container of sugar-free gelatin labeled with 2/6/25-2/28/25, an opened non-dairy creamer without labeled open-date and lettuce salad mix without labeled open-date were stored in the refrigerator. The RD stated that refrigerators were checked every morning. The RD stated that the non-dairy creamer must be labeled with the date it was opened and can be used within seven days. The RD verified that the lettuce salad mix was wilted and must be thrown out. During a concurrent interview and record review on 3/6/25 at 9:40 a.m. with the Regional Registered Dietician (RRD), the RRD stated ,Produce should not be necessarily labeled. According to the non-dairy creamer manufacturer's guidelines, once opened, the product can be refrigerated up to three weeks. (https://www.richsusa.com/products/toppingscreams/creamers/02209/#:~:text=KEEPS%203%20WEEKS%20IN%20REFRIGERATOR.) A review of facility document entitled Produce Storage Guidelines dated 2023 indicated, lettuce, salad greens, parsley may be refrigerated for three to five days. A review of facility's policy and procedure (P&P) entitled, Dietary Department-General revised 6/1/2014, the P&P indicated, .I. The primary objectives of the dietary department include: .B. Maintenance of standards for sanitation and safety; C. Maintenance of standards for quality of food . A review of facility's policy and procedure (P&P) entitled, P-DS52 Food Storage and Handling dated 6/4/24, the P&P indicated, .9. Fresh Vegetable Storage .f. Label and date all food items

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	055388	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Jose Healthcare & Wellness Center	75 N. 13th Street San Jose, CA 95112

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to explain the arbitration agreement (a contract requires that person who signed it resolve disputes by a neutral third party, rather than in court before a judge and/or jury) which Resident 23 and Resident 31 signed during their admission to the facility. This failure resulted in Resident 23 and Resident 31 signing the facility's arbitration agreement without their full understanding of the same. Findings: Review of Resident 23's clinical record indicated he was admitted to the facility on [DATE], and he signed the facility's arbitration agreement on 1/20/25. Review of Resident 23's Minimum Data Set (MDS, a clinical assessment tool), dated 1/9/25, indicated his cognition was intact. Review of Resident 31's clinical record indicated she was admitted to the facility on [DATE], and she signed the facility's arbitration agreement on 1/22/25. Review of Resident 31's MDS, dated [DATE], indicated her cognition was intact. During an interview with Resident 23, on 3/5/25 at 12:15 p.m., he stated that he did not know about arbitration agreement; no one explained about it to him. Resident 23 stated that the facility gave him document to sign, and he signed it. During an interview with Resident 31, on 3/5/25 at 12:30 p.m., she stated that she did not know about arbitration agreement; no one explained about it to her. Resident 31 stated that the facility gave her document to sign, and she signed it. During an interview with the admission director (AD), on 3/7/25 at 10:55 a.m., she stated that she oversaw the facility's arbitration agreement, and she would make sure to explain the arbitration agreement to the residents. Review of the facility's policy, AD 17 Arbitration Agreements, dated 5/26/23, indicated . 3. If the facility presents an arbitration agreement to the resident, the person presenting the arbitration agreement will: a. Explain the agreement to the resident in a form and manner that they understand, including in a language the resident understand; and b. Confirm that the resident understands the agreement.

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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. 42819 Based on observation, interview, and record review, the facility failed to ensure staff followed proper infection control procedures when: 1. Licensed Vocational Nurse D (LVN D) did not wash or sanitize hands before checking Resident 21's vital signs (blood pressure [BP], pulse, and oxygen saturation [SpO2], which measures the amount of oxygen in the blood); 2. Certified nursing assistant C (CNA C) did not wash or sanitize her hands before feeding Resident 40; licensed vocational nurse A (LVN A) and registered nurse F (RN F) did not wash or sanitize their hands before opening the plate lids to check the residents' meals on the meal tray; and 3. Licensed vocational nurse A (LVN A) did not clean the used scissors before cutting the granufoam dressing (designed to adapt to irregular wound contours) and the vacuum assisted closure tape for Resident 31's wound. These failures had the potential to increase the risk of spreading infections in the facility. Findings: 1. During an observation and concurrent with interview on 3/4/25, at 3:53 p.m., LVN D was observed pushing a portable vital signs machine into Resident 21's room. LVN D placed the BP cuff around Resident 21's left upper arm and proceeded to check the resident's other vital signs. However, LVN D did not wash or sanitize hands before entering the resident's room or before checking the vital signs. LVN D confirmed the observations and acknowledged that hand hygiene should have been performed before checking Resident 21's vital signs. Review of the Centers for Disease Control and Prevention's (CDC) guidance titled, Clinical Safety: Hand Hygiene for Healthcare Workers, updated 2/27/24, recommends performing hand hygiene immediately before touching a patient. 37409 2. During a dining observation, on 3/3/25 at 12:23 p.m., certified nursing assistant C (CNA C) brought the chair over, sat down, and fed Resident 40 without sanitizing her hands. During a concurrent interview with CNA C, she acknowledged that she should sanitized her hands before feeding Resident 40. During an observation, on 3/3/25 at 12:37 p.m., licensed vocational nurse A (LVN A) pushed Station 2 lunch cart over and opened the lids of residents' lunch plates to check on the meals without washing or sanitizing her hands; then registered nurse F (RN F) came over and opened the lids of residents' lunch plates to check on the meals without washing or sanitizing her hands. (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, LVN A and RN F acknowledged that they should wash or sanitize their hands before opening the plate lids to check on the meals on residents' meal trays. Review of the facility's policy, DD05 Dining Program, dated 2/20/25, indicated . Facility staff will perform hand hygiene prior to distribution of trays. The Centers for Disease Control and Prevention (CDC) recommends healthcare professionals practice hand hygiene before and after interacting with patients, especially before feeding them, using alcohol-based hand rubs or washing hands with soap and water. 3. During a wound treatment observation, on 3/5/25 at 2:11 p.m., licensed vocational nurse A (LVN A) cut the bag of the V.A.C. Granufoam Dressing [(VAC, vacuum assisted closure of a wound; granufoam - designed to adapt to irregular wound contours; it is a negative pressure wound therapy dressing)] with the scissors. Then without cleansing the scissors, she used it to cut the granufoam dressing and inserted it into Resident 31's sacral wound; and cut the vacuum assisted closure tape and applied the tapes on Resident 31's sacral wound. During an interview with LVN A, on 3/5/25 at 3:20 p.m., LVN A acknowledged that she should cleaned the scissors before cutting the granufoam dressing and the vacuum assisted closure tape to apply them to Resident 31's wound. For infection control during wound care, the Centers for Disease Control and Prevention (CDC) recommends standard precautions, proper use of personal protective equipment (PPE), hand hygiene, and meticulous cleaning and disinfection of equipment and surfaces.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 37409 Based on observation, interview, and record review, the facility failed to ensure 10 bedrooms measured at least 80 square feet per resident. Having less than 80 square feet per resident could potentially compromise the care and services the residents receive. Findings: The residents' bedroom measurements were as follows: Room Number Bed Capacity Square Feet per Resident 1 2 78 9 3 69 10 3 69 11 2 66 12 3 76 14 3 76 17 3 69 18 3 69 21 3 77 23 3 77 During the survey, residents were observed in their rooms. Nursing care and services were not negatively impacted by the shortage of space. During the survey, residents and staff were interviewed to determine if there were any concerns or issues with the lack of space. The residents and staff verbalized no complaints or concerns regarding space. Recommend continuance of room waiver.