STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055412	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute Care	101 S Orchard Ave Vacaville, CA 95688

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to issue a SKILLED NURSING FACILITY ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (SNF ABN, a form that is issued in order to transfer financial liability to beneficiaries before the SNF provides an item or service that is usually paid for by Medicare (federal health insurance for anyone age 65 and older, and some people under 65 with certain disabilities) but may not be paid for in this particular instance because it is not medically reasonable and necessary), when the facility determined that one out of three sampled resident (Resident 13) no longer qualified for Medicare Part A (helps cover inpatient care in hospitals, SNF care, hospice care and home health care) skilled services and had not used all the Medicare benefit days for that episode. This failure could lead to Resident 13 unknowingly assuming financial liability for receiving services that were not covered by Medicare and she or her family feeling upset, angry and frustrated. Findings: A review of Resident 13's face sheet (demographics) indicated she was admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (high blood pressure) and Alzheimer's Disease (AD, a disease that destroys nerve cells in the brain. As a result, the brain stops working correctly and memory is affected). Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 12/11/23, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 6, indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 13's functional status indicated she needed staff assistance when performing her Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). A record review on 2/7/24 at 6:33 a.m., indicated Resident 13 was discharged from Medicare Part A on 9/278/23, but still had remaining Medicare days. Resident 13 elected to stay at the facility. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/8/24 at 11:01 a.m., the Social Services Director (SSD) stated she was in charge of filling out and distributing a Notice of Medicare Non-Coverage (NOMNC, a notice that indicates when your care is set to end from a SNF) and SNF ABN (notice when residents exhausted their Medicare days or if skilled services were no longer necessary). The SSD indicated Resident 13 was a long-term patient and was receiving rehabilitation therapy services under Medicare part A. The SSD confirmed Resident 13 was not issued the SNF ABN at this time. When asked why, the SSD did not respond. When asked what the risk could be if the SNF ABN was not issued to residents when they still had Medicare days but elected to stay at the facility, the SSD stated it could potentially result in miscommunication and residents' might be shocked, frustrated and upset that they now must pay for services that were previously paid for by Medicare. During an interview on 2/8/24 at 11:34 a.m., when asked if she knew which notice to issue if a resident was on part A but did not exhaust the Medicare days and elected to stay at the facility, the Minimum Data Set (MDS) coordinator stated she did not really know. When asked what the risk could be if the facility suddenly shifted financial liability to a resident without proper notice, the MDS coordinator did not respond. During an interview on 2/8/24 at 11:42 a.m., the Director of Nursing (DON) stated she was not sure which notices needed to be issued to residents when they still had Medicare days but elected to stay at the facility. When asked what the risk could be if the facility suddenly shifted financial liability to a resident without proper notice, the DON stated residents, or their family, would be upset and angry. During an interview on 2/8/24 at 11:47 a.m., when asked if she knew which notice to issue if a resident was on Medicare Part A, did not exhaust the Medicare days and elected to stay at the facility, the Business office Manager (BOM) stated she thought it was only the NOMNC that would be issued to the resident. When asked what the risk could be if the facility suddenly shift financial liability to a resident without proper notice, the BOM stated resident would be caught off guard, would be surprised and upset when their coverage changed and they were not aware of it. A policy for Medicare Beneficiary Notice was requested but not provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 37797 Based on observation and interview, the facility failed to ensure hot water in the sink of bathrooms used by seven of ten residents (Residents 29, 30, 33, 92, 95, 192 and 243). This failure placed Residents 29, 30, 33, 92, 95, 192 and 243 at risk of not having hot water for their hygiene. Findings: During a resident group interview on 2/6/24, at 11:02 a.m., two of six confidential residents reported there was no hot water in the sink in their bathrooms. The residents reported they must wait up to 15 minutes for the water get hot. The residents stated it bothered them because they used the sink to wash their hands and other hygiene tasks. During an interview on 2/7/24, at 9:30 a.m., the Director of Maintenance (DM) stated the water in the sink of some resident bathrooms took up to ten minutes to get hot. During an observation on 2/7/24, at 9:33 a.m., the DM opened the hot water faucet handle in the bathroom used by Resident 192 and measured the water temperature. During a concurrent interview, the DM stated the water temperature was 68 Fahrenheit (F). The water felt cold to the touch. After five minutes of the water running, the water temperature was 88 F and felt lukewarm. After seven and one-half minutes, the water temperature was 91 F. After ten minutes, the water was temperature was 100 F and felt hot. During an observation on 2/7/24, at 9:46 a.m., the DM opened the hot water faucet handle in the bathroom used by Residents 30 and 33 and measured the water temperature. During a concurrent interview, the DM stated the water temperature was 63 F. After five minutes of the water running, the water temperature was 83 F. After seven and one-half minutes, the water temperature was 99 F. During an observation on 2/7/24, at 9:58 a.m., the DM opened the hot water faucet handle in the bathroom used by Residents 29, 92, 95 and 243 and measured the water temperature. During a concurrent interview, the DM stated the water temperature was 66 F. After three minutes of the water running, the water temperature was 78 F. After four and one-half minutes, the water temperature was 100 F. A review of facility policy titled, Maintenance Service, Revised December 2009, indicated: The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in safe and operable manner at all times.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41333 Based on interviews and record reviews, the facility failed to ensure staff were aware of what a Basic Care Plan (BCP, a plan that promotes continuity of care and communication among nursing home staff to increase resident safety) was and its completion time frame, when there were no BCP's completed for four out of four sampled residents (Residents 13, 34, 41 and 242). These failures had the potential to put residents' safety at risk and for residents not receiving the care they needed. Findings: A review of Resident 34's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (high blood pressure) and Anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness. His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 1/9/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 13, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 34's functional status indicated he was dependent on staff when performing his Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). Resident 34 was a recipient of hospice care (focuses on a person's quality of life as they near the end of life). Resident 34 did not have a BCP completed within 48 hours of admission. A review of Resident 13's face sheet indicated he was initially admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia, Essential Hypertension (high blood pressure) and Alzheimer's Disease (AD, a disease that destroys nerve cells in the brain. As a result, the brain stops working correctly and memory is affected). Her MDS, dated [DATE], BIMS score was 6, indicating severely impaired cognition. Resident 13's functional status indicated she needed assistance when performing her ADLs. Resident 13 did not have a BCP completed within 48 hours of admission. A review of Resident 242's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included Encephalopathy (a disease, damage, or malfunction of the brain manifested by an altered mental state that is sometimes accompanied by physical changes), Type 2 Diabetes Mellitus (a chronic disease that affects the way your body processes glucose (sugar) for fuel) and Essential Hypertension. His MDS, dated [DATE], BIMS score was 12, indicating moderately impaired cognition. Resident 242's functional status indicated he needed assistance when performing his ADL's. A review of Resident 41's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (excess of lipids or fats in your blood), Anxiety disorder and Chronic Obstructive Pulmonary Disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems). His MDS, dated [DATE], functional status indicated he needed supervision when performing his ADL's. Resident 41 did not have a BCP completed within 48 hours of admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/06/24 at 10:36 a.m., the Minimum Data Set (MDS) Coordinator stated Residents 242, 13, 34, did not have a BCP. During an interview on 2/06/24 at 10:47 a.m., the MDS Coordinator stated the facility used a different form called an Interim Care Plan (ICP) which was equivalent to BCP. The MDS Coordinator stated this ICP was completed by the Admission Nurse. The MDS Coordinator was not sure what a BCP was and was not sure of the BCP process and its completion time frame. The MDS Coordinator stated a BCP was important so staff could provide adequate and quality care to residents. The MDS Coordinator stated, if a BCP was not done or if it was completed late, it could put residents' safety at risk because staff would not know about residents' needs. The MDS Coordinator stated this also put residents at risk for not receiving adequate and quality care. During an interview on 2/6/24 at 11:03 a.m., the Activity Director (AD) stated she was not sure what a BCP was and its completion time frame. During an interview on 2/06/24 at 11:04 a.m., the Director of Rehabilitation (DOR) stated he was not aware of what a BCP was and its completion time frame. The DOR stated he had not done or completed a BCP for the residents. During an interview on 2/06/24 at 11:28 a.m., the Registered Dietician (RD) stated she had no idea of what a BCP was and its completion time frame. During an interview on 2/06/24 at 12:45 p.m., the Assistant Director of Nursing (ADON) stated it was important to have the BCP completed within 48 hours of admission. The ADON stated Friday late admissions BCPs were completed on Monday the following week. When asked if this made the BCP completion late, she stated, Yes. The ADON stated the facility did not complete a BCP but rather used an ICP form which was completed by the Admission Nurse only. The ADON stated the ICP was completed with no input from the team, the resident or the Responsible Party (RP, the person in charge of overseeing and managing the resident's care or funds). The ADON stated it was important to complete the BCP timely to ensure staff were providing safe, appropriate and adequate care to the residents. She stated not completing a BCP, or completing the BCP late, could put residents' safety at risk. During a concurrent interview and ICP record review on 2/06/24 at 1:19 p.m., the ADON verified the ICP did not have information on a resident's initial goal based on admission orders, the physician orders, dietary orders, therapy services, social services or PASARR recommendation, if applicable. When asked if the ICP was the same as BCP, the ADON stated, No. During an interview on 2/07/24 at 9 a.m., the Social Services Director (SSD) stated BCPs needed to be completed within 72 hours of admission. During an interview on 2/07/24 at 11:36 a.m., the SSD stated neither the resident, nor the RP, was part of baseline care planning. The SSD stated the BCP was important because it was a foundation of resident's care. The SSD stated the potential risk of not completing a BCP or completing a BCP late, was care could fall through the cracks which could lead to a wrong treatment plan. The SSD stated it could also put the resident's safety or comfort at risk. The SSD stated the ICP did not include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services or PASARR recommendation, if applicable. When asked if the ICP was the same as BCP, she stated, No. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/08/24 at 9:29 a.m., the ADON stated Resident 41 did not have a BCP, just like the other residents. During a review of the facility's policy and procedure (P & P) titled, Care Plans - Baseline, revised 12/2016, the P & P indicated to assure that residents' immediate care needs were met and maintained, a BCP will be developed within 48 hours of admission .the Interdisciplinary Team (IDT) will review the healthcare practitioner's order and implement a BCP to meet the residents immediate care needs including but not limited to initial goals based on admission order, physician orders, dietary orders, therapy services, social services and Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), if applicable. 46132

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, the facility failed to ensure one out of three sampled residents (Resident 34), received the necessary care and services to attain his or maintain the highest practicable physical, mental, and psychosocial well-being, when: 1. the facility activity care plan (CP, a form that summarizes a resident's health conditions, specific care needs, and current treatments and outlines what needed to be done to manage resident's care needs) was not followed; and, 2. staff were utilizing Spanish-speaking staff and Resident 34's daughter to communicate with him. These failures could lead to mood swings, depression, frustration, miscommunication, misinterpretation of resident's report of symptoms which could lead to misdiagnosis and inappropriate action taken in an emergency. Findings: A review of Resident 34's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (high blood pressure) and Anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness. His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 1/9/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 13, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 34's functional status indicated he was dependent on staff when performing his Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). Resident 34 was on hospice care (care that focuses on a person's quality of life as they near the end of life). 1. During an observation on 2/6/24 at 1:08 p.m., Resident 34 was still in bed, with his wife at his bedside. No Spanish music was playing, and the television (TV) was off. During an observation on 2/6/24 at 3:09 p.m., Resident 34 was still in bed; his wife at his bedside. There was no Spanish music playing, and the TV was off. During an interview on 2/06/24 at 3:15 p.m., the Activity Director (AD) stated she and the Activity Assistant (AA) spoke very minimal Spanish. The AD stated she called a Spanish-speaking staff when she needed to communicate with Resident 34. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/6/24 at 3:22 p.m., Resident 34 was still in bed; his wife at bedside. Resident 34 was Spanish speaking, and understood and spoke very minimal English. Unlicensed Staff H interpreted. When asked about activities, Resident 34 stated activity staff did not really talked to him but they would drop off crossword puzzles sometimes. Resident 34 stated he had not received a Spanish newspaper from the activity staff. Resident 34 stated, keeping up with the news was important to him. Resident 34 stated there was really no activity for him. Resident 34 stated he wanted to attend a religious service but had yet to attend one at the facility. Resident 34 stated he would like to watch TV in a Spanish-speaking channel and would like to hear Spanish music. When asked when the last time was the activity staff visited him, Resident 34 stated he did not remember. Resident 34 stated the activity staff did not visit daily. Resident 34 stated the activity staff did not visit him today or yesterday. During an interview on 2/7/24 at 8:27 a.m., when asked about activities for Resident 34, the AD stated activity staff would bring him Spanish puzzles and would turn the TV on to Spanish channels. The AD stated they did not visit him daily although the activity care plan stated daily visits from activity staff. The AD stated they did not really talk to Resident 34 but they would drop off crossword puzzles from time to time. The AD stated Resident 34 had not attended a religious service at the facility since admission. When asked why, the AD was did not answer. The AD stated there were no other activities for Resident 34. When asked what the risk could be if Resident 34 did not have activities, the AD stated Resident 34 could be sad, depressed and frustrated. During a concurrent interview and activity care plan record review on 2/7/24 at 4:18 p.m., the AD verified Resident 34's activity CP indicated the activity staff would visit him daily. The AD stated, based on the activity documentation, Resident 34 was not being visited by activity staff daily which meant Resident 34's activity CP was not followed. The AD stated Resident 34 did not have any documentation that he was asked by the activity staff to attend religious services although this was somewhat important to Resident 34. The AD stated the activity staff did not ensure Resident 34's TV was turned on a Spanish channel and the radio was turned to Spanish music. The AD stated the radio was given to another resident. During an interview on 2/8/24 at 2:48 p.m., Unlicensed Staff E stated it was crucial and vital for residents to have activities, and activities were great for residents' psyche (all parts of human mind that affects personality). Unlicensed Staff E stated, if residents did not have activity, residents' would be at risk for depression, feeling moody, cranky and frustrated. During an interview on 2/8/24 at 3:12 p.m., Licensed Staff C stated it was important to follow the activity care plan. Licensed Staff C stated, if there were no activities for residents or if the activity care plan was not followed, it could affect residents' mental health. Licensed Staff C stated it put residents at risk for further depression, agitation, and frustration. Licensed Staff C stated residents might become more emotional. During an interview on 2/8/24 at 3:58 p.m., the Registered Dietician stated care planning was important, and staff had to follow the care plan in place. The RD stated a care plan was important because it guided staff on how to properly care for residents. The RD stated care plans also mitigate risk factors. The RD stated, if an activity care plan was not followed, it could affect residents psychosocially. The RD stated, not having activities put residents at risk for feeling depressed and isolated. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/24 at 8:41 a.m., Unlicensed Staff G stated a care plan was important because it helped staff to meet residents care needs safely. Unlicensed Staff G stated activities were very important for socialization. Unlicensed Staff G stated she had not heard any Spanish music playing for Resident 34. Unlicensed Staff G stated she noticed Resident 34's TV was on one time, but it was not a Spanish channel. Unlicensed Staff G stated, not having any activities put residents at risk for mood swings, mood changes, depression, anxiety, and frustration. During an interview on 2/9/24 at 9:17 a.m., the Assistant Director of Nursing (ADON) stated activities were important to help engage the residents and for socialization. When asked what the risk could be if residents did not have any activities, the ADON stated it was a potential risk for isolation and feeling isolated. The ADON stated care plans were important because it provided staff a plan on how to care for a resident adequately and safely. The ADON stated care plans had to be followed and adjusted as needed. A review of the facility's policy and procedure (P & P) titled, Activity Program, revised 8/2006, the P & P indicated activity programs to meet the needs of each resident are available on a daily basis .activity programs are geared to the individual resident's need .individualized activities are provided that reflect the schedules, choices and rights of the resident . individualized activities are offered at hours convenient to the residents including evenings, holidays and weekends .individualized activities are provided that reflect the cultural and religious interest, hobbies, life experiences and personal preferences of the resident. 2. During a concurrent observation and interview on 2/5/24 at 3:50 p.m., Resident 34 was speaking Spanish. Resident 34 spoke and understood very minimal English. There was no communication board to aid in communicating with Resident 34. Unlicensed Staff G stated the facility has no system for communicating with Spanish-speaking residents. Unlicensed Staff G stated non-Spanish speaking facility staff usually just sought help from a Spanish-speaking staff when communicating with Resident 34. When asked if Resident 34 was under the care of Spanish-speaking staff, she stated, No. During an interview on 2/6/24 at 3:15 p.m., the Activity Director (AD) stated she and the Activity Assistant (AA) spoke very minimal Spanish. The AD stated she would call a Spanish-speaking staff when she needed to communicate with Resident 34, if needed. During an interview on 2/6/24 at 3:22 p.m., Unlicensed Staff G stated most of the facility nurses and the hospice nurse who took care of Resident 34 were English speaking only so communication had to be through Resident 34's daughter or Spanish-speaking staff. Unlicensed Staff G stated they called Resident 34's daughter to communicate with Resident 34. During an interview on 2/6/24 at 3:33 p.m., Resident 34's daughter stated her dad would call her if he was not feeling well because the staff taking care of him did not speak or understand Spanish. Resident 34's daughter stated she was worried and felt it was unsafe the facility depended on her to communicate with Resident 34. Resident 34's daughter stated she was worried about her dad especially in cases where immediate help was needed. Resident 34's daughter stated she wished the facility could formulate a plan on how staff could better communicate with Resident 34. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/7/24 at 6:17 a.m., Resident 34 was calling for help. Unlicensed Staff I was trying to communicate with Resident 34. Unlicensed Staff I asked what Resident 34 needed; however Unlicensed Staff I was having difficulty communicating with Resident 34. Unlicensed Staff I stated, It's hard, because I don't speak Spanish. During an interview on 2/7/24 at 6:51 a.m., Unlicensed Staff I stated the facility had no system in place to help communicate with Resident 34 if they were not Spanish speaking. Unlicensed Staff I stated, even before Resident 34, the facility had a resident that was Spanish speaking. Unlicensed Staff I stated staff had to go look for a laundry staff member to translate for them because at that time, no one from their shift spoke Spanish. Unlicensed Staff I stated it could have been easier and safer for Resident 34 to have a staff assigned to him who spoke Spanish. Unlicensed Staff I stated the Certified Nursing Assistant (CNA) and the nurse who were actually assigned to care for Resident 34 last night, did not speak Spanish. Unlicensed Staff I stated it would be safer if the facility had a system in place to assist non-Spanish speaking staff to communicate with Resident 34. Unlicensed Staff I stated not having a system in place, all staff were aware of and consistently used, could result in miscommunication and not providing the care Resident 34 needed. Unlicensed Staff I stated it placed Resident 34's safety at risk. During an interview on 2/7/24 at 7:34 a.m., Licensed Staff J stated it was difficult for her to communicate with Resident 34 because she did not speak Spanish. Licensed Staff J stated there was no communication board readily accessible for staff to use to communicate with Resident 34. Licensed Staff J stated she relied on other Spanish-speaking staff to communicate with Resident 34. Licensed Staff J stated, not really understanding what Resident 34 was trying to say could result in miscommunication and not being able to provide for Resident 34's needs accurately. Licensed Staff J stated this could result in Resident 34's frustration and confusion and could put Resident 34's safety at risk. During an interview on 2/7/24 at 8:27 a.m., the AD stated there were no Spanish communication boards in the Resident 34's room, so staff usually relied on Spanish speaking staff or Resident 34's daughter to interpret. When asked if it was acceptable to use staff or Resident 34's daughter to interpret, the AD stated, No. When asked what the risks could be for using staff or Resident 34's daughter to interpret, the AD stated it was a risk for miscommunication. During a concurrent interview and activity care plan record review on 2/7/24 at 4:18 p.m., the AD stated Resident 34 did not have any communication board that would help to better communicate with him. The AD stated having this communication board could be easier for Resident 34 and staff to use. The AD stated having this communication board could prevent miscommunication. During an interview on 2/8/24 at 2:37 p.m., Unlicensed Staff E stated a communication board was important to communicate with non-English speaking residents. Unlicensed Staff E stated the facility used staff mainly to translate. Unlicensed Staff B stated it was not appropriate to use staff or family members to translate for residents. Unlicensed Staff E stated, using a family member to translate for residents was a safety risk and could result in miscommunication. During an interview on 2/8/24 at 3:06 p.m., Licensed Staff C stated the facility had (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute Care	101 S Orchard Ave Vacaville, CA 95688

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no known policy on communicating with non-English speaking residents. Licensed Staff C stated the facility used family members to interpret as needed. Licensed Staff C stated, using a family member to translate for residents could lead to possible miscommunication or pertinent information may be left out if family translated. During an interview on 2/8/24 at 3:35 p.m., the Registered Dietician (RD) stated, using a family member to translate for residents could lead to possible risk of omission of information as they may leave things out, and there could be a possible risk of miscommunication. During an interview on 2/8/24 at 5:15 p.m., Licensed Staff D stated the facility staff needed to use a professional translator. Licensed Staff D stated it was not acceptable to use a family member to interpret. Licensed Staff D stated, using a family member to translate for residents could result in miscommunication, omission of information and could result in the resident not getting the care they needed. During an interview on 2/9/24 at 8:01 a.m., Licensed Staff F stated sometimes Resident 34 would say something, and the family would omit information. Licensed Staff F stated it was not acceptable to use a family member as interpreter. Licensed Staff F stated, using a family member to translate for residents could result in miscommunication, which could lead to residents' unmet needs. Licensed Staff F stated the facility should use a professional interpreter- a neutral party, to translate for the facility staff. During an interview on 2/9/24 at 8:35 a.m., Unlicensed Staff G stated she recalled dragging one of the staff to interpret for here while attending to a Spanish-speaking resident. Unlicensed Staff G stated this was not an isolated incident since she also helped translate for residents and staff if needed. Unlicensed Staff G stated the facility did not provide proficiency testing for a specific language prior to using them as a translator. Unlicensed Staff G stated, using a family member to translate for residents could result in miscommunication. Unlicensed Staff G stated it also put residents' safety at risk. During an interview on 2/9/24 at 9 a.m., the Assistant Director of Nursing (ADON) stated, using a family member as translator could potentially lead to miscommunication, risk for not meeting residents' needs, or residents receiving inappropriate care. During an interview on 2/9/24 at 10:19 a.m., the Director of Nursing (DON) stated it was not a good practice to use family members as interpreters especially when translating for medical terminologies. The DON stated, using a family member as translator could potentially lead to risk for misinterpretation as family members might have knowledge deficit on medical terms. The DON stated, using a family member to translate could result in misinterpretation during an emergency and misinterpretation of a resident's report of symptoms which could lead to misdiagnosis and inappropriate action taken in an emergency. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P & P) titled, Translation and/or Interpretation of Facility Services, revised 5/2017, the P & P indicated the facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility competent oral translation of vital information shall be provided in a timely manner through a staff member who is trained and competent in the skill of interpreting, a staff interpreter who is trained and competent in the skill of interpreting, contracted interpreter service, voluntary community interpreters who were trained and competent in the skill of interpreting, telephone interpretation service . interpreters and translators must be appropriately trained in medical terminology, confidentiality of protected health information and ethical issues that may arise in communicating health related information .family members and friends shall not be relied upon to provide interpretation services for the resident .if a family member or friend were used as interpreter, the resident must provide a written consent for disclosure of protected health information.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on interview and record review, the facility failed to provide supervision and other fall prevention interventions to prevent falls for two of two residents at risk for falls (Residents 20 and 14). For Resident 20, the facility failed to supervise and monitor Resident 20 and failed to ensure Resident 20 had access to a call light to ask for help when she needed to ambulate. These failures resulted in Resident 20 falling and fracturing her hip. For Resident 14, the facility failed to supervise and monitor Resident 14 to prevent falls resulting in Resident 14 sustaining three falls within a period of two weeks and placing her at risk of injuries. Findings: RESIDENT 20 A review of Resident 20's Admission Record indicated a date of initial admission of 3/25/29. Resident 20's Admission record indicated she was [AGE] years-old and had diagnoses including generalized muscle weakness, abnormalities of gate and mobility, and senile degeneration of the brain (age-related cognitive impairment). A review of Resident 20's care plans indicated one fall care plan, dated 7/10/23, titled, Potential for falls r/t [related to] decreased mobility (The Fall Care Plan). The Fall Care Plan indicated the following fall prevention interventions: Ensure resident is wearing appropriate footwear, ensure call light is within reach and encourage resident to use it, and if fall occurs, investigate, find cause and monitor for signs and symptoms of injury. A review of Resident 20's Fall Care Plan indicated it was updated on 8/16/2,3 with the intervention to ensure Resident 20's wheelchair was locked as needed for transfers. A review of Resident 20's MDS Assessment, dated 10/4/23, indicated Resident 20 had a BIMs score of 11 (scores below 12 indicate impaired cognition), required staff assistance for transfer and ambulation, used a wheelchair for locomotion, and had a history of falls. A review of Resident 20's Morse Fall Scale, dated 10/4/23, indicated Resident 20 was at high risk for falls due to a history of falls, impaired gait (difficulty rising from chair, uses chair arms to get up, bounces to rise . cannot walk unassisted) and impaired mental status (overestimates or forgets limits). A review of SBAR Communication, dated 12/23/23, at 8:09 p.m., indicated Resident 20 had a fall that day. The noted indicated the fall was unwitnessed. The note indicated Licensed Nurse C heard Resident 20 yelling for help and then observed Resident 20 on the ground next to her wheelchair, on her right side, outside her room. The note indicated no visible injuries but Resident 20 reported being unable to move her right leg because of pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Fall IDT Note, dated 12/26/23, at 4:27 p.m., indicated the IDT team met to review Resident 20's fall on 12/23/23. The note indicated the fall occurred on 12/23/23 at 3:25 p.m., when she was observed laying on her right side on the floor at the end of the hallway outside her room where she sat with her tray table. The note indicated no visible injuries, and Resident 20 initially denied pain. The note indicated Resident 20 subsequently reported pain at her right leg at a level 9 (on a progressive zero to 10 scale). The note indicate Resident 20 fell when she stood out of the wheelchair to pick up something on the floor and then fell out of the wheelchair onto the floor. The note indicated an x-ray was performed the following day which indicated a right hip fracture. The note indicated Resident 20 was taken to the hospital for evaluation and treatment of her injuries. During an interview on 2/7/23, at 2:23 p.m., the DON stated she was familiar with Resident 20. During the same interview, the DON reviewed Resident 20's clinical record. The DON stated Resident 20 had dementia and was at high risk of falls. The DON stated Resident 20's most recent fall was on 12/23/23, during shift change when Resident 20 fell out of her wheelchair and landed on the floor, right side first. The DON stated Resident 20 was on her wheelchair and attempted to pick up something from the floor and fell . The DON stated Resident 20 suffered a hip fracture because of the fall and was taken to the hospital for evaluation and treatment. The DON stated the Fall Care Plan was the only fall care plan in place when Resident 20 fell on [DATE]. The DON was asked what fall prevention interventions were in place when Resident 20 fell . The DON stated to ensure the call light was within reach, that Resident 20 was wearing appropriate footwear and her wheelchair wheels were locked. During an interview on 2/7/24, at 3:09 p.m., Licensed Nurse C stated she was on duty on 12/23/23, when Resident 20 fell , and was assigned to care for Resident 20 that day. Licensed Nurse C stated Resident 20 fell in the afternoon of 12/23/2,3 during shift change. Licensed Nurse C stated she just had received report from the outgoing nurse and was checking resident records in front of the nurse's station when she heard someone yelling, Help, help. Licensed Nurse C stated she turned towards the yelling and saw Resident 20 on the floor in the hallway, next to her wheelchair, in front of the entrance to her room, calling for help. Licensed Nurse C stated she ran towards Resident 20 and assisted her back onto her wheelchair. Licensed Nurse C stated she asked Resident 20 what happened, and Resident 20 told he she was on her wheelchair and tried to pick an object from the floor and then fell out onto the floor. Licensed Nurse C stated, prior to the fall, Resident 20 was on her wheelchair in front of her room engaged with writing supplies placed on a table in front of her wheelchair. Licensed Nurse C stated it was customary for Resident 20 to be on her wheelchair in the hallway in front of her room playing with arts and crafts. Licensed Nurse C stated sometimes Resident 20 placed stuffed animals on side rails next to her wheelchair on the hallway. Licensed Nurse C stated, when Resident 20 fell , there was no staff in the hallway monitoring Resident 20. Licensed C restated she was at the nurse's station [roughly 100 feet from Resident 20's location] and was the first to report to the scene and assist Resident 20, followed by two Certified Nursing Assistants (CNAs), who came after her. Licensed Nurse C stated Resident 20 was, very good at using her call light to request assistance but there was no call light in the hallway where Resident 20 was, within her reach when she fell . RESIDENT 14 A review of Resident 14's Admission Record indicated a date of admission of 4/28/23. Resident 14's Admission record indicated she was [AGE] years-old and had diagnoses including generalized muscle weakness, difficulty walking, and dementia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident 14's Care Plans (documents indicating the care to be provided to the resident) indicated the following care plans relating to fall prevention: 4/28/23: Resident at risk for falls due to cognitive deficits, non-compliance, weakness, decline in function (the Fall Care Plan). Interventions listed included: Be sure call light is within reach and encourage using it for assistance as needed, encourage activities that promote physical activity and improved mobility, and investigate and determine cause if falls occur; 5/8/23: Resident 14 had an ADL (Activities of Daily Living: Dressing, eating, hygiene, ambulation) self-care performance deficit related to weakness. Intervention included providing 1-2 staff assistance for bed mobility, transfers, toileting, bathing, feeding and ambulation; 5/8/23: Resident 14 had impaired cognitive function related to dementia. Interventions included to monitor Resident 14 for changes in cognitive function; 7/11/23: Resident 14's Fall Care Plan was updated to include a pressure alarm to chair; and, 7/14/23: Resident 14 was at risk of injury related to non-compliance . refusal to call staff for assistance. Interventions included adapting regimen to Resident 14's level of comprehension and Resident 14 had a right to refuse care/treatment. A review of Resident 14's MDS Assessment (MDS stands for Minimum Data Set and is a mandated comprehensive resident assessment), dated 8/4/23, indicated Resident 14 had a BIMS (Brief Interview form Mental Status - the part of the MDS assessment that measures the resident's cognition level) score of 3 (on a 0-15 scale; the lower the score the more cognitive impaired), indicating severe cognition deficits. The MDS further indicated Resident 14 needed staff assistance during transfers and ambulation. A review of Resident 14's Morse Fall Scale (a standardized assessment tool that indicates a resident's risk for falls), completed on 8/4/23, indicated Resident 14 was at, High Risk for Falling, due to the following fall risk factors including: History of falling, weak gait (manner of walking), use of ambulatory aids such as crutches, cane or walker, and Resident 14, overestimates or forgets limits. A review of Resident 14's Fall Care Plan indicated it was updated on 8/16/23, with two additional interventions to prevent falls: Confirm alarms are on during walking rounds and ensure appropriate footwear is on at all times. First fall A review of Resident 14's Progress Note, dated 10/20/23, at 7:20 p.m., titled, SBAR Communication Form, (SBAR stands for Situation, Background, Assessment and Recommendation; it is a standard form used to document incidents in health care facilities) indicated Resident 14 fell that day. The note indicated, Res[ident] was seen standing unassisted w/[ith] walker in front of nurses station, lost balance and fell on her bottom . no injuries noted. A review of Resident 14's Fall Care Plan indicated no new fall interventions after the first fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident 14's Progress Note, dated 10/23/23, at 12:02 p.m., titled, Fall IDT (IDT stands for Interdisciplinary Team, which is a committee of professionals from different disciplines who meet to review incidents reported in SBAR forms, identify the causes and implement interventions to prevent reoccurrence) indicated factors that contributed to Resident 14's fall on 10/20/23, included: Impulsive behaviors, dementia, and history of non-compliance with safety measures. The IDT note indicated recommendations to encourage use of wheelchair with pad alarm (a pad alarm is a pressure sensor placed on the wheelchair that emits a noise when the resident gets up from the wheelchair). A review of Resident 14's Fall Care Plan indicated it was updated on 10/25/23, with one additional intervention: Physical and Occupational Therapy to evaluate and treat. Second fall A review of Resident 14's Progress Note, dated 11/2/23, at 10:02 p.m., titled SBAR Communication Form, indicated Resident 14 fell on e more time. The note indicated the fall was detected around 9 p.m., when: Resident [14] was found on the floor next to her bed. The note indicated, no injuries noted. A review of Resident 14's Progress Note, dated 11/6/23, at 9:56 a.m., titled, Fall IDT, indicated the second fall happened when Resident 14 attempted to get up from the bed to use the bathroom and tripped on the blanket. The note indicated the pad alarm on the bed was disconnected. The note indicated contributing factors to the fall included dementia and disorientation. The IDT note indicated the recommendations for frequent visual checks and room change closer to the nurse's station for increased monitoring of residents. Third fall A review of Resident 14's Progress Note, dated 11/6/23, at 10:29 a.m., titled, Fall IDT, indicated Resident 14 fell a third time, less than 24 hours after the second fall, on 11/3/23 at around 10:40 a.m. The note indicated the fall occurred in the activities room when Resident 14 was observed by the Activity's Assistant getting up from the table using her walker, and the walker rolled out under her and she fell to the floor. The note indicated contributing factors to the fall included dementia and non-compliance with safety measure provided. The IDT note indicated the recommendations for removal of walker and use of wheelchair. A review of Resident 14's Fall Care Plan indicated it was updated with thee additional fall prevention interventions on 11/6/23: Encourage use of wheelchair instead of walker, room change to be closer to the nurse's station, and frequent visual checks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 2/9/24, at 9:30 a.m., the Director of Nursing (DON) stated she was familiar with Resident 14. During the same interview, the DON reviewed Resident 14's clinical record. The DON stated Resident 14 was non-compliant with care. The DON stated Resident 14 had dementia and was at high risk of falls. The DON stated Resident 14 had three recent falls at the facility: On 10/20/23, 11/2/23 and 11/3/23. The DON stated all falls were documented in SBAR notes, and the facility's investigation of the falls was found in the IDT notes following the falls. The DON was asked what fall interventions the facility implemented to prevent falls for Resident 14. The DON stated the 4/28/23, Care Plan titled, Resident at risk for falls . was the facility's fall prevention care plan for Resident 14, and it contained the fall prevention interventions implemented by the facility to prevent falls for Resident 14. The DON stated only one new intervention was implemented after the first fall on 10/20/23 (PT/PT evaluation and treatment dated 10/25/23), none after the second fall on 11/2/23, and three new interventions after the third fall on 11/3/23 (encourage use of wheelchair instead of walker, room change to be closer to the nurse's station, and frequent visual checks on 11/6/23). A review of the facility's policy titled, Falls and Fall Risk, Managing, Revised March 2018, indicated: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes and try to prevent the resident from falling and try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If falling recurs despite initial interventions, staff will implement additional or different interventions . Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. A review of facility policy and procedure titled, Dementia - Clinical Protocol, Revised November 2018, indicated: Direct care staff will support the resident in initiating and completing activities and tasks of daily living . Bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day .

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, the facility failed to ensure adequate pain relief for one out of one sampled resident (Resident 34), when: 1. the nurse administered acetaminophen (APAP, a non-opioid analgesic and antipyretic agent utilized for treating pain) 650 milligram (mg, a unit of weight) for an 8 out of 10 pain level (8/10 PL, severe pain, hard to do anything at all); 2. the facility honored the family's preference over Resident 34's comfort; and, 3. the facility did not follow the physician's order to relieve Resident 13's severe pain. These failures led to resident grimacing, moaning and continuously complaining of 8/10 PL. Findings: A review of Resident 34's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (high blood pressure) and Anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness. His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 1/9/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 13, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 34's functional status indicated he was dependent on staff when performing his Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). Resident 34 was a recipient of hospice care (focuses on a person's quality of life as they near the end of life). During a concurrent observation and interview on 2/7/24 at 7:33 a.m., Resident 34 was moaning and shaking his right leg. When asked if he was experiencing, dolor (pain in Spanish), Resident 34 nodded his head. Unlicensed Staff A interpreted and stated Resident 34 was reporting an 8/10 PL on his right leg and his back. During a concurrent observation and interview on 2/7/24 at 8:09 a.m., Resident 34 was still moaning and was seen shaking his right leg. When asked if he was still experiencing, dolor, Resident 34 nodded his head. Unlicensed Staff A interpreted and stated Resident 34 was still reporting an 8/10 PL on his right leg and his back. During an interview, via the language interpreter line service, on 2/7/24 at 8:13 a.m., Resident 34 stated he was still experiencing an 8/10 PL. During an interview on 2/7/24 at 8:20 a.m., when asked if staff had notified her of Resident 34's complaint of 8/10 PL, Licensed Staff B stated, Yes, however had not gone to see him yet because she got busy passing medications to other residents. Licensed Staff B was notified Resident 34 was experiencing an 8/10 PL. Licensed Staff B stated Resident 34 received a 0.5 milligram (mg, a unit of measure) of morphine (a non-synthetic narcotic- a medication that reduce tension, pain and anxiety; a strong pain reliever) at 6:30 a.m. , and was not due for another dose until 10:30 a.m. Licensed Staff B stated she would see Resident 34 later and ask him if he was still in pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 2/7/24 at 8:42 a.m., Licensed Staff B was again notified Resident 34 was still experiencing an 8/10 PL. Licensed Staff B stated she was still busy and had not seen Resident 34 yet. Licensed Staff B stated she would ask another nurse to see him now. During a concurrent observation and interview on 2/7/24 at 8:44 a.m., the Infection Control Preventionist (IP) did not use the language interpreter line service and relied on Unlicensed Staff A to translate for her. Resident 34 was noted to be grimacing and shaking his right leg. The IP was heard telling Resident 34 (through Unlicensed Staff A), the nurse could only give him APAP to address his pain since he was not due to receive a morphine dose at this time. Resident 34's wife asked when the last time Resident 34 received morphine to which the IP responded, 6:30 a.m. The IP stated the nurse would give him APAP for breakthrough pain and then would give him the morphine in two hours. The IP confirmed Resident 34 was still complaining of an 8/10 PL on his right leg. The IP stated she would tell the nurse in charge of his care to give him APAP for now. During an interview, using the language interpreter line service on 2/7/24 at 11:13 a.m., Resident 34 stated he was still experiencing an 8/10 PL, and the APAP given him earlier was not effective in managing his pain. Resident 34 stated the nurse did not come to see him after he was given APAP, to reassess his pain. Resident 34 stated he moved his right leg because it helped alleviate the pain a little. During an interview on 2/7/24 at 12:18 p.m., the IP confirmed Resident 34 received APAP 650 mg to address his complaint of 8/10 PL earlier. The IP stated the facility pain protocol was to give residents their pain medication as ordered, and if not effective to give another type of pain medication. When asked if it was appropriate for Resident 34 to receive APAP 650 mg for a complaint of 8/10 PL after he was given morphine, the IP stated, Why not? What we do is give the resident what was available, even if the medication available would only provide a little pain relief. The IP stated, since Resident 34 was not due for another dose of morphine earlier, Resident 34 could only receive APAP at that time and that was acceptable. During an interview on 2/7/24 at 12:32 p.m., the Director of Nursing (DON) stated Resident 34 did have an issue with pain management. When asked what the facility's pain management policy was, the DON stated, if a medication was ineffective, the nurses should call to notify the physician the pain medication was ineffective. The DON stated that in Resident 34's case, the nurses should have called the physician to ask whether they could give another dose of morphine. The DON stated it was not appropriate to give APAP 650 mg when Resident 34 was complaining of an 8/10 PL. The DON stated Resident 34's family was heavily involved in his care and would interfere with his pain management. When asked who made the decision for Resident 34, the DON stated Resident 34 was responsible for himself. The DON stated the facility had conversations with Resident 34's family regarding pain management but his family would say they would not want him to be sedated, so they would not like the nurse to give 1 mg of morphine for severe pain despite the physician's order. When asked why the facility nurses chose to honor Resident 34's family's wishes versus that of Resident 34's comfort, the DON stated the nurses probably felt intimidated not following Resident 34's family wishes. When asked if the nurses followed the facility policy for pain management, the DON stated, No, and she understood. The DON stated she would educate the nurses on the facility's policy and procedure (P & P) for pain management. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute Care	101 S Orchard Ave Vacaville, CA 95688

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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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 2/7/24 at 3:04 p.m., the Medical Director (MD) stated Resident 34's pain started about two weeks ago. MD stated Resident 34 was able to make decisions for himself however his wife would sometimes intervene. When asked if it was acceptable for Resident 34 to receive APAP 650 mg for an 8/10 PL if the morphine was ineffective and was still not due for another dose, the MD stated, No. The MD stated the nurse should have called him after the initial dose of morphine was ineffective as he could easily give an order to give another dose of morphine to address Resident 34's complaint of an 8/10 PL. The MD stated he was sorry this happened. The MD stated this should not have happened. During an interview on 2/7/24 at 3:20 p.m., when asked if it was acceptable for Resident 34 to receive APAP 650 mg for an 8/10 PL, Licensed Staff C stated, Yes. Licensed Staff C stated, if Resident 34 was not due for a dose of morphine, even if the initial dose was ineffective, then the nurse should give him what was available, even if it was a lower form of analgesic (pain reliever). When asked if she thought APAP 650 mg would effectively relive Resident 34 of 8/10 PL, Licensed Staff C stated a little but not enough to make him comfortable. When asked what the risk was if Resident 34's pain was not relieved by APAP 650 mg, or if Resident 34 continued to have an 8/10 PL, Licensed Staff C stated Resident 34 would be uncomfortable, he would be in pain. Licensed Staff C stated Resident 34 would also be upset and frustrated and he would feel like his concerns were not heard. During an interview on 2/8/24 at 5 p.m., Resident 34's daughter stated three days ago, Resident 34 called her to tell her he was in pain. Resident 34's daughter stated the facility did not address Resident 34's pain adequately. During an interview on 2/8/24 at 5:15 p.m., Licensed Staff D stated pain was subjective. Licensed Staff D stated, if a resident was responsible for himself, staff should listen to what the resident's wishes were. When asked if it was appropriate to give APAP 650 mg to a resident complaining of an 8/10 PL, Licensed Staff D stated, No. Licensed Staff D stated an 8/10 PL meant the pain was severe and APAP 650 mg would not be effective in addressing a complaint of 8/10 PL. Licensed Staff D stated the goal of pain management was to keep residents comfortable. Licensed Staff D stated, giving APAP 650 mg for an 8/10 PL was ineffective and would result in the resident still being in a lot of pain. During an interview on 2/9/24 at 8:01 a.m., Licensed Staff F stated Resident 34 was under hospice care. Licensed Staff F stated the pain management goal was to keep Resident 34 comfortable and to have a dignified end of life. Licensed Staff F stated APAP 650 mg would not be appropriate to administer if Resident 34 was complaining of an 8/10 PL. Licensed Staff F stated APAP 650 mg would not significantly keep Resident 34 comfortable. Licensed Staff F stated, giving Resident 34 an APAP 650 mg when he was complaining of an 8/10 PL, could result in him being in considerable pain. Licensed Staff F stated Resident 34 would be uncomfortable and upset. A review of Resident 34's electronic medication administration record (EMAR, an electronic patient record system used to document information about medications) indicated, on 1/29/24, Resident 34's order for morphine was to give 0.5 mg by mouth every four hours as needed for mild to moderate pain and 1 mg by mouth every four hours as needed for severe pain. The EMAR also indicated Resident 34 received APAP 650 mg for a complaint of 8/10 PL on these dates: 1/27/24 and 1/30/24. (continued on next page)

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	055412	A. Building B. Wing	02/09/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility's policy and procedure (P & P) titled, Pain Protocol, revised 3/2018, the P & P indicated: With input from resident to the extent possible, the physician and staff will establish goals of pain treatment, freedom from pain .pain medications should be selected based on pertinent treatment guidelines . staff will reassess the individual's pain and related consequences at regular intervals. 37797

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on interview and record review, the facility failed to ensure one of two residents (Resident 2) received physician visits every 60 days when Resident 2 did not have a physician visit for over 8 months. This failure had to potential to deprive Resident 2 of medical care. Findings: A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE]. A review of the facility census for 2/5/24, indicated Resident 2 was still a resident at the facility. During an interview and record review on 2/7/24, at 2:47 p.m., the Director of Nursing (DON) was asked for evidence Resident 2 had been seen by a physician at least every 60 days. The DON reviewed Resident 2's medical record, and stated there had been no documented physician visits since Resident 2 was admitted to hospice care on 5/16/23. The DON stated, once a resident became a hospice patient, the hospice provider, drives the resident's care, and is responsible for providing physician visits to the resident. The DON was asked for all the hospice records for Resident 2 since her admission to hospice on 5/16/23, including physician notes. The DON stated the facility did not have the hospice records for Resident 2, but would request them from the hospice provider. During an interview on 2/7/24, at 4 p.m., the DON stated she received by fax all the hospice records for Resident 2. The DON provided a fax from the hospice provider, 34 pages in length. A review of these records did not indicate physician visits for Resident 2 after 5/16/23.

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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 - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41333 Based on observation, interview and record review, the facility failed to post the daily direct care staffing schedule of the facility where it was visible and accessible to all residents, staff, and visitors daily for each shift. The daily staffing schedule did not have all the necessary information: The census (number of residents in the facility) in the beginning of the shift, the number of nursing personnel responsible for providing direct care to residents, the actual time worked during that shift for each category and type of nursing staff and total number of licensed and non-licensed staff working for the posted shift. This failure had the potential to result in poor and inadequate care that compromised the health and safety of residents. Findings: During a concurrent observation and interview on 2/7/24 at 9:50 a.m. the daily staffing schedule for licensed and un-licensed nurses was not visible and accessible to the view of the staff and visitors. When asked where the daily staffing scheduled was posted, the Unit Manager (UM) stated the daily staffing schedule was inserted in the binder located in the rack inside the Nurses' Station. The UM stated the daily schedule for CNAs was taped inside the Nurses' Station counter. The UM stated the schedule was not visible to the residents and visitors, only visible to CNAs and other staff. During a concurrent observation and interview on 2/8/24 at 11 a.m. When asked whether the format of the daily staffing schedule, for licensed and un-licensed nurses, was new or derived from the previous owner of the facility, the Assistant Director of Nursing (ADON) stated she believed it was the old format derived from the previous owner. The ADON stated it had been the same daily schedule the current facility used since the beginning of the new ownership. During a concurrent observation and interview on 2/8/24 at 11:30 a.m., the Director of Nursing (DON) stated the daily staffing schedule was kept inside the binder located in the rack inside the Nursing Station. A review of the daily staffing schedule for the licensed and un-licensed nurses indicated, the name of facility, date, hours of assigned shift, name of licensed and un-licensed nurses and hallway and room assignments. The daily staffing schedule did not have the daily census, the completed hours of direct care provided by each license and un-licensed nurse, total number of licensed & un-licensed nurses who provided care to residents. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of the Policy & Procedure titled, Posting direct Care Daily Staffing Numbers, revised 7/2016, indicated, Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Under Policy Interpretation and Implementation, indicated, 3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include a. The name of the facility, b. The date for which the information is posted, c. The resident census at the beginning of the shift for which the information is posted, d. Twenty-four (24) shift schedule by the facility, e. The shift for which the information is posted, f. Type (RN, LPN, LVN or CNA) and category (licensed or non-licensed) of nursing staff working during the shift, g. The actual time worked during that shift for each category and type of nursing staff, h. Total number of licensed and non-licensed nursing staff working for the posted shift. #10. Direct-care staffing information will be reported quarterly to CMS through the IQIES Payroll-Based Journal electronic reporting system.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41333 Based on Interview and record review, the Consulting Pharmacist (PharmD) failed to perform the Medication Regimen Review (MRR) accurately and safely provide recommendations on antibiotic usage for two (2) residents, Residents 5 & 25, when: 1) The PharmD did not review Resident 5's medical record to review the duration of antibiotic treatment. 2) The PharmD reviewed the MRR but did not provide recommendations on antibiotic usage for Residents 5 & 25. The order did not have an end date and reason for antibiotic treatment. These failures had the potential to result in adverse reaction from a long-term use of antibiotics such as antibiotic resistance, abdominal discomfort and infectious diarrhea that could lead to severe illness and possible death. Findings: (1) Resident 5 A review of the, Order Summary, for Resident 5, dated 1/5/24, indicated, Doxycycline Hyclate oral tablet 100 mg. Give 1 tablet by mouth two times a day for Bulllous Phemphogoid. The order did not indicate the end date for evaluation for antibiotic effectiveness. A review of the Doctor's medication order prescribed to send to the Pharmacy dated 1/5/24 indicated Doxycycline Hyclate Oral tablet 100mg, give 1 tablet by mouth two times a day for Bullous Phemphigoid, Update start date, 1/5/24, End date, Indefinite. (2) Resident 25 A record review of Resident 25 titled, Order Summary Report, dated 12/11/23, indicated, Keflex (Cephalexin) (antibiotic) oral capsule 500mg give 1 capsule by mouth one time a day for Prophylactic for 6 months. This order did not have an indication of the antibiotic usage. During a record review for Resident 25's, Care Plan, initiated on 12/12/23, under, Focus indicated, Resident 25 was, On antibiotic therapy starting 12/11/23 for prophylaxis (prevention) for 6 months). Revision on 12/12/23. A record review for Resident 25's, Physician Order, in written format, dated 12/11/23, indicated, Keflex 500 mg (milligram) daily x 6 months. The Doctor did not indicate the reason for the antibiotic usage. The Doctor later added the reason for the antibiotic usage on the Physician Order, dated 2/8/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 2/28/24 at 2:14 p.m., the Pharmacist (PharmD) stated, in the medication order, the word, Indefinitely or STOP DATE PENDING, should not be used in antibiotics order. The PharmD stated the medication label or medication order must have a reason for the antibiotic usage. The PharmD stated, when there was a question with labeling of the medication, the License Nurse must notify the Doctor for clarification of the order. When asked what could be the potential outcome for long term use of Antibiotics without re-evaluation for effectiveness, the PharmD stated residents may develop an antibiotic resistance and could develop symptoms such as stomach upset, diarrhea (loose stool). PharmD stated the antibiotic order must have a monthly evaluation and must state the reason for using the antibiotic. During a concurrent telephone interview and record review on 2/28/24 at 2:20 p.m., the PharmD stated he reviewed the MRR, dated 1/31/24, for Resident 5's antibiotic usage but did not provide a recommendation. A review of the computer report of PharmD indicated, No Recommendation. When asked if he reviewed Resident 5's medical record to check of the duration of treatment, the PharmD stated, No. A review of the P&P titled, Medication utilization and Prescribing - Clinical Protocol, revised 4/2018, under Assessment and Recognition indicated, 1. When a medication is prescribed for any reason, the physician and staff will identify the indication (condition or problem for which it is being given, or what the medication is supposed to do or prevent), considering the resident's age, medical and psychiatric condition, risk, health status and existing medication regiment. Under cause & identification, 2. The physician and staff will evaluate the effectiveness and effects of the medications in a resident's regiment. 3. The physician will participate in the facility's antibiotic stewardship protocols including documentation of the clinical criteria for infection and laboratory reports of susceptibility, if necessary, when an antibiotic is ordered. 4. The consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medication regimens that are not supported based on clinical signs and symptoms. Under treatment/Management indicated, 2. The physician will provide and/or document a rationale when the indication, dose, duration or frequency of a prescribed medication. Under Monitoring, 1. The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to determine if the medication and doses are still relevant and are not causing undesired complications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 41333 Based on interview ad record review, the facility failed to ensure Residents 5 & 25 were free from unnecessary medications such as antibiotic usage, when: 1) The Doctor's order did not indicate an end date on prescribed Doxycycline (antibiotic) 100 mg 1 tablet daily as prophylaxis (prevention) for Resident 5. 2) The Doctor's order did not indicate the reason for the antibiotic usage for Resident 25. The Doctor prescribed Keflex (Cephalexin, generic name for antibiotic) 500 mg 2 x/ day for 6 months. A Urinalysis (Urine test for infection) was done on 12/1/23. The Urine culture & sensitivity (C&S) (test to check for germ & sensitivity to check which antibiotic was effective to treat germ) result, dated 12/1/23, indicated the bacteria causing the urine infection were sensitive to a list of antibiotics. The current antibiotic ordered to treat Resident 25's urine infection was not tested for Sensitivity. The urine C&S for Resident 25 was not repeated for re-evaluation. These failures had the potential to result in antibiotic resistance. Residents 5 & 25 may develop abdominal discomfort that could lead to infectious diarrhea, that may lead to severe illness and possible death. Findings: (1) Resident 5 A record review of Resident 5's, Admission Record, dated 2/6/23, indicated she had a medical condition named, Chronic Obstructive Pulmonary Disease, Bullous Phemphigoid (skin disease), pruritis (itchy skin), rash & other skin eruption. A review of the Medication label for Resident 5 indicated the Doctor's order, Doxycycline Hyclate 100mg, give 1 tablet by mouth two times a day for Bullous Phemphigoid (skin disease) STOP DATE PENDING. The label did not have an end date of antibiotic usage. A review of the, Order Summary, for Resident 5, dated 1/5/24, indicated, Doxycycline Hyclate oral tablet 100 mg. Give 1 tablet by mouth two times a day for Bullous Phemphogoid. The order did not indicate the end date. A review of the, Doctor's medication order, prescribed and sent to the Pharmacy, dated 1/5/24, indicated, Doxycycline Hyclate Oral tablet 100mg, give 1 tablet by mouth two times a day for Bullous Phemphigoid. Update start date, 1/5/24. End date, Indefinite. A review of the, Care Plan, for Resident 5, initiated on 1/9/24, indicated, [Resident 5] is on antibiotic therapy related to, Bullous Phemphigoid. Under Intervention, it did not indicate when to re-evaluate the effectiveness of the antibiotics. (1) Resident 25 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 25 titled, Admission Record, dated 12/1/23, indicated, acute cystitis (inflammation of the bladder) with hematuria (blood in the urine), retention of urine, chronic kidney disease. A record review of Resident 25's Baseline Interview of Mental status (BIMS), dated 1/26/24, indicated a score of 13, suggesting mild cognitive impairment. A record review of Resident 25 titled, Order Summary Report, dated 12/11/23, indicated, Keflex (Cephalexin) (antibiotic) oral capsule 500mg give 1 capsule by mouth one time a day for Prophylaxis (prevention) for 6 months. This order did not document an indication of the antibiotic usage. During a record review for Resident 25 titled, Care Plan, initiated on 12/12/23, under, Focus indicated, Resident 25 was, On antibiotic therapy starting 12/11/23 for prophylaxis (prevention) for 6 months). Revision on 12/12/23. A record review for Resident 25's, Physician Order in written format, dated 12/11/23, indicated, Keflex 500 mg (milligram) daily x 6 months. The Doctor did not indicate the reason for the antibiotic usage. The Doctor later added the reason for the antibiotic usage on the Physician Order, dated 2/8/24. During an interview on 2/7/24 at 3:30 p.m., in the Conference Room with Medical Director (MD) to discuss the expectations of antibiotic orders by the Doctor, the MD stated it was not acceptable to write an order of antibiotics without a stop date and the purpose for usage. The MD stated an order for antibiotics should have an ending date and re-evaluation after one month usage of antibiotics for effectiveness. When asked the potential outcome of long-term use of antibiotics without end date, the MD stated there was a potential for antibiotic resistance to the germ that caused the infection. The MD stated that License Nurse and Pharmacist should have verified the end date of the antibiotic usage and the purpose for usage. During an interview and record review on 2/7/24 at 4:14 p.m., in the Assistant Director of Nursing's (ADON's) office, the ADON reviewed the medication label for Doxycycline 100mg with, STOP END PENDING, for Resident 5. The ADON stated she agreed, STOP END PENDING, was not an acceptable order. The ADON stated the Infection Preventionist (IP) should have read this and handled this issue immediately. When asked what happened when there was a discrepancy with the medication label or medication order, the ADON answered Resident 5 could develop antibiotic resistance (antibiotic stopped working to destroy the germ). The ADON stated the LAN should have notified the Doctor to clarify the order of the medication and would notify the Pharmacy of the discrepancy of the medication label. A record review of Resident 25's, Laboratory result report, dated 12/1/23, indicated a urine C&S test was done. In the report, the Keflex (Cephalexin) antibiotic was not tested for sensitivity. The Urine C&S report did not indicate if Keflex was the choice of antibiotic to treat. During an interview on 2/8/24 at 11:05 a.m., with Assistant Director of Nursing (ADON) in her office, to request for the Urinalysis (UA) and C&S for Resident 25, the ADON stated a UA & C&S was not repeated or re-evaluated since 12/1/23. The ADON stated, We don't need to repeat the U/A C&S since [Resident 25] was on Antibiotics. When what would be the outcome of the long-term use of antibiotics, the ADON answered the resident could develop resistance to the antibiotics (antibiotic stopped working to treat the infection) and diarrhea.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interviews and record reviews, the facility failed to ensure: 1. food to be served for the residents was not stored in the staff refrigerator; 2. residents' food items were labeled with names and dated, and expired food items were discarded; and, 3. there was a safe way for residents to store their perishable food. These failures could lead to cross-contamination, and unsafe and unsanitary storage of food, and were also a safety risk that could lead to accidental ingestion of expired food items. Findings: During a concurrent observation and interview on [DATE] at 6:35 a.m., there was dough and a box of tater tots stored in the staff refrigerator/freezer. Cook 1 stated these items were not supposed to be there and should be stored at the refrigerator in the kitchen. Cook 1 stated the reason why food to be served for residents should not be stored in the staff refrigerator/freezer was because of risk for cross-contamination and risk of residents' getting sick. During an interview on [DATE] at 7:33 a.m., the Dietary Manager (DM) stated the tater tots and cookie dough in the staff refrigerator/freezer should not even be there due to risk for cross-contamination and infection, like diarrhea. The DM stated it put residents' safety at risk, and residents could get sick from cross-contamination. During an observation on [DATE] at 1:50 p.m., the staff refrigerator/freezer still contained the tater tots and cookie dough meant for residents' consumption. During an observation on [DATE] at 8:38 a.m., the resident's refrigerator, located in the Activity Room, was noted with these items: In the freezer, there was one cup of strawberry sorbet, four cups of orange sorbet, three cups of pineapple sorbet, one cup of peach sorbet. These sorbets did not have an identification on who they belonged to. There was no visible expiration date noted. There were unboxed popsicle bars with no identification and no visible expiration date. There were banana twin pops with no identification noted as well. In the residents' refrigerator, there was one cup of strawberry yogurt, with no resident identifier, with used-by date of [DATE]. During an interview on [DATE] at 8:52 a.m., the Activity Director (AD) stated the strawberry flavored yogurt should not be in the refrigerator and should be tossed because it was already expired. The AD stated, keeping expired food items in the refrigerator put residents at risk for ingesting expired food which could result in food poisoning and Gastrointestinal illness (GI, stomach bugs, any ailments linked to the digestive system, including the throat, stomach and intestines). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute Care	101 S Orchard Ave Vacaville, CA 95688

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:32 p.m., Unlicensed Staff E stated residents' food from outside sources were kept in the resident's refrigerator located at the Activity Room. Unlicensed Staff E stated residents' food should be labeled with name and with open and discard date. Unlicensed Staff E stated labeling the food with a resident name could prevent resident food being served to another resident. Unlicensed Staff E stated it was for safety purposes. Unlicensed Staff E stated expired food items should be discarded for safety. Unlicensed Staff E stated residents could get sick with food poisoning from expired food. Unlicensed Staff E stated food for residents' consumption should not be kept in the staff refrigerator due to risk of cross-contamination. When asked where would staff keep residents' food brought in by family or visitors until the resident was ready to consume it, Unlicensed Staff E stated the food would be kept in the residents' refrigerator in the Activity Room. Unlicensed Staff E was not aware that at this time, there was no refrigerator dedicated for residents' food. Unlicensed Staff E stated he would not know where to keep residents' food now that the refrigerator, meant to store residents' food from outside, was gone. During an interview on [DATE] at 3:02 p.m., Licensed Staff C stated, per policy, the facility accepted food brought in from outside. Licensed Staff C stated unconsumed residents' food from outside was kept in the residents' refrigerator located at the Activity room. Licensed Staff C stated residents' food, kept in the residents' refrigerator in the Activity Room, would have to be labeled with the resident's complete name and should have an open and discard date. Licensed Staff C stated food would be discarded after three days. Licensed staff C stated it was important to put a date on when the resident food was opened and when to discard it because food grew bacteria. Licensed Staff C stated expired foods could cause GI bacterial infection like diarrhea (loose stool) and nausea (a feeling of sickness or discomfort in the stomach that may come with an urge to vomit) and vomiting. Licensed Staff C stated resident food should be labeled with name for safety and to prevent accidentally serving food not meant for that resident. Licensed Staff C stated food meant for residents' consumption should not be kept in the staff refrigerator due to risk of cross-contamination and risk of residents getting sick with GI illness. Unlicensed Staff C was not aware at this time, there was no refrigerator dedicated for residents' food coming from the outside. Licensed Staff C stated she would not know where to keep residents' food now that the refrigerator, meant to store residents' perishable food from the outside, was gone. During an interview on [DATE] at 7:55 a.m., Licensed Staff F stated it was the facility's policy to accept food for residents which was brought in by visitors or loved ones. Licensed Staff F stated, prior to keeping the food in the refrigerator in the Activity Room, the food had to be labeled with the resident's name and should have a date on it indicating when it was brought in and the discard date. Licensed Staff F stated labeling the food with resident name and dating the food should be done for safety purposes. Licensed Staff F stated they would not want feed a resident's food to another resident, for disease prevention and for safety purposes because of risk for allergies and choking hazards. Licensed staff F stated food meant for residents' consumption should not be stored in the staff refrigerator because of risk for cross-contamination. Licensed Staff F was not aware the residents' refrigerator in the Activity Room was now gone. When asked where staff would keep a resident's perishable food brought in by family or visitors, until the resident was ready to consume it, Licensed Staff F did not respond. Licensed Staff F stated it would be good if the facility had informed staff on what the plan would be in case a resident wanted to keep food in the refrigerator. Licensed Staff F stated it was a resident's right to get the food they wanted. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:28 p.m., the Registered Dietician (RD) stated residents were allowed to receive food from outside brought in by family or visitors. The RD stated residents' food brought in from outside should be clearly labeled with the resident's name and should be dated. The RD stated it was important to clearly label food brought in for a resident to ensure the right resident was receiving the food brought for them. The RD stated it was for safety purposes. The RD stated, food meant for residents' consumption should not be kept in the staff refrigerator due to risk of cross-contamination, for sanitary purposes and risk for bacterial growth and food-borne illnesses. The RD stated she asked the DM to throw away the tater tots and the cookie dough in the staff refrigerator. During an interview on [DATE] at 4:48 p.m., Licensed Staff D stated residents were allowed to receive food from outside and the facility policy allowed the facility to keep residents' food in the resident's refrigerator until they were ready to consume it. Licensed Staff D stated the food should be labeled with the resident's name and should have an open and discard date. Licensed Staff D stated these were in place for residents' safety. Licensed Staff D stated, not clearly labeling the food with the resident's name could result in accidentally serving the food to another resident and could result in an allergic reaction and choking hazard. Licensed Staff D was not aware the residents' refrigerator, located in the Activity Room, was now gone. When asked where staff would keep a resident's perishable food brought in by family or visitors until the resident was ready to consume it, Licensed Staff D responded she did not know. Licensed Staff D stated, food meant for resident's consumption should not be kept in the staff refrigerator for risk of cross-contamination and to prevent infection. During an interview on [DATE] at 8:32 a.m., Unlicensed Staff G stated it was the facility's policy to accept food for residents brought in by family or visitors. Unlicensed Staff G stated food brought in from outside should be labeled with the resident's name, not just initials and should have the opened and discard dated, before being stored in the resident's refrigerator located in the Activity Room. Unlicensed Staff G stated, food in the resident's refrigerator were tossed in two to three days. Unlicensed Staff G stated the facility's policy was not followed if food items were not clearly labeled and dated. Unlicensed Staff G stated it was for residents' safety to prevent food poisoning. Unlicensed Staff G stated, not labeling the food with the resident's name had a risk of serving the food to another resident, which could be a safety issue, as a resident could be allergic to the food or could choke. During an interview on [DATE] at 8:56 a.m., the Assistant Director of Nursing (ADON) stated per policy, the facility accepted food for residents brought in by family or visitors. The ADON stated the food should be labeled with the resident's name, not just initials and should be open-dated before being stored in the resident's refrigerator. The ADON stated, if not properly labeled and dated, residents would be at risk for consuming food that was not theirs or not within the date range. The ADON verified the facility got rid of the resident's refrigerator in the Activity Room, and the facility did not have a refrigerator dedicated for residents' food at this time. When asked where staff would keep a resident's perishable food brought in by family or visitors until the resident was ready to consume it, the ADON stated they would refuse to keep the food until the facility had an appropriate means to safely keep the food for them. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:33 a.m., the Social Services Director (SSD) stated the facility had been accommodating residents' food from outside, per facility policy. The SSD did not know the facility did not have a refrigerator to store residents' food which needed to be refrigerated. The SSD stated she would not know where to keep a resident's left-over food if a resident asked her to keep it in the residents' refrigerator. The SSD stated this could result in a negative outcome like inconvenience for the residents and not being able to meet their needs. During an interview on [DATE] at 9:39 a.m., the Activity Director (AD) stated the facility got rid of the refrigerator used to store residents' food. The AD stated it would now be three or four days residents did not have a dedicated refrigerator for their food brought in by their family or visitors. The AD stated the facility had no solid plan on where to keep residents' perishable food if needed. The AD stated, maybe the facility could use the staff refrigerator in the staff lounge. When asked what the risk could be if resident's food were stored in staff refrigerator, the AD did not respond. The AD stated, not having a refrigerator dedicated for resident's food could result in residents feeling [NAME], not happy. The AD stated the facility needed a better plan to safely keep residents' food brought in by family or visitors. During an interview on [DATE] at 10:01 a.m., the Director of Nursing (DON) stated the facility accepted food for residents coming from family or visitors. The DON stated, if residents' food was to be kept in the designated residents' refrigerator, the food should be labeled with the resident's name not initials, and it had to be open-dated. The DON stated it was for residents' safety. The DON stated labeling the food item with the resident's name decreased the risk of the food being consumed by another resident, which could result in allergies and choking hazard. The DON stated, dating the food kept residents from ingesting food which was already spoiled or expired. The DON stated she was not initially aware the facility got rid of the residents' refrigerator. The DON stated she found out about it when a staff member asked her where they would put residents' food that needed to be refrigerated. The DON stated the plan was to no longer allow residents to store food in the refrigerator. When asked if the facility policy was followed when they refused to keep residents' food in the refrigerator, the DON stated, No. The DON stated the facility would have to change the policy. When asked what was the potential outcome of not allowing residents to store their food in the refrigerator, the DON stated residents' mental and social well being would be at risk, and changes in a resident routine could be disruptive. The DON stated the facility strived to make this place a homelike environment. A review of the facility's policy and procedure (P & P) titled, Food Brought by Family or Visitors, revised , d+[DATE], the P & P indicated, Food brought to the facility by visitors and family is permitted .perishable food must be stored in resealable containers with tightly fitting lids in a refrigerator .containers will be labeled with the residents name, the item and the use by date .the nursing staff will discard perishable food on or before the use by date.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on interview and record review, the facility failed to ensure the medical record of one of two residents (Resident 2) was complete and readily accessible. This failure resulted in Resident 2 having an incomplete medical record. Findings: A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE]. A review of the facility census for 2/5/24, indicated Resident 2 was still a resident at the facility. During an interview and record review on 2/7/24, at 2:47 p.m., the Director of Nursing (DON) was asked for Physician Progress Notes for Resident 2. The DON reviewed Resident 2's medical record, and stated there had been no documented physician visits since Resident 2 was admitted to hospice care on 5/16/23. The DON stated, once a resident became a hospice patient, the hospice provider, drives the resident's care, and is responsible for providing physician visits to the resident. The DON was asked for all the hospice records for Resident 2 since her admission to hospice on 5/16/23, including physician notes. The DON stated the facility did not have the hospice records for Resident 2, but would request them from the hospice provider. During an interview on 2/7/24, at 4 p.m., the DON stated she received by fax all the hospice records for Resident 2. The DON provided a fax from the hospice provider, 34 pages in length, containing Resident 2's hospice records.

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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. 37797 Based on interview and record review, the facility failed to ensure binding arbitration agreements were explained to residents in a language and form they understood, and the residents acknowledged they understood the arbitration agreement, for one of three residents (Resident 94). This failure resulted in Resident 94 signing a document they did not understand. Findings: During an interview on 2/5/24, at 1 p.m., Administrator II stated the facility offered arbitration agreements to residents (an agreement where the resident and the facility give up the right to sue before a court and instead agree to bring disputes to private arbitrators). The Administrator stated the staff responsible for arbitration agreements was the Director of Admissions. During an interview on 2/7/24, at 4:01 p.m., the Director of Admissions (DA) stated she was responsible for arbitration agreements at the facility. The DA stated arbitration agreements were offered to all residents upon admission. The DA was asked to provide copies of arbitration agreements signed by three sampled residents: Resident 92, 93 and 94. A review of the arbitration agreements provided indicated Resident 94's Responsible Party (RP) signed the arbitration agreement on 2/5/24. During an interview on 2/8/24, at 11 a.m., Resident 94's RP stated she signed all admission papers for Resident 94. The RP was asked if she remembered signing an arbitration agreement on the day of Resident 94's admission, on 2/5/24. The RP stated she signed a lot of forms when Resident 94 was admitted but did not know if she signed an arbitration agreement. The RP was asked if she knew what an arbitration agreement was. The RP stated she did not. When explained that parties who sign arbitration agreements give up the right to sue in court and agree to submit disputes to private arbitrators, the RP stated she would not have signed the arbitration agreement if she knew what it meant.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41333 Based on interview and record review, the facility failed to electronically submit to the Federal Agency (CMS) the staffing information on payroll-based journal (PBJ) data for the month of September, October, November, December 2023, and January 2024. This failure had the potential to result in an inaccuracy of numbers of Licensed Nurses and Unlicensed Nurses to provide care to residents to promote health and safety. Findings: During an interview on 02/08/24, at 4 p.m., in the Administrator's office with the Administrator, ADM & Office Manager (OM), regarding Payroll based Journal (PBJ) reporting, the OM stated he could not report the PBJ to the Federal Agency because he had no access to submit electronically. The OM stated the facility was still operating under the previous owner's provider number, therefore he did not have access to the computer for PBJ data submission. The ADM stated the reason they did not have their own provider number was because the Change of Ownership (CHOW) was pending process of approval. The ADM stated that was the reason why they could not access the computer to submit the PBJ electronically. The OM stated the CHOW was still pending. A review of Health & Safety code indicated: S483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. S483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS). (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interview and record review, the facility failed to ensure: 1) hand hygiene (HH, a way of cleaning one's hands that substantially reduces potential pathogens (harmful microorganisms) on the hands) were offered/provided for six out of six sampled residents (Residents 6, 12, 13, 24, 198 and 93) before and after meals; 2) residents valuables were not kept in the medication carts mixed with residents' medications; 3) laundry staff used aprons or gowns during handling of clean resident laundry to prevent contamination; and, 4) the facility had a detailed description and diagram of the water system in the facility and identification of areas in the water system that could encourage the growth and spread of Legionella (a bacteria found if water that can lead to infections). These failures placed residents at risk of infections. Findings: 1) During an observation on 2/6/24 at 7:07 a.m., Resident 93 started eating his breakfast with no HH offered/provided by staff. During an observation on 2/6/24 at 7:08 a.m., Resident 13 was being assisted by Unlicensed Staff and started eating her breakfast with no HH provided by staff. During an observation on 2/6/24 at 7:09 a.m., Resident 12 was being assisted by Unlicensed Staff K. Unlicensed Staff K did not offer HH to the Resident 12 prior to eating her breakfast. During an observation on 2/6/24 at 7:10 a.m., Unlicensed Staff AL did not offer HH to Resident 24 prior to feeding her breakfast. Resident 24's fingernails on both hands were long. Resident 24 had black colored material under her fingernails. During an observation on 2/6/24 7:15 a.m., Resident 93 was being assisted by Unlicensed Staff AL. Unlicensed Staff AL did not offer HH to Resident 93 prior to eating his breakfast. During an observation on 2/6/24 at 7:50 a.m., there was no HH offered or provided to Resident 6 prior to eating her breakfast. During an interview on 2/6/24 at 8:10 a.m., Resident 6 stated staff did not perform or offer her HH prior to eating her breakfast. During an interview on 2/6/24 at 3:04 p.m., Resident 198 stated staff did not offer/perform HH to residents before and after meals. Resident 198 stated he would like it if staff offered him HH prior to and after meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/8/24, at 2 p.m., the IP stated residents should be offered hand hygiene before and after meals. During an interview on 2/8/24 at 2:28 p.m., Unlicensed Staff E stated staff should offer or perform HH to residents before and after meals. Unlicensed Staff E stated the facility's hand-washing policy was not followed if staff did not offer HH to residents before and after meals. Unlicensed Staff E stated HH was important for cleanliness, to prevent cross-contamination and for infection control. Unlicensed Staff E stated, not offering/performing HH on residents before and after meals could result in gastrointestinal infection (GI, digestive infection caused by bacteria), and residents could get sick. During an interview on 2/8/24 at 2:59 p.m., Licensed Staff C stated HH should be offered/performed for residents before and after meals. Licensed Staff C stated the Hand-washing policy was not followed if staff did not offer/perform HH for residents before and after meals. Licensed Staff C stated HH reduced risk of GI infection and cross-contamination. Licensed Staff C stated HH reduced the risk of sickness or disease. During an interview on 2/8/24 at 3:25 p.m., the Registered Dietician (RD) stated staff should offer/perform HH to the residents before and after meals. The RD stated HH was important to make sure there was no contamination and no transfer of germs from something the resident touched. The RD stated HH reduced the risk for food-borne illness like norovirus (group of viruses that causes severe emesis (vomiting) and diarrhea). During an interview on 2/9/24 at 7:51 a.m., Licensed Staff F stated it was expected for staff to offer/perform HH for the residents before and after meals. Licensed Staff F stated HH was important for residents' safety. Licensed Staff F stated HH could prevent the spread of microorganisms or diseases like Clostridium Difficile infection (C-diff, a bacterium (germ) that causes diarrhea and colitis (an inflammation of the colon). During an interview on 2/9/24 at 10:17 a.m., the Director of Nursing (DON) stated it was the facility's policy to offer/perform HH for the residents before and after meals. The DON stated if this was not being done, the facility hand-washing policy was not followed. The DON stated, staff not offering/performing HH for the residents before and after meals was an infection control issue and could result in GI illness and norovirus. A review of the facility's policy and procedure (P & P) titled, Handwashing/Hand Hygiene, revised 8/2015, the P & P indicated: The facility considered hand hygiene as the primary means to prevent the spread of infection .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents or visitors use an alcohol based hand rub or alternatively soap and water before and after eating or handling food. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) A review of Resident 41's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (excess of lipids or fats in the blood), Anxiety disorder (A condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and Chronic Obstructive Pulmonary Disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems). His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 10/23/23, indicated he needed supervision when performing his Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). During a Nursing Progress Note record review, dated 12/15/2023 1:14 a.m., it indicated Resident 41 had a watch on at the time of death. The Nursing Progress Note also indicated the watch was removed and locked in the medication cart until Resident 41's family could pick it up. During a concurrent observation and interview on 2/8/24 at 9:47 a.m., Licensed Staff B stated staff would keep residents' valuables in the medication cart, specifically the narcotic drawer if needed. Licensed Staff B opened Medication Cart A's narcotic drawer and showed reading glasses belonging to Resident 26. When asked if there should be residents' valuables/belongings mixed with residents' medications in the medication cart, Licensed Staff B stated, No. When asked why, Licensed Staff B stated it was for infection control and to prevent risk of cross-contamination. During an interview on 2/8/24 at 9:55 a.m., Licensed Staff M stated he was not aware of the facility's policy on where to keep residents' valuables if needed. Licensed Staff M stated nurses would just put residents' valuables in the medication cart, if needed for safekeeping. When asked if there should be residents valuables/belongings mixed with residents' medications in the medication cart, Licensed Staff M stated, No. When asked what was the risk of keeping residents' valuables in the medication cart mixed with residents' medications, Licensed Staff M stated it was an infection control issue and risk for cross-contamination. During an interview on 2/8/24 at 10:13 a.m., when asked where staff kept residents' valuables, if needed for safekeeping, Licensed Staff N stated they would keep it in the narcotic box for safe keeping. Licensed Staff N stated sometimes staff would also keep residents' hearing aids in the medication cart. When asked if there should be residents' valuables/belongings mixed with residents' medications in the medication cart, Licensed Staff N stated, No. When asked what should be kept in the medication cart, Licensed Staff N stated, residents' medication only. During a concurrent observation and interview on 2/8/24 at 10:16 a.m., Licensed Staff O's medication cart had a yellow-tinged bracelet in the narcotic box. Licensed Staff O stated she did not know whom it belonged to. Licensed Staff O stated the yellow-tinged bracelet in the narcotic box was probably there longer than she had been at the facility. When asked where staff would put residents' valuables for safe keeping, Licensed Staff O stated they would keep them in the narcotic box. When asked what the risk was if a residents' valuable was kept in the medication cart mixed with residents' active medications, Licensed Staff O stated residents could get sick. Licensed Staff O stated it was a potential for cross-contamination and was an infection control issue. During an interview on 2/8/24, at 2 p.m., the IP stated, storing residents' personal property in the medication carts posed a risk of infection for the residents. The IP stated, any resident personal property stored in the medication carts should be contained by a bag. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055412	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute Care	101 S Orchard Ave Vacaville, CA 95688

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 2/8/24 at 2:13 p.m., the Pharmacist stated it was not appropriate to have residents' valuables mixed with residents' medications. The Pharmacist stated this was an infection control issue. During an interview on 2/9/24 at 9:24 a.m., the Assistant Director of Nursing (ADON) stated staff were not allowed to put residents' valuables in the medication cart. The ADON stated, putting residents' valuables in the medication cart along with residents' medications was an infection control issue and a risk for contamination. During an interview on 2/9/24 at 10:46 a.m., the Director of nursing (DON) stated staff were keeping residents' valuables in the medication cart but that was not acceptable. When asked what the risk was if residents' valuables were kept in the medication cart mixed with residents' active medications, the DON stated it was a risk for contamination and an infection control issue. The facility's policy and procedure specific for keeping residents' valuables for safekeeping was requested but not provided. 37797 3) During an observation of the laundry area on 2/8/24, at 1:45 p.m., Laundry Staff Q was folding linen in the clean section of the laundry without wearing a gown or a protection over his clothing, while the clean linen touched his clothing. During a concurrent interview, Laundry Staff Q sated he was folding clean resident linen. During an interview on 2/09/24, at 9:21 a.m., the IP stated laundry staff should wear gowns or aprons when folding residents' clean linen, to prevent contamination of the linen from staff clothing. 4) During an interview on 2/8/24, at 2 p.m., Licensed Nurse P stated she was the facility's full-time Infection Preventionist (IP). The IP stated she was responsible for infection prevention and control at the facility. The IP was asked if the facility had a water management program. The IP stated the Administrator was responsible for it. During an interview on 2/9/24, at 11 a.m., Administrator II was asked about the water management program. He stated water was tested annually for Legionella. Administrator II was asked if the facility had a detailed description and diagram of the water system in the facility, and identification of areas in the water system which could encourage the growth and spread of Legionella. The Administrator II stated, No, the facility did not have it. A review of facility policy and procedure titled, Legionella Water Management Program, Revised July 2017, indicated: The water management program includes the following elements: . b) A detailed description and diagram of the water system in the facility . c) the identification of areas in the water system that could encourage the growth and spread of Legionella and other waterborne bacteria .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 37797 Based on interview and record review, the facility failed to maintain a system to monitor and track antibiotic use, when the facility did not maintain an updated surveillance log of residents receiving antibiotics. This failure placed residents at risk of receiving antibiotics for longer than needed and developing antibiotic resistant organisms. Findings: During an interview and record review on 2/8/24, at 2 p.m., Licensed Nurse P stated she was the facility's full-time Infection Preventionist (IP). The IP stated she was responsible for infection prevention and control at the facility, including the Antibiotic Stewardship Program. The IP was asked how many residents were receiving antibiotics. The IP stated there were currently eight residents receiving antibiotics at the facility. The IP was asked if the facility kept a spreadsheet or a database of residents receiving antibiotics. The IP stated, Yes, and provided spreadsheet titled, Infection Prevention and Control Surveillance Log (The Surveillance Log), dated February 2024. A review of this spreadsheet indicated a column for the names of residents receiving antibiotics followed by dozens of fields for data about their infection(s), signs/symptoms, laboratory tests, treatments, antibiotics and other information. A further review of the Surveillance Log for February 2024, revealed it contained data for only one resident. The IP was asked if this was the most current Surveillance Log and stated, Yes. The IP confirmed the Surveillance Log was incomplete and had not been updated with the information and data of all residents receiving antibiotics. A review of facility policy titled: Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, Revised December 2016, indicated: Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a) Resident name and medical record number; b) unit and room number; (c) date symptoms appeared; d) name of antibiotic; e) start date of antibiotic; f) pathogen identified; g) site of infection; h) date of culture; i) stop date; j) total days of therapy; k) outcome; and l) adverse events. 41333

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 37797 Based on interview and record review, the facility (1) failed to ensure three of five sampled residents (Residents 13, 30 and 34) were offered and provided COVID-19 vaccines; (2) failed to maintain documentation staff were provided education regarding the benefits and risks of COVID-19 vaccines and were offered the COVID-19 vaccine; and, (3) failed to develop and maintain current COVID-19 policies and procedures. These failures placed residents at risk of COVID-19. Findings: During an interview and record review on 2/8/24, at 2 p.m., Licensed Nurse P stated she was the facility's full-time Infection Preventionist (IP). The IP stated she was responsible for infection prevention and control at the facility, including COVID-19. During a review of the immunization records of five sampled residents, the IP stated Resident 13 had not received the latest COVID-19 booster, which the IP stated had been released in September 2023. The IP stated Resident 13 was offered the booster but could not find any documentation of it in his clinical record or documentation Resident 13 declined the booster. During the same review, the IP stated Resident 34 had consented to the latest COVID-19 booster on 1/3/24, but had not received it yet because the facility had not ordered the booster. The IP then ordered the booster for Resident 34. During the same review, the IP stated Resident 30 had not received the latest COVID-19 booster. The IP stated there was no documentation in Resident 30's clinical record that he was offered or refused the booster. During the same interview on 2/8/24, at 2 p.m., the IP was asked for documentation COVID-19 vaccines and education about the vaccines were offered to staff. The IP stated regulations no longer required healthcare staff to be vaccinated for COVID-19. The IP further stated all staff were offered education and COVID-19 vaccines, but there was no documentation of it. During the same interview on 2/8/24, at 2 p.m., the IP was asked for the facility's Policies and Procedures on COVID-19. The IP provided a document titled, COVID-19 MITIGATION PLAN, dated 6/1/20. A review of this policy indicated no updates or revisions since 6/1/20.