STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055563	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Maria Post Acute	820 W Cook St Santa Maria, CA 93458

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 48668 Based on interview and record review, the facility failed to ensure there was an informed consent for the use of medication Xanax (drug that helps to control anxiety and panic attacks) in one of two sampled residents (Resident 44). This failure had the potential for Resident 44 to be on Xanax without being informed of the risk and benefits of the drug. Findings: During a concurrent interview and record review on 11/20/24 at 3:35 p.m. with the director of nursing (DON), Resident 44's physician's order was reviewed. The order indicated, Xanax Oral tablet 0.25 mg (milligram) 1 tablet every 8 hours if needed for anxiety and panic. There was no informed consent found for the use of Xanax indicating resident or representative was educated on the risk and benefits of the medication. DON was unable to locate a consent for the Xanax in Resident 44's chart. During a review of the facility's policy and procedures (P&P) titled, Informed Consent-Psychotherapeutic Medications and Restraint Devices, (undated), the P&P indicated in part, The healthcare practitioner ordering a psychotherapeutic medication is responsible for obtaining informed consent and providing documentation that informed consent was obtained.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50657 Based on observation, interview, and record review, the facility failed to have the most recent recertification survey results available to residents, family members and legal representatives of residents. This facility failure denied the opportunity for residents, family members, and legal representatives of residents to be aware of the facility's survey results. Findings: During an observation on 11/18/24 at 2:40 p.m. at the entrance check-in counter, the survey binder was inspected. The survey binder was missing the recertification survey results and plan of correction from the most recent recertification survey held 8/15/22 - 8/18/22. During an interview on 11/19/24 at 11:45 a.m. with the director of nursing (DON), the DON confirmed the most recent survey results inside the binder was dated July 2021. The DON was unaware a recertification survey had been conducted August 2022 and stated, It was? I will look into it and get back to you. During an interview on 11/19/24 at 12 p.m. with the administrator (ADM), the ADM stated the results of the last recertification survey from August 2022 was in his office and not in the survey binder at the check-in counter. During a review of the facility's policy and procedure (P&P) titled, Examination of Survey Results, dated April 2007, the P&P indicated, A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50707 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of four sampled residents (Residents 44 and 17) when: 1. No care plan was developed for Resident 44 for the use of the medication Xanax (medication that helps control anxiety and panic attacks). 2. No care plan was developed for Resident 17 for the use of the anticoagulant medication Apixaban (a medication that helps prevent blood clots). These failures had the potential to result in misidentifying potential unneccessary use and abnormal bleeding complications for these residents. Findings: 1. During a concurrent interview and record review on 11/20/24 at 3:50 p.m. with the Director of Nursing (DON), Resident 44's Plan of Care was reviewed and there was no care plan addressing behavior monitoring and continuous use of Xanax found in the record. DON acknowledged there was no care plan regarding the use of the medication Xanax. 2. During a review of Resident 17's Admission Record (AR), the AR indicated, Resident 17 is a [AGE] year old female with diagnosis including, anemia (a condition where the body does not have enough healthy red blood cells) and atrial fibrillation (irregular heart rhythm). During a concurrent interview and record review on 11/20/24 at 10:19 a.m. with the DON, Resident 17's electronic clinical record was reviewed. Review of Resident 17's Order Summary Report (OSR), dated 11/2024, the OSR indicated, a physician order for the medication Apixaban oral tablet 5mg two times a day for anticoagulation. Further review of Resident 17's clinical record failed to indicate that a care plan was developed for the resident's use of this medication. The DON was unable to locate and produce a documented care plan for the resident's use of the said medication and stated, There should be a care plan and there isn't. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated in part, The interdisciplinary team (IDT - a group of healthcare professionals with various expertise who work together toward the goal of their patients), in conjunction with the resident and his/her family or legal representative, develops, and implements a comprehensive, person-centered care plan for each resident . 7. The comprehensive, person-centered care plan: . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, interview, and record review, the facility failed to ensure the timely revision/update of a comprehensive care plan for one of four sampled residents (Resident 12), to reflect changes in Resident 12's choices and change in condition. This failure resulted in an inaccurate care plan and had the potential to result in placing the resident at risk of not receiving the appropriate care. Findings: During an observation on 11/18/24 at 4:04 p.m. in room [ROOM NUMBER]-2, Resident 12 was observed in bed with a foot cradle (a frame attached to the foot of the bed to keep sheets and blankets away from feet and legs for pressure relief). Resident 12's feet were observed positioned on opposite sides of the pillow instead of above the pillow (used to off load feet to prevent pressure ulcer(s) from developing in the heel(s)), with a very pronounced foot drop (difficulty in lifting the front part of the foot). The foot board distance to the soles of the feet was approximately one (1) foot (12 inches). During an interview on 11/18/24 at 4:23 p.m. with the restorative nurse aide (RNA), in room [ROOM NUMBER]-2, RNA stated Resident 12 had an order for bilateral lower extremities splinting, but the resident is non-compliant. Resident 12 takes the bilateral splints off and throws them on the floor. RNA verbalized only the Rehab Director was notified about Resident 12's non-compliance verbally and not the licensed nurses. RNA further verbalized there was no documentation regarding Resident 12's refusal/non-compliance. RNA added documentation is entered electronically and there was no option to type a narrative in the electronic charting, only checkmarks. During an interview on 11/18/24 at 4:25 p.m. with the rehab director (ReD), ReD stated Resident 12 has been discharged from rehab and is on the RNA program and nursing is responsible for care planning for any changes. ReD further stated Resident 12's non-compliance was reported to him by the RNA, but he did not report the information to anyone else. During a concurrent interview and record review on 11/21/24 at 8:55 a.m. with the MDS nurse, Resident 12's Physician Orders and care plans were reviewed. The MDS nurse confirmed off-loading Resident 12's bilateral heels was not in the physician orders or on the resident's care plans. MDS nurse stated it should have been in the care plan and updated as needed. Resident 12's refusal/non-compliance to wear the bilateral splints and foot drop were not documented/care planned. The foot drop was not in the change of condition documentation. The MDS nurse said that a foot drop is a change of condition and should have been documented. During a record review of Resident 12's task titled, RESTORATIVE: Bilateral splints ankle/foot. Monitor skin for signs of edema, infection, wounds. Resident 12 was to receive 30 minutes of restorative nursing assistant (RNA) therapy. Review of Resident 12's tasks indicated on the following dates the resident received: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/23/24 - 15 minutes 10/25/24 - no RNA therapy 10/28/24 - 15 minutes 10/30/24 - no RNA therapy 11/6/24 - no RNA therapy 11/13/24 - 15 minutes 11/15/24 - 15 minutes 11/18/24 - 5 minutes. There was no documentation as to why Resident 12 did not receive the ordered 30 minutes of RNA therapy or resident's refusal/non-compliance. During a review of Resident 12's Care Plan, dated 4/24/24 and revised 11/18/24, the Care Plan indicated, Resident able to tolerate Bilateral ankle foot splint 2-3 hours or as tolerated by patient. For contracture management. pt (patient) often resistant to wearing. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident and Policy Interpretation and Implementation: #3) The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, interview, and record review, the facility failed to ensure staff followed professional standards to provide quality care for three of seven sampled residents (Residents 403, 50, and 34) when: 1. A medication for Resident 403 was not administered per doctors' order. 2. A physician order was not carried out for Resident 50. 3. Post dialysis (treatment for kidney failure where blood is cleaned through an artificial filter) assessments were not completed for Resident 34. These failures had the potential to inappropriately identify and manage resident's health issues that may lead to serious harm. Findings: 1. During a review of Resident 403's Medication Orders, 11/19/24 the Orders indicated, an order for Furosemide (a medication that increases amount of urine output, helping the body eliminate accumulated/excess fluids) Oral Tablet 20 mg. (milligram). Give one tablet by mouth two times (9 a.m. and 9 p.m.) a day for CHF (Congestive Heart Failure - a long term condition that happens when the heart cannot pump blood well enough to normally supply the body. Blood and fluids accumulate in the lungs and legs over time.) During a review of Resident 403's Medication Administration Record (MAR), for November 2024, the MAR indicated, Furosemide Oral Tabled 20 mg was administered as follows: 11/18/24 at 10:44 a.m. by LN 3 - 1 hour, 44 minutes late. 11/19/24 at 00:21 a.m. by LN 4 - 3 hours, 21 minutes late. 11/17/24 at 1:44 p.m. by LN 5 - 4 hours, 44 minutes late. 11/16/24 at 2:20 p.m. by LN 5 - 5 hours, 20 minutes late. 11/14/24 at 10:32 a.m. by LN 6- 1 hour, 32 minutes late. 11/13/24 at 10:10 p.m. by LN 7- 1 hour , 10 minutes late. 11/10/24 at 10:14 p.m. by LN 6 - 1 hour, 14 minutes late. 11/09/24 at 10:30 p.m. by LN 6 - 1 hour, 30 minutes late. 11/09/24 at 11:51 a.m. by LN 8 - 2 hours, 51 minutes late. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/08/24 at 10:13 a.m. by LN 6 - 1 hour, 13 minutes late. 11/06/24 at 10:14 a.m. by LN 6 - 1 hour, 14 minutes late. 11/05/24 at 2:26 p.m. - 1 hour, 26 minutes late. There was no documentation as to why the medication was administered late on the above dates. During a concurrent interview and record review on 11/19/24 at 12:07 p.m. with the director of nursing (DON), Resident 403's MAR was reviewed. The DON concurred with the findings and stated, These are all registry nurses. During a review of the facility's policy and procedure (P&P) titled, IIA2: MEDICATION ADMINISTRATION - GENERAL GUIDELINES, the P&P indicated, Part B. Administration ii) Medications are administered in accordance with written orders of the attending physician . x) Medications are administered within (60 minutes) before or after the scheduled time . According to the National Library of Medicine, authored by [NAME] and [NAME] M. [NAME], dated 9/4/23, 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms. 50657 2. According to [NAME] and Perry's, Fundamentals of Nursing, eighth edition, on page 336, Nurses follow physicians' orders unless they believe the orders are in error or harm clients. During a review of Resident 50's, Admission Record (AR), dated 11/21/24, the AR indicated, Resident 50 was admitted on [DATE] with diagnoses including, Hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time), chronic kidney disease (a condition where the kidneys are damaged and can't filter blood properly), Type 2 diabetes mellitus (a chronic disease that occurs when your body doesn't produce enough insulin or doesn't use insulin properly), resulting in high blood sugar levels: Chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe and worsen over time), Vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), and Post COVID-19 condition. During a review of Resident 50's Order Recap Report (ORR - facility's communication tool regarding physician orders and communication method), dated 08/30/24, the ORR indicated, CBC (complete blood count - a blood test used to measure the amount and types of cells in the blood, including red blood cells, white blood cells, and platelets to help identify and monitor conditions like anemia and infection) & CMP (comprehensive metabolic panel - a blood test to measure various substances in the blood, including blood sugar, electrolytes, and proteins, to assess overall metabolic health) one time only for swollen abdomen with left upper quadrant rebound tenderness for 1 day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/21/24 at 9:15 a.m., with the minimum data set coordinator (MDS), MDS acknowledged that the ORR indicated a verbal physician order was received on 08/30/24 for a CBC and CMP lab tests for Resident 50. MDS looked through Resident 50's paper chart and was unable to locate any lab results for the ordered tests. During a concurrent interview and record review with licensed nurse (LN 1) on 11/21/24 at 9:27 a.m., LN 1 acknowledged she received a verbal order from the physician for a CBC and CMP for Resident 50. LN 1 reviewed the lab log binder but was unable to locate a copy of the completed laboratory requisition. LN 1 called the two laboratories used by the facility and neither laboratory had test results for Resident 50 collected on 8/30/24. LN 1 stated there were no lab results for Resident 50 for 8/30/24. 50707 3. During a review of Resident 34's Clinical Record (CR), dated 11/20/24, the CR indicated in part, Resident 34 was a [AGE] year-old female with diagnoses including, end stage renal disease (a condition where the kidney reaches advanced state of loss of function, dependence on renal dialysis, essential primary hypertension (high blood pressure), and paroxysmal atrial fibrillation (irregular heart rhythm). During an interview on 11/18/24 at 4:32 p.m. with Resident 34, Resident 34 stated, I go to dialysis every Monday, Wednesday and Friday at 10 a.m. During a concurrent interview and record review on 11/19/24 at 3:37 p.m., with Licensed Nurse 1 (LN 1) at the nurse's station, LN 1 stated the Nurses Dialysis Communication Record (NDCR) is to be completed by the facility once the resident returns from dialysis. LN 1 stated, We are supposed to take vital signs and assessment of dialysis access sites before and after each time a resident goes to dialysis. During a concurrent interview and record review on 11/20/24 at 10:22 a.m. with Director of Nursing (DON), Resident 34's NDCRs were reviewed. The NDCRs dated 10/28/24 (Monday), 10/30/24 (Wednesday), and 11/8/24 (Friday) indicated, post dialysis assessment information was incomplete by nursing staff. DON reviewed the records and confirmed nursing staff did not complete the resident's post dialysis vital signs and access assessments for the said dates. DON verbalized that it was expected for the nurses to completely fill out the post dialysis assessment portion of the NDCRs and they were not. During a review of the facility's Policy and Procedure (P&P) titled, Hemodialysis catheters - Access and care of, dated February 2023, the P&P indicated in part, Documentation .The nurse should document in the resident's medical record every shift as follows: . 5. Observations post dialysis.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43019 Based on interview and record review, the facility failed to provide nursing staff on a 24-hour basis to care for the residents' needs. This failure had the potential to result in residents not receiving necessary care. Findings: During a review of Report: Calculated Time by Entry, transmitted by the facility for the Payroll Based Journal (PBJ - quarterly staffing data report submitted to the Centers for Medicare and Medicaid Services [CMS] by long-term care facilities including the hours nursing staff are paid to work each day) Report for Quarter 1, 2024 (October 1, 2023 - December 31, 2023) with infraction dates of 11/05 (Sunday), 11/09 (Thursday), 11/12 (Sunday), 12/10 (Sunday) and 12/25 (Monday), there were no assigned Registered Nurses on the staffing assignments. For Quarter 2, 2024 (January 1, 2024 - March 31, 2024) with infraction dates of 1/19 (Friday), 3/02 (Saturday), 3/03 (Sunday) and 3/15 (Friday), there were no assigned Registered Nurses on the staffing assignments. During an interview on 11/20/24 at 3:15 p.m. with the facility Administrator (ADM), ADM validated the PBJ report and acknowledged the facility did not have assigned registered nurses for the infraction dates listed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48668 Based on observation, interview, and record review, the facility failed to ensure: 1. Acetaminophen (treat minor aches and pains, and reduces fever) was given as ordered for one of four sampled residents (Resident 403) 2. Levothyroxine (to treat an underactive thyroid gland [hypothyroidism]) was given before breakfast for one of four sampled residents (Resident 404) 3. Acamprosate (a medication used to help overcome alcohol dependence), and Magnesium Oxide (a supplement) were administered as prescribed to one of four sampled residents (Resident 202) These failures had the potential for the residents to not receive the maximum benefit from the medications. Findings: 1. During a medication administration observation on 11/19/24 at 08:02 a.m. with Resident 403, licensed nurse (LN 3) administered Acetaminophen (treat minor aches and pains, and reduces fever) 325 mg (milligrams) 1 tablet instead of 2 tablets as per the physician order to give Acetaminophen 650 mg. 2. During a medication administration observation on 11/19/24 at 8:18 a.m. with Resident 404, LN 3 administered Levothyroxine (to treat an underactive thyroid gland [hypothyroidism]) 88 mcg (micrograms) after the resident had eaten breakfast and had taken the other oral medications. Review of Davis's Drug Guide for nurses (a drug reference handbook) used by the facility indicated, Levothyroxine should be taken on an empty stomach at least 1 hour before eating. 3. During a medication administration observation and interview on 11/19/24 at 8:31 a.m. with LN 3, did not administer Magnesium Oxide 40 mg and Acamprosate as per physician order to Resident 202. LN 3 documented in the Medication Administration Record (MAR) as refused in both medications however reasons for refusal was not indicated. When clarified, LN 3 stated Resident 202 refused the Magnesium Oxide due to causing stomach upset while Acamprosate was refused because he did not want to be on it anymore. During an interview on 11/19/24 at 11:45 a.m. with Resident 202, the resident denied having stomach symptoms from the Magnesium Oxide and did not refuse it and stated would have taken the medications if they were available.

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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. 48668 Based on interview and record review, the facility failed to ensure there was a Medication Regimen Review for Xanax (drug that helps to control anxiety and panic attacks) for one of two sampled residents (Resident 44). This failure had the potential for Resident 44 to have complications from the medication. Findings: During a concurrent interview and record review on 11/20/24 at 3:15 p.m. with the Director of Nursing (DON), Resident 44's physician's order was reviewed and indicated, Xanax oral tablet 0.25 mg (milligrams) was ordered on 10/30/24. Review of Resident 44's Medication Regimen Review (MRR), dated November 2024 indicated, there was no review for Xanax's continued use beyond 14 days. DON confirmed not finding any pharmacist review for Xanax. During a review of facility's policy and procedure (P&P) titled, Consultant Pharmacist Services Provider Requirements, (undated), the P&P indicated in part, Reviewing the medication regimen of each resident at least monthly, or more frequently under certain conditions and Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders as well as recommendations for changes in medication therapy and monitoring of medication therapy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48668 Based on interview and record review, the facility failed to ensure there was a practitioner's (physician) justification for the continued use of Xanax (drug that helps to control anxiety and panic attacks) beyond 14 days for one of two sampled residents (Resident 44). This failure had the potential for Resident 44 to receive an unnecessary medication and have complications due to the medication. Findings: During a concurrent interview and record review on 11/20/24 at 3:15 p.m. with the director of nursing (DON), Resident 44's physician's orders and progress notes were reviewed. The order indicated, Xanax Oral tablet 0. 25 mg 1 tablet every 8 hours if needed for anxiety and panic. There was no documentation found in the physician's progress notes justifying the need for continuous use of Xanax beyond 14 days. DON acknowledged there was no provider justification for the continued use of the drug (Xanax) beyond 14 days. During a review of facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated July 2022, the P&P indicated in part, PRN (if needed) orders for psychotropic medications are limited to 14 days and if the prescriber or attending physician believes it is appropriate to extend the order beyond 14 days, he will document the rationale for extending its use.

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	055563	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Maria Post Acute	820 W Cook St Santa Maria, CA 93458

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48668 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. During medication administration for three of five residents (Residents 403, 404 and 202) four medication errors were observed out of 27 opportunities which resulted in an error rate of 14.81 percent. This failure had the potential for the residents to not receive the maximum benefit from the medications and sustain complications and side effects. Findings: 1. During a medication administration observation on 11/19/24 at 8:02 a.m. with Resident 403, licensed nurse (LN 3) administered Acetaminophen (treat minor aches and pains, and reduces fever) 325 mg (milligrams) 1 tablet instead of 2 tablets as per the physician order to give Acetaminophen 650 mg. 2. During a medication administration observation on 11/19/24 at 08:18 a.m. with Resident 404, LN 3 administered Levothyroxine (to treat an underactive thyroid gland [hypothyroidism]) 88 mcg (micrograms) after the resident had eaten breakfast and had taken other oral medications. Review of Davis's Drug Guide for nurses (a drug reference handbook) used by the facility indicated, Levothyroxine should be taken on an empty stomach at least 1 hour before eating. 3. During a medication administration observation and interview on 11/19/24 at 8:31 a.m. with LN 3, LN 3 did not administer Magnesium Oxide 40 mg (supplement) and Acamprosate (a medication used to help overcome alcohol dependence) as per physician order to Resident 202. LN 3 stated Resident 202 refused the pill (Magnesium Oxide) due to causing stomach upset. LN 3 documented the medication, Acamprosate as refused. During the interview on 11/19/24 at 11:45 a.m. with Resident 202, the resident denied having stomach symptoms from the Magnesium Oxide and did not refuse it and stated would have taken the medications if they were available.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48668 Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were safely labeled and stored in the medication storage room when: 1. An opened one-liter bottle of 0.9% Sodium Chloride solution (a solution used for wound cleaning) was found without an open date label. 2. Temperature logs for three sampled months for the two refrigerators used to store medications had days when temperature readings were out-of-range. The log did not have a section to indicate if adjustment was done when temperature readings were out-of-range. 3. A box of lemon glycerin swab sticks (cotton swabs used to soothe dry mouth) was found in the freezer. 4. Two plastic bags containing multiple labeled and unlabeled medications were found in the medication storage room sink. 5. One opened container of glucometer strips (a strip inserted in a device used to measure blood sugar level) was found in one medication cart without an open date label. These failures had the potential to result in ineffective and unsafe medication administration. Findings: 1. During a concurrent observation and interview on 11/18/24 at 11:15 a.m. with a licensed nurse (LN 2) inside the medication storage room, an opened one-liter bottle of 0.9% Sodium Chloride solution was observed with no open date label on it. LN 2 confirmed the finding and acknowledged that there was no way of determining when to discard the solution. The bottle label instructions indicated, to discard the unused portion. 2. During a concurrent interview and record review on 11/18/24 at 11:30 a.m. with LN 2, the facility log, titled, Medication Room and Refrigerator Temp. Logs, dated November 2024, were reviewed. The logs indicated to notify the Director of Nursing (DON) if the refrigerator temperature is not ranging from 36 degrees F (Fahrenheit) to 46 degrees F. An entry dated, 11/14 /24 during the morning (AM) shift indicated, a temperature reading of 48 degrees F. LN 2 verbalized the medication refrigerator was not within the safe temperature range and confirmed that there was no section in the log to write what action was taken to correct the temperature. LN 2 also confirmed there were numerous out-of-range readings between 47 degrees F to 58 degrees F logged (25 during morning shifts and 11 during night shifts) during the periods of September 2024 through October 2024. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, (undated), the P&P indicated in part, Medications requiring refrigeration should be kept within temperatures of 36 degrees F to 46 degrees F (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a concurrent observation and interview on 11/18/24 at 11:45 a.m. with LN 2, a box of Lemon Glycerin Swab Stick was observed inside the freezer of a refrigerator used to store medications. The box label indicated, Do Not Freeze. LN 2 acknowledged the swab sticks were frozen and should have not been. 4. During a concurrent observation and interview on 11/18/24 at 12:10 p.m. with LN 2 inside the medication storage room, two plastic bags containing multiple labeled and unlabeled resident medications were found in the sink. The labeled medications belonged to a current resident. LN 2 verbalized not being aware why the medications were in the sink and was not sure what to do with them. During a review of the facility's P&P titled, Disposal of Medications and Medication-Related Supplies, (undated), the P&P indicated in part, Medications awaiting disposal are stored in a locked, secured area for that purpose until destroyed 5. During a concurrent observation and interview on 11/18/24 at 12:20 p.m. with LN 4 the medication cart in the north nurse station was observed to have an opened container of glucometer strips with no label indicating the date it was opened. The instruction in the container indicated, to discard after 60 days of opening. LN 4 acknowledged there was no reference as when to discard the test strips if there was no indication on the container when it was opened.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43745 Based on observation, interview, and record review, the facility failed to ensure food safety standards were followed when: 1. A dietary aide/cook (DAC) was observed not following proper hygiene and sanitary practices during lunch tray preparation. 2. The frequency of the facility's ice machine sanitization schedule was not followed according to manufacturer's recommendations. These failures had the potential to cause food-borne illness to vulnerable residents currently residing in the facility. Findings: 1. During a lunch tray line observation on 11/19/24 at 12:15 p.m. inside the facility kitchen, with the registered dietitian (RD), certified dietary manager (CDM), and DAC, DAC was observed preparing cooked food for resident lunch tray distribution. DCA was noted measuring the food temperatures with gloved hands. Using the same pair of gloves, DCA continued to open/close cabinets and drawers, taking out spoons and scoops placing them onto the food trays for serving. Upon further observation, DCA was noted resting the plate against her body while scooping food onto the plate. DCA's apron and identification (ID) badge were noted touching the edge of the plate. During a concurrent observation and interview on 11/19/24 at 12:20 p.m. with CDM, CDM was informed of DCA's food handling practices who confirmed them through direct observation. CDM acknowledged that DCA should have changed gloves and performed hand hygiene frequently and should have been mindful and cautious not to contaminate plated foods which will be served to the residents. During a review of the facility's policy and procedure (P&P) titled, Food Handling, dated 2023, the P&P indicated in part, POLICY: Food will be prepared in a safe and sanitary manner. During a review of the facility's P&P titled, Food Preparation and Service, dated 11/22, the P&P indicated in part, General Guidelines . 3) Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness 50657 2. During a review of the facility ice machine's, Manitowoc S Model Ice Machines Installation, Use and Care Manual, dated 10/2009, the manual indicated in part .Sanitizing Procedure: This procedure must be performed a minimum of once every six months. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 11/18/24 at 4:32 p.m. with the facility's maintenance supervisor (MS), MS was asked how often the ice machine was sanitized. MS opened the ice machine's top access panel to reveal the dates when sanitization was performed. The most recent sanitization date noted was on 3/18/24. MS verbalized the sanitization procedure is performed by an outside vendor and would look for the service record/invoices for the said date. During a concurrent interview and record review on 11/19/24 at 10:50 a.m. with MS, MS presented the ice machine service record/invoice and acknowledged the ice machine was last sanitized on 3/18/24. MS could not produce any other ice machine sanitization service records/invoices after 3/18/24 and acknowledged it was not done in the past six months. During an interview on 11/19/24 at 11:31 a.m. with the Director of Nursing (DON), DON confirmed the ice machine was not sanitized within the last six months as recommended by the ice machine care manual. During a review of the facility's P&P titled, Ice Machine Policy, (undated), the P&P indicated in part, Policy: It is the policy of (name of facility) to clean/disinfect exterior and interior of the ice machine . Person Responsible: (name of outside vendor) (six months) During a review of the FDA (Food & Drug Administration) Food Code Annex, 2017, the FDA Food Code indicated, Ice that has been in contact with unsanitized surfaces .may contain pathogens and other contaminants (3-303.11). The FDA Food Code indicated further, Pathogens can be transferred to food from utensils that have been stored in surfaces which have not been cleaned and sanitized (3-304.11).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32661 Based on interview and record review, the facility failed to ensure measures/system were in place to prevent the growth of Legionella (a bacteria found in water systems such as air conditioners, shower, sinks, and water fountains) and other opportunistic waterborne (a disease/infection from infected water) pathogens in their water system. This failure resulted in not having a water management program/system which had the potential to expose the residents of the facility to Legionella and other harmful waterborne pathogens. Findings: During a concurrent interview and record review on 11/20/24 at 4:52 p.m. with the Administrator (ADM) and Director of Nursing (DON), in the ADM's office, the Facility Assessment did not address a water management program. The ADM admitted they did not have a system in place to test and track for Legionella and other waterborne pathogens. The ADM stated they had not conducted water testing to ensure Legionella or other harmful waterborne pathogens were not present in the facility's water system. The ADM added that the facility did not have a water management program or a water management team in place to prevent the development and transmission of Legionnaires' disease (a type of pneumonia caused by the legionella bacteria), caused by the bacteria Legionella pneumophilla, found in potable and non-potable water systems (showers, sinks, air conditioning, water systems) and other opportunistic waterborne pathogens. During a review of the facility's policy and procedure (P&P) titled, Legionella Water Management Program, dated September 2022, the P&P indicated in part, 1. As part of the infection control program, our facility has a water management program, which is overseen by the water management team. During a review of the facility's P&P titled, Legionella Surveillance and Detection, dated September 2022, the P&P indicated in part, 4. Microbiologic sampling of ice, ice machines and ice storage chest/containers will be conducted during epidemiological investigations. The policy statement of the P&P indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. The Centers for Disease Control and Prevention (CDC) guideline, titled, Legionella-Water Management in Healthcare Facilities, dated March 25, 2021, indicated, CDC encourages healthcare facilities included in the scope of ASHRAE (American Society of Heating and Air-Conditioning Engineers) Standard 188 (Section 5.2) to develop and implement comprehensive water management programs. Water management programs can help reduce the risk for Legionella growth and transmission. A comprehensive water management program can have additional benefits in the control of other water related healthcare associated infections. Water management programs should therefore be monitored for their efficacy in reducing the risk for a variety of pathogens.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, interview, and record review, the facility failed to ensure to provide a safe, functional, sanitary, and comfortable environment for two of four sampled residents (Residents 6 and 12). This failure resulted in compromising the comfort and safety of the residents and had the potential to result in adversely affecting the resident's health and well-being. Findings: During an observation on 11/18/24 at 12:56 p.m. in room [ROOM NUMBER]-2, Resident 6's bed was not in working order. Resident 6 was observed having difficulty feeding self. Attempts to elevate the head of the bed using the bed control switch proved unsuccessful. Resident 6 occupied B bed, next to her was A bed which was fully functional. During an interview on 11/18/24 at 1:04 p.m. with the maintenance supervisor (MS), MS stated was verbally informed on 11/14/24 by a night shift CNA the bed was not working. MS further stated parts have been ordered to repair the defective bed. When asked why Resident 6 was not moved to the other unoccupied bed (bed A), MS stated the nursing department should have moved the resident to the next bed (bed A). During an observation on 11/18/24 at 4:04 p.m. in room [ROOM NUMBER]-2, an extension cord with six (6) sockets was positioned on the bedside table to Resident 12's right side approximately a foot (12 inches) from Resident 12's head. The bed control switch had a frayed wire, which was observed on the Resident 12's right side of the bed and within easy reach of the resident. During a concurrent interview and observation on 11/19/24 at 10:30 a.m. with the director of nursing (DON) and the maintenance supervisor (MS), in room [ROOM NUMBER]-2, Resident 12's extension cord and frayed wiring were observed. The DON and MS confirmed the finding. Record review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated December 2009, the P&P indicated in part, 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's P&P titled, EQUIPMENT IN SAFE OPERATING CONDITION, (undated), the P&P indicated in part, 1. The facility has procedures to maintain mechanical, electrical and patient care equipment is maintained in safe operating condition. 3. Facility personnel routinely inspect residents' beds, including the control panel for safe operating condition. 4. Facility personnel inspect the bed's power cord, cord plug, and wall plug for safe operating condition.