STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055573	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsburg Center	1101 Stroud Ave Kingsburg, CA 93631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to ensure a physician informed consent (the process in which residents are given important information of the possible risk and benefits of psychoactive medications) for the use of psychotropic medication (medication capable of affecting mind, emotions, and behavior) was obtained for three of six sampled residents (Residents' 3, 13 and 64) when: 1. Resident 3 was administered escitalopram oxalate tablet (medication used to treat depression [serious mental illness affecting person's though, feelings, behavior, and sense of well-being] from 6/2/24-6/31/24, 7/1/24-7/31/24 and 81/24-8/27/24 and informed consent was not obtained prior to medication administration. 2. Resident 13 was administered sertraline HCl tablet (medication used to treat depression) from 8/1/24 to 10/14/24 and informed consent was not obtained prior to medication administration. 3. Resident 64 was administered buspirone HCl tablet (medication used to treat anxiety [feeling of fear, dread, and uneasiness that can be a normal reaction to stress]) from 8/29/24 to 10/11/24 and accurate informed consent was not obtained prior to medication administration. These failures resulted in Residents' 3, 13 and 64 to be administered psychotropic medications and not be fully informed of the risk and benefits and did not have the knowledge to make an informed decision which placed Residents' 3, 13 and 64 at risks for negative side effects. Findings: 1. During a concurrent observation and interview, on 10/8/24 at 12::40 p.m. in Resident 3's room, Resident 3 was observed sitting at the edge of her bed eating lunch. Resident 3's bed was in the lowest position and a fall mat was at bedside and Resident 3 stated she did not know what she was eating and did not have any complaints. During a review of Resident 3's Admission Record, (AR) dated 10/11/24, the AR indicated Resident 3 was admitted in the facility on 4/26/24 with diagnoses which included Respiratory failure, perforation (hole) of intestine and gastrointestinal hemorrhage (bleeding). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Order Summary Report, dated 10/11/24, the Order Summary Report indicated, . Escitalopram Oxalate Tablet 10 MG[milligram-unit of measurement]. Give one [1] tablet by mouth one time a day . related to DEPRESSION . During a review of Resident 3's Medication Administration Record (MAR-a document that shows the medications ordered and taken by a resident), dated 6/1/24-6/30/24, 7/1/24-7/31/24 and 8/1/24-8/30/24, the MAR indicated, escitalopram oxalate was administered every day starting from 6/1/24 thru 6/30/24, 7/1/24 thru 7/31/24 and 8/1/24 thru 8/1/24 thru 8/28/24. During a concurrent interview and record review on 10/14/24 at 10:15 a.m. with Registered Nurse (RN) 2, RN 2 reviewed Resident 3's clinical record and stated Resident 3's escitalopram oxalate was ordered on 5/30/24. RN 2 stated the informed consent for the medication was signed 8/28/24, RN 2 stated medication was administered everyday to Resident 3 since 6/1/24. RN 2 stated psychotropic medication can not be administered until an informed consent was signed. During an interview on 10/14/24 at 10:45 a.m. with Licensed Vocational Nurse (LVN) 4, she stated psychotropic medications cannot be administered without a signed informed consent. LVN 4 stated informed consent had to be accurate and matched the physician order. 2. During a concurrent observation and interview on 10/8/24 at 8:58 a.m. during an initial tour in Resident 13's room, Resident 13 was observed sitting up in bed with oxygen via nasal cannula (a tube used to deliver supplemental oxygen through the nose). Resident 13 stated she did not know how long she had been in the facility and did not have any complaints. During a review of Resident 13's Admission Record, (AR) dated 10/11/24, the AR indicated Resident 13 was admitted to the facility on [DATE] with diagnoses which included anxiety (intense, excessive, and persistent worry and fear about everyday situations) and depression (feeling of sadness and loss of interest). During a review of Resident 13's Order Summary Report, dated 10/11/24, the Order Summary Report indicated, . Sertraline HCl [hydrochloride] Oral Tablet 25MG[milligram-unit of measurement] . related to DEPRESSION . During a review of Resident 13's MAR dated 8/1/24-8/31/24, 9/1/24-9/30/24 and 10/1/24-10/14/24, the MAR indicated, sertraline was administered every day starting from 8/1/24-8/31/24, 9/1/24-9/30/24 and 10/1/24-10/14/24. During a concurrent interview and record review on 10//14/24 at 10:05 a.m. RN 2 reviewed Resident 13's clinical record and stated Resident 13's informed consent for sertraline was incomplete. RN 2 stated sertraline medication should not have been administered to Resident 13 without informed consent. RN 2 stated licensed nurses are responsible in making sure informed consent was accurate and signed. 3. During an observation on 10/8/24 at 9:48 a.m. in Station 1 hallway, Resident 64 was observed sitting up at the edge of the bed, holding a phone to her ear, appeared agitated and crying on the phone. Several facility staff was in the room with Resident 64 talking to her. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 64's Admission Record, (AR) dated 10/11/24, the AR indicated Resident 64 was admitted to the facility on [DATE] with diagnoses which included anxiety and Alzheimer's (progressive disease that destroys memory and other important mental functions. During a review of Resident 64's Order Summary Report, undated, the Order Summary Report indicated, . busPIRone HCl. Give one [1] tablet by mouth two times a day for Anxiety M/b [manifested by] episodes of hyperventilation . During a review of Resident 64's MAR dated 8/29/24-8/31/24, 9/1/24-9/30/24 and 10/1/24-10/14/24, the MAR indicated, buspirone was administered every day starting from 8/29/24-8/31/24, 9/1/24-9/30/24 and 10/1/24-10/14/24. During a concurrent interview and record review on 10/11/24 at 2:45 p.m. with Registered Nurse (RN) 1, Resident 64's informed consent for buspar was reviewed and she stated Resident 64's informed consent was not accurate and therefore was not valid. RN 1 stated buspar should not have been administered to Resident 64 because the informed consent was not accurate. During an interview on 10/14/24 at 1:40 p.m. with the Director of Staff Development (DSD), she stated psychotropic medications can not be administered to a resident without a signed informed consent. The DSD stated licensed nurse receiving the psychotropic medication order should ensure an informed consent was signed by physician and resident or family member. During an interview on 10/14/24 at 8:25 a.m. with Medical Records Director (MRD), she stated she is also an LVN and part of her job was to audit resident's medical records including psychotropic medications informed consents. MRD stated she made sure the informed consents was signed both by family or resident and physician. MRD stated she also checked to ensure the medication order and the informed consent was the same. The MRD stated licensed nurses can not administer psychotropic medications without a signed and accurate informed consent. During an interview on 10/14/24 at 2:55 p.m. with the Director of Nursing (DON), the DON stated, . Psychotropic medications needed to have an updated, accurate and signed informed consent prior to administering medications . DON stated it was the resident's and or resident family's right to be informed of changes in psychotropic medications. During a review of facility's policy and procedure (P&P) titled, . The facility should comply . to the use of psychoactive medications . It is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulation. The informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication .

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for one of four sampled residents (Resident 39) when: 1. Licensed Vocational Nurse (LVN) 1 checked Resident 39's blood pressure (B/P-measures the pressure of circulating blood against the walls of blood vessels [channels that carry blood throughout the body]) and did not provide privacy. 2. LVN 1 administered medication to Resident 39 and did not provide privacy. These failures resulted in Resident 39 not being provided with respect and dignity while his B/P was checked and while taking his medication. Findings: 1. During an observation on 10/10/24 at 7:38 a.m. in Station 2 in Resident 39's room, Resident 39 was sitting up in bed watching TV and appropriately dressed. LVN 1 approached Resident 39's bedside and checked Resident 39's blood pressure without closing the privacy curtain or the door, while staff, residents and visitors walked by. During an interview on 10/10/24 at 10:10 a.m. with LVN 1, LVN 1 stated she checked Resident 39's blood pressure in his room and did not close the privacy curtain or the door. LVN 1 stated there are always staff, residents and visitors walking by and did not need to know what was going on in the room. LVN 1 stated she should have provided Resident 39's privacy when she checked his blood pressure by closing the privacy curtain or the door. During an interview on 10/10/24 at 10:30 a.m. with Infection Preventionist (IP), IP stated LVN 1 should have provided Resident 39 privacy when she checked his blood pressure by closing the privacy curtain or the door. IP stated it was not an acceptable practice to not provide privacy to residents when providing care or just performing tasks. IP stated it was one of their rights to provide residents with privacy. 2. During an observation on 10/10/24 at 7:50 a.m. in Station 1 hallway, LVN 1 prepared resident 39's medications, walked in Resident 39's room and administered his (Resident 39)medications and did not provide privacy. LVN 1 did not close the privacy curtain or closed the door, staff and other residents walking by. During an interview on 10/10/24 at 10:12 a.m. with LVN 1, she stated she administered medications to Resident 39 in his room and did not closed the privacy curtain or the door. LVN 1 stated it was Resident 39's rights to be provided with privacy and she did not provide privacy to Resident 39 when she administered his medications and she should have. LVN 1 stated staff, residents and visitors walking by did not need to know what was going on inside the room. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 2:50 p.m. with LVN 2, she stated the practice was to always provide privacy to residents when administering medications and checking blood pressure. LVN 2 stated the privacy curtain should be closed or closed the door. LVN 2 stated residents have rights and one of those rights is privacy, we should always make sure their privacy was respected. During an interview on 10/14/24 at 2:45 p.m. with the Director of Nursing (DON), the DON stated, . The practice had always been to provide privacy during medications administration including checking blood pressure and heart rate . The DON stated LVN 1 should have made sure she closed the privacy curtain or closed the door when she checked Resident 39's blood pressure and again when she administered medications. DON stated there are always staff, residents and visitors walking by and did not need to see what was going on inside Resident 39's room. During a review of Resident 39's Admission Record, dated 10/11/24, the Admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (one-sided muscle weakness) and hemiparesis (partial weakness on one side of the body), and aphasia (a language disorder that affects how you communicate). During a review of Resident 39's Minimum Data Set, assessment dated [DATE], indicated Resident 39's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 4 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 39 had severe cognitive deficit. During a review of facility's policy and procedure (P&P) titled, Dignity, dated 2/2021 the P&P indicated, . Residents are treated with dignity and respect at all times . Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .2 and 557 During a review of facility's policy and procedure (P&P) titled, Resident Rights, dated 12/21, the P&P indicated, . right to a dignified existence . be free of interference, coercion . right to be fully informed . right to personal privacy and confidentiality .

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48424 Based on observation, interview, and record review the facility failed to post the results of the most recent survey document titled Statement Survey Binder in a place readily accessible for 83 of 83 residents, families, and their legal representatives. This failure had the potential to violate the rights of residents and their representatives to be informed of previous survey deficiencies and the facility's plan of correction. Findings: During an observation on 10/10/24 at 9:31 a.m., a binder titled, State Survey Binder was located in the hallway near the Director of Nursing's (DON) office. During a review of the facility's, State Survey Binder binder, undated, the binder did not contain results for the facilities last recertification survey conducted on 7/14/23. During a concurrent interview and record review on 10/10/24 at 9:07 a.m. with the Administrator (ADM), the facility's State Survey Binder, undated, was reviewed. The State Survey Binder did not contain the results from the facility's last recertification survey on 7/14/24. The ADM stated the last recertification survey's results were not included in the binder. The ADM stated the survey results should have been included, accessible, and available to everyone. During a concurrent interview and record review on 10/10/24 at 9:07 a.m. with the DON, the facility's State Survey Binder, undated, was reviewed. The State Survey Binder did not contain the results from the facility's last recertification survey on 7/14/24. The DON stated she could not find the last recertification survey's results in the binder. The DON stated the last survey results should have been available in the binder for people to see. During a review of the facility's policy and procedure titled, Resident Rights', dated 12/2021, indicated, .1. Federal and state laws guarantee certain basic right to all rights of this facility. These rights include the resident's right to: w. examine survey results .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status of one of five sampled residents (Resident 75) when Resident 75's diagnosis of indwelling urinary catheter was not coded on the MDS assessment. This failure had the potential to result in Resident 75's care needs to not be met. Findings: During a concurrent observation and interview on 10/8/24 at 10:15 a.m. in Resident 75's room, Resident 75 was laying in bed with eyes open, urinary catheter was observed hanged on the side of the bed with yellow urine. Resident 75 stated she needed the catheter because she was not able to void. Resident 75 stated she prefers to stay in bed. During a review of Resident 75's Admission Record (document with resident demographic and medical diagnosis information), dated 10/11/24, indicated Resident 75 was admitted in the facility on 10/11/24 with diagnoses which included anxiety (feeling of fear, dread, and uneasiness that can be normal reaction to stress), kidney failure and neuromuscular dysfunction (general term for a range of diseases that affect the nerves and muscles). During a review of Resident 75's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive [pertaining to reasoning, memory, and judgement] and physical functional level), assessment dated [DATE], indicated Resident 75's Brief Interview for Mental Status (BIMS-screening toll used in a nursing home to assess cognition) assessment score was 12 out of 15 (0-115 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 75 had moderate cognitive deficit. During a concurrent interview and record review on 10/10/24 at 2:45 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 75's clinical document titled Order Summary Report was reviewed, LVN 2 stated Resident 75 was admitted in the facility with indwelling urinary catheter. LVN 2 stated she did not find an order for indwelling urinary catheter, no diagnosis for the use of indwelling urinary catheter and no care plan. LVN 2 stated there should have been an order for indwelling urinary catheter but there was none. LVN 2 stated there should have been a diagnosis for the indwelling urinary catheter use. LVN 2 stated there should have been a care plan initiated to guide staff to properly care for Resident 75's indwelling urinary catheter. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of 10/11/24 at 9:32 a.m. Resident 75's admission/medicare - 5 day assessment dated [DATE], section H (bladder and bowel), section I (active diagnosis) and section V (care area assessment summary) was reviewed by Minimum Data Set Nurse (MDSN). The MDSN stated Resident 75 had a indwelling urinary catheter since she was admitted to the facility on [DATE]. The MDSN stated Resident 75 was put on bladder retraining from 8/21/24-8/23/24 and indwelling urinary catheter was re-inserted on 8/25/24 because Resident 75 did not void for eight hours. MDSN stated Resident 75's use of indwelling urinary catheter was coded on the MDS assessment, but diagnosis of the use of indwelling urinary catheter was not coded in the MDS assessment. MDSN stated Resident 75's diagnosis of the use of foley catheter should have been coded in the MDS assessment but was not coded. MDSN stated Resident 75's MDS was inaccurately coded. The MDSN stated all assessments was based on Resident Assessment Instrument (RAI-core set of screening, clinical, and functional status elements including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid). During a concurrent interview and record review on 10/14/24 at 8:35 a.m. with the Medical Records Director (MRD), the MRD stated she was also a licensed nurse. The MRD stated she did not know Resident 75 had an indwelling urinary catheter, she only visited her (Resident 75) once since admitted in the facility. Resident 75's clinical record was reviewed by MRD and stated Resident 75 was admitted with foley catheter to the facility on [DATE]. The MRD stated there should have been a physician order, diagnosis and care plan for indwelling urinary catheter use. The MRD stated the physician order, diagnosis and care plan was only started on 10/10/24. During an interview on 10/14/24 at 2:35 p.m. with the Director of Nursing (DON), the DON stated Resident 75 was admitted in the facility with foley catheter. The DON stated nursing staff tried to discontinue indwelling urinary catheter but had to be re-inserted because Resident 75 did not void for eight hours. The DON stated the licensed nurse who received the order to re-insert the indwelling urinary catheter should have entered the order and asked the physician for the diagnosis. The DON stated she did not know how the order, diagnosis and care plan for the indwelling urinary catheter was missed. The DON stated MDS should have made sure there was a diagnosis when they coded Resident 75 had a foley catheter and initiated a care plan. During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.18.11 Manual (RAI- core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) dated 10/23, indicated, . Physician-documented diagnoses . that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments . Medical record sources for physician diagnoses include progress notes . During a review of facility's policy and procedure (P&P) titled, Urinary Catheter, dated 11/15/24, the P&P indicated, . To ensure there is a valid medical justification for the use of an indwelling catheter and that the catheter is discontinued as soon as clinically warranted .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40641 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for two of eight sampled residents (Resident 75 and Resident 29) when: 1. Resident 75 did not have a care plan (a document that outlines how a resident's health care needs will be met, and is used by the resident and their care team to facilitate communication and collaboration) for the use of indwelling urinary catheter (thin, flexible tube inserted into the bladder through the urethra to drain urine). This failure placed Resident 75 at risk for her indwelling urinary catheter needs to not be met. 2. Resident 29 did not have a care plan for urinary tract infection (UTI- common infections that happen when bacteria, often from the skin or rectum, enter the urethra and infect the urinary tract). This failure had the potential to result in Resident 29's care needs to go unmet. Findings: 1. During a concurrent observation and interview on 10/8/24 at 10:13 a.m. in Resident 75's room, Resident 75 was laying in bed with eyes open watching TV. Resident 75 stated she had been in the facility for three weeks and preferred to stay in bed. There was an indwelling urinary catheter bag that hanged on the side of the bed and covered with a privacy bag. Resident 75 stated she needed the indwelling urinary catheter due to her weakness and had it since she was in the hospital. During a review of Resident 75's Admission Record (AR-a document with personal identifiable and medical information), dated 10/11/24, the AR indicated, Resident 75 was admitted to the facility on [DATE] with diagnoses which included acute kidney failure (sudden decline in kidney function), rhabdomyolysis (skeletal muscle breaks down and releases its content into the bloodstream) and fall. During a review of Resident 75's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 8/19/24, indicated the Brief Interview for Mental Status (BIMS) score was 12 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 75 was moderately impaired in daily decision making. During a concurrent interview and record review on 10/10/24 at 2:45 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 reviewed Resident 75's clinical record titled Order Summary Report, dated 10/11/24 and stated Resident 75 was admitted to the facility on [DATE]. LVN 2 stated Resident 75 was admitted with an indwelling urinary catheter. LVN 2 stated she did not find a care plan for Resident 75's use of indwelling urinary catheter. LVN 2 stated there should have been a care plan developed and licensed nurses are responsible in creating a care plan. LVN 2 stated a care plan was important to guide nursing staff in providing care to Resident 75's indwelling urinary catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/24 at 9:32 a.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated Resident 75 was admitted with an indwelling urinary catheter. The MDSN stated there should have been a care plan initiated for the use of the indwelling urinary catheter but there was none. The MDSN reviewed the MDS admission and 5 day assessment dated [DATE] and stated Resident 75 was coded as using foley catheter and care plan was also triggered in Section V (Care Areas Assessment) CAAs and Care Planning but there was no care plan initiated for Resident 75's use of indwelling urinary catheter. During an interview on 10/14/24 at 2:35 p.m. with the Director of Nursing (DON), the DON stated Resident 75 had been in the facility since 8/17/24 and had the indwelling urinary catheter since admitted in the facility. The DON stated her expectation was for licensed nurses to initiate care plan to monitor for any side effects of the use of indwelling urinary catheter. During a review of facility's policy and procedure (P&P) titled Care Plan Comprehensive dated 8/25/21, the P&P indicated, . An individualized comprehensive care plan that include measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident . The resident's comprehensive care plan is developed within seven (7) days . 49949 2. During a review of Resident 29's AR, dated 10/10/24 the AR indicated, Resident 29 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2 (disease in which your blood glucose, or blood sugar, levels are too high), hypertension (high blood pressure- is when the pressure in your blood vessels is too high (140/90 mmHg or higher) end stage renal disease, (ESRD- is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) anemia (blood disorder that occurs when your body doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to your body's tissues) and pain. During a review of Resident 29's MDS, dated [DATE], indicated the BIMS score was 14 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 29 was cognitively intact in decision making. During an observation and interview on 10/8/24 at 10:32 a.m. in Resident 29's room, Resident 29 had an enhanced standard precaution sign outside the door. Resident 29 stated she was taking antibiotic for a urinary tract infection recently but could not recall the date. During a concurrent interview and record review on 10/10/24 at 3:25 p.m. with License Vocational Nurse (LVN) 4 , LVN 4 stated Resident 29's was started on antibiotic for UTI. LVN 4 stated Resident 29 had a SBAR ((Situation, Background, Assessment, Recommendation-is a tool for standardizing and improving interprofessional communication) done on 9/27/24 and started on antibiotics on 9/28/24. LVN 4 stated a UTI care plan should have been done on 9/27/24. LVN 4 stated there was no care plan done on 9/27/24 and a care plan was created on 10/4/24. LVN 4 stated, a UTI care plan was important for patient care. LVN 4 stated, the nurse should have done the care plan when the SBAR was done. LVN 4 stated the care plan allowed the nurse to monitor Resident 29 was getting better or worse. (continued on next page)

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	055573	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsburg Center	1101 Stroud Ave Kingsburg, CA 93631

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/11/24 at 1:43 p.m. with the Infection Preventionist (IP), the IP stated, Resident 29 complained of decreased in urine output on 9/20/24. The IP stated the physician was notified and a urine sample was collected and sent out to the lab for testing. The IP stated, the physician gave a new order to repeat urine analysis on 9/23/24. The IP stated the urine was collected and sent out on 9/24/24. The IP stated the urine result came back on 9/27/24. The IP stated the urine sample was positive for E-coli (bacteria found in many places, including in the environment, foods, water, and the intestines of people and animals) and ESBL (enzymes that make some bacteria resistant to antibiotics, making infections harder to treat). The IP stated the nurse did a change in condition and notified the physician on 9/27/24. The IP stated the care plan should have been done on 9/27/24. The IP stated it was important to start the care plan to monitor Resident 29's condition. The IP stated the care plan updated physician, nurses, interdisciplinary team (IDT- group of professionals with different areas of expertise who work together to achieve a common goal). During an interview on 10/14/24 at 3:21 p.m. with the DON, the DON stated the nurse should update the care plan when there was a change in condition. The DON stated the care plan was not patient centered. During a review of the facility's policy and procedure (P&P) titled, Care Plan-Baseline dated 8/25/25, the P&P indicated, .An individualized comprehensive care plan that includes measurable objective and timetable to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident . 1.Each resident's comprehensive care plan is designed to: 1.Indoperate identified problem area .

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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** 49949 Based on interview and record review, the facility failed to timely revise and implement a person-centered comprehensive care plan for one of 8 sampled resident (Resident 29) when the care plan was not updated to reflect the insulin (a hormone that regulates blood sugar levels by moving glucose from the bloodstream into cells throughout the body) medication was discontinued on 7/23/24. This failure had the potential for Resident 29's care needs to go unmet. Findings: During a review of Resident's Admission Record (AR-a document with personal identifiable and medical information), dated 10/10/24 the AR indicated, Resident 29 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2 (disease in which your blood glucose, or blood sugar, levels are too high), hypertension (high blood pressure- is when the pressure in your blood vessels is too high (140/90 mmHg or higher) end stage renal disease, (ESRD- is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) anemia (blood disorder that occurs when your body doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to your body's tissues) and pain. During a review of Resident 29's eMAR (Electronic Medication Administration Record dated 7/1/24-7/31/24, the eMAR indicated, [brand name] kwikPen solution . Resident 29's Humalog (brand name) was ordered on 2/19/24 and discontinued on 7/23/24. During a review of Resident 29's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 9/10/24, indicated the Brief Interview for Mental Status (BIMS) score was 14 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 29 was cognitively intact in decision making. During a concurrent interview and record review at 3:20 p. with LVN 3, LVN 3 stated Resident 29 was not taking insulin. LVN 3 stated, Resident 29's care plan should have been changed and updated when the insulin was discontinued. LVN 3 stated, the care plan needed to be individualized and matched the needs of the resident. LVN 3 stated, there was a potential for the nurses to missed issues for the resident when the care plan was not updated. LVN 3 stated, the care plan should be specific and individualized to the resident's goals. During an interview on 10/14/24 at 3:01 p.m. with the Director of Nursing (DON) the DON stated, she expected the nurses to update the care plan when the insulin was discontinued. The DON stated the care plan was not personalized when it was not updated. The DON stated the care plan was not individualized to the Resident 29 needs when the care plan continues to have insulin in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Care Plan-Baseline dated 8/25/25, the P&P indicated, .An individualized comprehensive care plan that includes measurable objective and timetable to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident . Assessment of residents are ongoing and care plans are reviewed and revised as information about the resident and resident's condition changed .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for two of eight sampled residents (Resident 29 and Resident 55) when: 1. License nurses continued to sign the physician's order to monitor for side effects for Resident 29's anticoagulant medication which was discontinued on 9/5/24. This failure resulted in an inaccurate documentation and monitoring of Resident 29's medical symptoms related to the side effects if a medication that has been discontinued. 2. Licensed Vocational Nurse (LVN) 1 prepared and signed Resident 55's medications, and the Infection Preventionist (IP) administered the medication prepared by LVN 1. This failure had the potential for Resident 55 to not received the medication and could lead to medication error and or drug diversion. Findings: 1. During a review of Resident's Admission Record (AR-a document with personal identifiable and medical information), dated 10/10/24 the AR indicated, Resident 29 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2 (disease in which your blood glucose, or blood sugar, levels are too high), hypertension (high blood pressure- is when the pressure in your blood vessels is too high (140/90 mmHg or higher) end stage renal disease, (ESRD- is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) anemia (blood disorder that occurs when your body doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to your body's tissues) and pain During a review of Resident 29's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 9/10/24, indicated the Brief Interview for Mental Status (BIMS) score was 14 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 29 was cognitively intact in decision making. During a review of Resident 29's [Facility Name] Order Summary Report (OSR) dated 10/10/24, the OSR indicated, .[Brand name] oral tablet 10 mg (Rivaroxanban) give 10mg PO [by mouth] one time a day for blood thinner take with evening meal. (dinner) .Order Status: Discontinue .Order Date: 09/05/024 .Start Date:09/06/2024 . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's Medication Administration Record (MAR) dated 10/24, the MAR indicated, [box] Schedule for October 2024 .[box]Anticoagulant Medication Monitoring [Brand name drug]: Monitor for discolored urine, black tarry stools, sudden severe headache, N&V [nausea and vomiting] diarrhea, muscle join pain, lethargy, bruising, sudden changes in mental status or v/s [vital signs] sob [shortness of breath] . [box]hours .[box]6a-2p .[box]2p-10 [p] 10 p-6 [a] .[box] Thu 10 .[nurse initial] . During a review of Resident 29's Changes since last Review dated no date the changes since last review indicated, .Description .The resident has a diagnosis of diabetes: Insulin Dependent .Revision Date: 10/10/2024 . During a concurrent interview and record review on 10/10/24 at 3:01 p.m. with LVN 4, LVN 4 stated, Resident 29 was not taking [Brand name drug]. LVN 4 stated Resident 29's medication was discontinued on 7/23/24 at 8:00 a.m. LVN 4 stated, the physician order to monitor for side effect of the medication should have been discontinue the same day the medication was discontinue. LVN 4 stated, it was important to update the physician order so that staff can monitor for the correct side effects for the right medication. LVN 4 stated, The potential outcome is we were looking for all side effects that was not there when there could be another issue for her black tarry stool. During an interview on 10/14/24 at 3:01 p.m. with the Director of Nursing (DON) the DON stated, the nurses should update the order when [brand name] medication was discontinued. The DON stated the physician order was not update. The DON stated the physician order to monitor for the [drug name] can cause confusion for the staff. During a review of the professional reference titled, If it's not documented, it's not done. But what if it is documented and it's not done? dated 2/9/2019, retrieved from, https://mnnurses. org/if-its-not-documented-its-not-done-but-what-if-it-is-documented-but-its-not-done, the article indicated, . Untimely documentation may also be considered fraud. False, misleading, and deceitful documentation may result in grave safety issues for the patient because the healthcare team depends on accurate and timely documentation to make patient care decisions. If a medication, assessment, procedure, etc., is not timely then other care providers do not have an accurate account of a patient's condition which may lead to poor outcomes, including death. 40641 2. During a concurrent interview and record review on 10/10/24 at 8:45 a.m. in Station 2 hallway with LVN 1 stated, . Resident 55's eMAR was red and LVN 1 stated Resident 55's lispro and naproxen medications were late and were due at 7 a.m. LVN 1 stated she was not able to go in Resident 55's room to administer his medications, she had to ask another nurse. During a review of Resident 55's Admission Record, (AR) dated 10/11/24 the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (blood supply to the brain is blocked or reduced), diabetes (high blood sugar level) and muscle weakness. During a review of Resident 55's, Order Summary Report, dated 10/11/24, the Order Summary Report, indicated, . Insulin Lispro [medication used to treat diabetes] . before meals related to . Naproxen [medication used Oral tablet . administer with meals . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/10/24 at 10:15 a.m. Resident 55's MAR was reviewed by LVN 1 and she stated Resident 55's fingerstick blood sugar was checked at 9:09 a.m. and the result was 145, he did not need the lispro insulin. LVN 1 stated the naproxen was administered with acetaminophen at 9:10 a.m. LVN 1 stated medications were administered late. LVN 1 stated she prepared the medications and asked the IP to administer then she signed the eMAR after medications were administered by the IP. LVN 1 stated she was pregnant and could not go in Resident 55's room because Resident 55 was on enhance barrier precaution. LVN 1 stated it was not an acceptable practice and should not have done it but she did. LVN 1 stated she should have just asked the IP to prepare Resident 55's medications and signed after she administered medications. During an interview on 10/10/24 at 10:30 a.m. with IP, the IP stated she administered Resident 55's medications because LVN 1 could not go in the room. The IP stated it was not the acceptable practice to administer medication you did not prepared. The IP stated medications could be given to the wrong resident which could result to adverse reaction or the prepared medications was not the right medications. During an interview on 10/14/24 at 10:36 a.m. with LVN 7, she stated, .Nurses can not administer medication prepared by another nurse . LVN 7 stated it was never acceptable to have a licensed nurse prepares residents medication then asked another licensed nurse to administer then the same nurse who prepared the medication signs the MAR. LVN 7 stated it was for the safety of the resident, it could be given to a different resident. During an interview on 10/14/24 at 2:43 p.m. with the Director of Nursing (DON), the DON stated it was in their policy to prepare medication, administer to resident then sign the eMAR. the DON stated licensed nurses can not prepare medication then asked another nurse to administer to resident then signed the eMAR. The DON stated asking another nurse to administer medication prepared by another nurse could result to medication error which could result to serious health condition. During a review of facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines dated 10/17, the P&P indicated, . Medications are prepared only by licensed nursing . The person who prepares the dose for administration is the person who administers the dose .The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review the facility failed to provide personal hygiene for two of eight sampled residents (Resident 233 and 32) when Resident 233 and 32's fingernails were long and had black particles underneath. This failure had the potential to result in Resident 233 and 32 to develop skin infections or sustain skin injuries. Findings: During a concurrent observation and interview on 10/8/24 at 8:37 a.m. in Resident 233's room, Resident 233 had long fingernails with black particles underneath. Resident 233 stated, he did not like his fingernails long and wanted them cleaned and cut. Resident 233 stated he did not remember the last time his fingernails were cut. During an interview on 10/8/24 at 8:44 a.m. with the Director of Staff Development (DSD), the DSD stated, Certified Nursing Assistant (CNA) 8 should have cleaned resident's fingernail daily. The DSD stated nurses were responsible cutting diabetic (a chronic disease that occurs when the body doesn't produce or use insulin properly, resulting in high blood sugar levels) resident's fingernails. The DSD stated, long and dirty fingernails were not acceptable. The DSD stated long dirty fingernails caused infections when resident scratch their skin. The DSD stated Residents resident ate with their hands and having long fingernails were uncleaned. During a concurrent observation and interview on 10/8/24 at 9:00 a.m. in Resident 32's room, Resident 32 had long dirty back particles underneath his fingernails. Resident 32 stated he liked his fingernails to be cleaned and did not remember when the last time they were cut. During an interview on 10/14/24 at 9:25 a.m. with CNA 8, CNA 8 stated, Every Sunday we provide fingernail care. CNA 8 stated, CNAs were responsible for trimming, cleaning, and filing of fingernails. CNA 8 stated nurses were responsible to cut and clean fingernails for residents with diabetes. CNA 8 stated long fingernails was not acceptable for residents. CNA 8 stated, long fingernail could cause infections when resident scratch their skins. CNA 8 stated, the fingernails should have been cleaned. During an interview on 10/14/24 with the Director of Nursing (DON) the DON stated, CNAs should have provided fingernail care during showers and as needed. The DON stated license nurses were responsible to cut the fingernails for diabetic residents. The DON stated, cleaned fingernails was important for hygiene. The DON stated, long fingernails caused skin tears when resident scratched their skins. The DON stated nail infection was caused by long dirty fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 233 's Admission Record (AR-a document with personal identifiable and medical information), dated 10/14/2024 the AR indicated, Resident 233 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, peripheral vascular disease (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the body's extremities), hyperlipidemia (is a condition where there are abnormally high levels of lipids or fats in the blood), diabetes mellitus type 2 (disease in which your blood glucose, or blood sugar, levels are too high), hypertension (high blood pressure- is when the pressure in your blood vessels is too high (140/90 mmHg or higher) and pain. During a review of Resident 233's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 10/1/24, indicated the Brief Interview for Mental Status (BIMS) score was 15 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 15 was cognitively intact. During a review of Resident 32 's Admission Record (AR-a document with personal identifiable and medical information), dated 10/14/24 the AR indicated, Resident 32 was admitted to the facility on [DATE] with diagnoses which included fracture (broke bone) of the right femur (part of thighbone next to the hip joint), chronic obstructive pulmonary disease (COPD- group of lung diseases that make it difficult to breathe), hyperlipidemia (is a condition where there are abnormally high levels of lipids or fats in the blood), diabetes mellitus type 2 (disease in which your blood glucose, or blood sugar, levels are too high), hypertension (high blood pressure- is when the pressure in your blood vessels is too high (140/90 mmHg or higher). During a review of Resident 32's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 7/26/24, indicated the Brief Interview for Mental Status (BIMS) score was 14 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 14 was cognitively intact. During a review of the facility's policy and procedure (P&P) titled, SNF Clinic Fingernails/Toenails, Care of dated revised 2/2018, the P&P indicated, .The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection .General Guideline 1. Nail care include daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure two of three sampled Residents (Resident 13 and Resident 33) received the necessary care and respiratory services, consistent with professional standards of practice when: 1. Resident 13's oxygen (a colorless, odorless, tasteless gas essential to living organisms) flow rate (the amount of oxygen being delivered to the body) was not administered according to the physician order (an order given for specific patient/resident by a health care provider). This failure resulted in Resident 13 not obtaining the ordered amount of oxygen via the oxygen concentrator (a machine that pulls in the air around you), which could lead to breathing problems which includes shortness of breath, headache, and confusion. 2. Resident 33's oxygen flow rate was given at a lower rate than the physician's order (a set of written or verbal instructions from a doctor that clinicians follow to care for a patient). This failure had the potential for Resident 33 to experience difficulty breathing, shortness of breath, respiratory distress and lung damage. Findings: 1. During a review of Resident 13's clinical record titled, Admission Record (document containing resident personal information) dated 10/11/24, indicated Resident 13 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe) and unspecified asthma (airways become inflamed, narrow and swell which makes it difficult to breathe). During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive [pertaining to reasoning, memory and judgement] and physical functional level) assessment dated [DATE], indicated Resident 13's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 13 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 13 had no cognitive deficit. During a concurrent observation and interview on 10/8/24 at 8:58 a.m. in Resident 13's room, Resident 13 was sitting up in bed with a nasal cannula (a tube used to deliver supplemental oxygen through the nose) and humidifier connected to oxygen concentrator (medical device that gives extra oxygen), the flow rate (amount of oxygen delivered to the body) indicated four liter per minute. Resident 13 stated her oxygen order is two liters per minute and she had been using oxygen for a long time because of her difficulty breathing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview and record review on 10/10/24 at 11:31 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 verified Resident 13's oxygen flow rate at bedside and stated Resident 13's oxygen flow rate is four liters per minute. LVN 4 reviewed Resident 13's clinical record titled Order Summary Report (a document used to authorize what was ordered by a patient's treating/prescribing physician) active orders dated 10/10/14. LVN 4 stated Resident 13's oxygen order is two liters per minute. LVN 4 stated she was not sure why Resident 13's oxygen flow rate was set at four liters per minute. LVN 4 stated Resident 13's physician order for oxygen should had been followed because receiving too much oxygen could cause change of mental status like hallucination. During an interview on 10/14/24 at 2:15 p.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses are responsible in ensuring resident's oxygen flow rate are accurate and physician's orders are followed. DON stated Resident 13 has COPD and receiving more oxygen than it was ordered could result in oxygen toxicity (too much oxygen causing lung damage and other harmful effects). DON stated oxygen is considered a medication. During a review of facility's policy and procedure (P&P) titled, Medication Administration-General Guideline, dated 10/17, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . During a review of facility document titled, Licensed Practical (Vocational) Nurse (LPN) (LVN), dated 5/22, the document indicated, . Administer medications within the scope of practice and accordance to practitioner orders. Report adverse consequences, side effects or any medication errors . During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse . 49949 2. During a review of Resident 33's Admission Record (AR), dated 10/10/24, the AR indicated, Resident 33 was admitted to the facility on [DATE] with diagnoses which included hypertension (when the pressure in your blood vessels is too high (140/90 mmHg or higher), type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as fuel, pneumonia (an infection of one or both of the lungs caused by bacteria, viruses, or fungi), Acute Respiratory Failure with hypercapnia (a serious medical condition that occurs when there is too much carbon dioxide (CO2) in the blood and the respiratory system is impaired). During a review of Residents 33's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive [pertaining to reasoning memory and judgement] and physical function) assessment dated [DATE], indicated, Resident 33's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 33 was cognitively intact. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsburg Center	1101 Stroud Ave Kingsburg, CA 93631

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/8/24 at 10:38 a.m. in Resident 33's room, Resident 33 was lying in bed and had a nasal cannula (a device that delivers extra oxygen through a tube attached from the oxygen concentrator) into her nose. A black oxygen concentrator was next to the bed. The oxygen concentrator had a liter flow rate at 1 liter per minutes (L/min-oxygen flow rate administered per minutes.) Resident 33 stated she returned from the hospital last week. Resident 33 stated she was in the hospital for pneumonia. Resident 33 stated she was dependent on oxygen since returning from the hospital. Resident 33 stated, the oxygen liter flow should be at 2 liters per minute. During a concurrent observation and interview on 10/9/24 at 5:10 p.m. in Resident 33's room, Resident 33 stated she was not feeling well. LNV 3 was assessing Resident 33. When asked what the oxygen liter flow rate was (LVN) 3 stated Resident 33's oxygen liter flow rate was at 1 liter per minute. During a concurrent interview and record review on 10/10/24 at 3:26 p.m. with LVN 4, Resident's 2 [Facility Name] Order Summary Report (OSR) dated 10/10/24 was reviewed. The OSR indicated, .Oxygen at 2L/min [liters per minutes] via nasal cannula as needed for SOB [shortness of breath] maintain above 90 may up to 4L if needed . LVN 4 stated, the physician's order was for 2 liters per minute nasal cannula. LVN 4 stated, Residents had a change in mental status and change in skin color with decrease in oxygen. LVN 4 stated Residents had respiratory distress due to the decreased in oxygen. LVN 4 stated, a decreased in oxygen caused hypoxia (a condition that occurs when the body's tissues don't have enough oxygen to function properly) and contributed to death. LVN 4 stated she checked on the oxygen liter flow rate in the beginning of her shift. During an interview on 10/14/24 at 3:21 p.m. with the Director of Nursing (DON) the DON stated, the license nurses should have check the physician order to make sure the oxygen liter flow rate was the correct. The DON stated, the license nurses should have checked the setting for the oxygen liter flow at the beginning of every shift. The DON stated, Resident had shortness of breath and decreased in oxygenation when the liter flow was less than what was ordered. The DON stated it was important to keep the oxygen at 92% and a decreased in oxygen liter flow caused residents to become hypoxic. During a review of the facility's policy and procedure (P&P) titled, SNFCLINIC Oxygen Administration dated no date , the P&P indicated, .Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. 2 Review the resident's care plan to assess for any special needs of the resident .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51284 Based on observation, interview, and record review, the facility failed to ensure two of seven sampled residents (Resident 48 and 133) were assessed for the use of bed (side rails) when Residents 48 and 133 had no assessment for the risk of entrapment, a physician's order specifying reason for use was not obtained and a care plan was not created. Additionally Resident 133 did not have informed consent obtained (a form signed by the resident or family explaining the risks). This failure had the potential to place Resident 48 and 133 at risk for decreased freedom of movement, entrapment and/or injury. Findings: During a review of Resident 48's Minimum Data Set (MDS- a resident assessment too used to identify cognitive (mental process) and physical functional level assessment, dated 9/22/2024, indicated Resident 48's Brief Interview for Mental Status (BIMS- screening tool used to assess resident cognitive level) score was 00 out of 15 indicating Resident 48 has severe cognitive impairment (0-7 indicated severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 cognitively intact). During a review of Resident 133's MDS, dated [DATE], the MDS assessment indicated Resident 133's BIMS score was 13 out of 15 indicating Resident 133 was cognitively intact. During a concurrent observation and interview on 10/08/2024 at 8:53 a.m. with Resident 133 in Resident 133's room, Resident 133 was laying up in bed with both side rails up watching television. Resident 133 stated she had been at the facility for one week. During an observation on 10/08/2024 at 10:35 a.m. with Resident 48 in Resident 48's room, Resident 48 had both side rails raised. During a concurrent observation and interview on 10/10/24 at 11:23 a.m. with certified nursing assistant (CNA) 1 in Resident 48's room, Resident 48 was laying in bed with both side rail raised. CNA 1 stated Resident 48 could sometimes help move and turn. CNA 1 stated doctor's orders are always needed if staff want to raise a resident's side rails. During a concurrent interview and record review on 10/10/24 at 11:08 a.m. with Licensed Vocational Nurse (LVN) 5, Resident 48's clinical record, dated 10/10/24, was reviewed. The clinical record indicated there was no physician's orders, no care planning, no consents obtained for the use of side rails and safety evaluation assessment was charted and dated 5/4/24 with recommendation of no rails. LVN 5 stated Resident 48 was on hospice (specialized care which provides comfort and emotional support for people nearing the end of life) and the facility nurse was responsible for ensuring all hospice orders were reflected on their chart. LVN 5 stated resident 48 should not have been using siderails unless physician's orders, care planning, safety evaluation, and consents were put in place. LVN 5 stated it was important to do all the required forms for side rails because it ensured safety for the residents. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/11/24 at 11:18 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 133's clinical record, dated 10/11/24, was reviewed. The clinical record indicated there was no physician's orders, no care planning, and no safety evaluation assessment for use of side rails. LVN 6 stated Resident 133 needed to have all the bedrail forms done otherwise staff could not raise the rails. LVN 6 stated staff needed to complete the required forms for use of bed rails within 24 hours of admission. During an interview on 10/14/24 at 8:05 a.m. with the Director of Staff Development (DSD), The DSD stated nurses were responsible for ensuring care plans, doctor's orders, safety assessments, and consents were obtained for a resident's use of side rails. The DSD stated care plans for the use of side rails get communicated to the CNAs so they could be aware of the reason for use. The DSD stated CNAs were not able to see orders, the nurses was responsible for communicating any pertinent orders to CNAs. The expectation was for the CNAs to know the residents who needed side rails in place, by a verbal communication from the nurses. During an interview on 10/14/24 at 10:18 a.m. with the director of nursing (DON), the DON stated all residents including hospice residents needed a physician's order, care planning, safety evaluation, and consents prior to using side rails. It was the responsibility of the nurse on duty to obtain and input the orders, create the care plans, obtain consent, and fill out a safety assessment. The DON stated these forms needed to be completed to ensure residents were using side rails for their intended ordered purpose. During a review of the facility's policy and procedure titled, clinical guidance for the assessment and implementation of bed rails in hospitals, long term care facilities and home care settings, undated, indicated, . individualized patient assessment, if bed rails have been determined to be necessary .care plans addressing conditions for which the use of bed rails is being considered .documentation of the risk-benefit assessment should be in the patient's medical chart . if determined that bed rails are required bed rails should be closely spaced to prevent entrapment .ensure mattresses are the appropriate size for selected bed frame . preventing the individual from falling between the mattress and bed rails . not medically necessary, it is recommended that they be avoided .

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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. 40641 Based on observation, interview and record review, the facility failed to provide pharmaceutical services which ensured the administration of medication to meet residents needs for one of four sampled residents (Resident 48) when Resident 48's metformin (brand name-medication used to control high blood sugar) medication was not available for administration for two days (10/9/24 and 10/10/24). This failure had the potential for Resident 48's blood sugar to increase which could result to serious medical condition. Findings: During a concurrent observation and interview on 8/10/24 at 8/:24 a.m. in Resident 48's room, Resident 48 was sitting up in bed watching TV, Resident 48 was appropriately dressed and stated he was happy in the facility. During a concurrent observation and interview on 8/10/24 at 8:30 a.m. in Station 2 hallway, Licensed Vocational Nurse (LVN) 1 was observed preparing Resident 48's medications. LVN 1 did not administer Resident 48's metformin. LVN 1 stated she did not administer the medication because it was not available. LVN 1 stated licensed nurse are responsible in making sure routine medications are available to administer to residents. LVN 1 stated Resident 48's blood sugar reading could go higher because he did not received his routine metformin and could result to serious health condition. During a review of Resident 48's Admission Record, dated 10/11/24, the admission record indicated Resident 48 was readmitted in the facility on 7/6/24 with diagnoses which included diabetes (high blood sugar level in the blood), hypertension (pressure in the blood vessels are too high) and unspecified multiple injuries. During a review of Resident 48's eMAR (Electronic Medical Administration Record) dated 10/1/24-10/31/24, the eMAR indicated [metformin brand name] Tablet 500MG [milligram-unit of measurement] Give 1 tablet by mouth two times a day . Resident 48 did not received metformin (brand name) on 10/9/24 and 10/10/24. During an interview on 10/10/24 at 11:40 a.m. with LVN 4, LVN 4 stated it was the responsibility of licensed nurse to ensure medications are available to administer to residents. LVN 4 stated licensed nurses had to be checking resident's medications ahead to ensure pharmacy know when medications are running low to make sure medications are available to administer to residents. During an interview on 10/14/24 at 2:50p.m. with the Director of Nursing (DON), the DON stated licensed nurses are responsible in making sure medications are available and ready to be administered to residents. The DON stated the licensed nurse who administered the last dose should have picked up the phone to pharmacy and have them deliver Resident 48's metformin. The DON stated Resident 48's blood sugar could increase as a result of Resident 48's not receiving the routine metformin. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Ordering And Receiving Medications From The Dispensing Pharmacy, dated 1/22, the P&P indicated, . If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form . Reorder medication five days in advance of need to assure an adequate supply is on hand . The refill order is called in, faxed, or otherwise transmitted to the pharmacy .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to ensure the facility medication error rate did not exceed five percent (6.9 % [percent]) when: 1. Licensed Vocational Nurse (LVN)1 did not administer Resident 48's metformin (brand name-medication used to control high blood sugar) medication during medication pass. This failure had the potential to result in a high blood sugar which could lead to serious medical condition. 2. Resident 23 had a lidocaine patch (transdermal[through the skin] skin patch- topical anesthetic that numbs pain by blocking the nerve signals in your skin) and in place for more than 12 hours. This failure resulted in Resident 23 receiving more than the recommended dose and had the potential for adverse side effects. Findings: 1. During a concurrent observation and interview on 10/10/24 at 8:24 a.m. in Station 2, LVN prepared Resident 48's medications and administered six of seven medications scheduled for Resident 48. LVN stated she did not administer metformin to Resident 48 because it was not available. LVN stated stated Resident 48's fasting blood sugar was 138 in the morning. LVN stated Resident 48's blood sugar level could go higher and cause more serious health condition since the medication was not administered. During a review of Resident 48's Admission Record, dated 10/11/24, the admission record indicated Resident 48 was readmitted in the facility on 7/6/24 with diagnoses which included diabetes (high blood sugar level in the blood), hypertension (pressure in the blood vessels are too high) and unspecified multiple injuries. During a review of Resident 48's eMAR (Electronic Medical Administration Record) dated 10/1/24-10/31/24, the eMAR indicated [metformin brand name] Tablet 500MG [milligram-unit of measurement] Give 1 tablet by mouth two times a day . Resident 48 did not received metformin (brand name) on 10/9/24 and 10/10/24. During an interview on 10/14/24 at 2:50p.m. with the Director of Nursing (DON), the DON stated licensed nurses are responsible in making sure they have medication available to administer to residents. The DON stated the nurse should have called pharmacy when the medication was not available for administration. The DON stated the licensed nurse who administered the last dose should have called pharmacy and let them know to deliver medication. The DON stated Resident 48' could have higher readings of blood sugar due to missing two doses of the medication. During a review of facility's policy and procedure (P&P) titled, Medication Error,: dated 6/28/22, the P&P indicated, . All errors related to the administration of medications or treatments will be reported to the Director of Nursing Services, the attending physician . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Ordering and Receiving from Pharmacy, dated 1/22, the P&P indicated, Medications and related products are received from the dispensing pharmacy on a timely basis . If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form . Reorder medication five days in advance of need to assure an adequate supply is on hand . During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 10/10, the P&P indicated, . Medications are administered in accordance with the prescriber orders, including any required time frame . Medication errors are documented, reported, and reviewed . https://mynextgenrx.com/diabetes/metformin-generic-glucophage/ the reference indicated . Take this medication regularly in order to get the most benefit from it. Remember to use it at the same times each day . Check your blood sugar regularly as directed by your doctor. Keep track of the results, and share them with your doctor. Tell your doctor if your blood sugar measurements are too high or too low. Your dosage/treatment may need to be changed . 49949 2. During an observation on 10/10/24 at 7:12 a.m. in Resident 23's room, License Vocational Nurse (LVN) 2 did not applied Resident 23's lidocaine patch. During an interview on 10/10/24 at 10:49 a.m. with LVN 2, LVN 2 stated, Resident 23 requested for a new [lidocaine] patch. LVN 2 stated the patch was rolled up and coming off Resident 23's back. LVN 2 stated the old lidocaine patch was dated 10/9/24 when she removed it from Resident 23's back. During a concurrent interview and record review on 10/10/24 at 11:00 a.m. with LVN 2, stated, The [lidocaine] patch should have been removed at bedtime. LVN 2 stated, Resident 23 needed the lidocaine patch removed every 12 hours to prevent skin irritation. LVN 2 stated the night nurse should have removed the patch at bedtime. During an interview on 10/10/24 at 11:31 with Resident 23, Resident 23 stated, the nurses applied a lidocaine patch in the morning and at night. Resident 23 stated the nurses applied the lidocaine patch two times a day for the last 2 months. During an interview on 10/14/24 at 11:32 a.m. with the Pharmacist Consultant (PC), the PC stated, the lidocaine patch is applied for 12 hours to the skin. The PC stated the lidocaine patch needed to be removed every 12 hours. The PC stated the lidocaine was not intended to be worn for 24 hours. The PC stated, lidocaine patches worn for more than 24 hours can cause harm to the residents. The PC stated the nurse should have follow what was written on the medication administration Records. The PC stated the MAR should indicate when to remove the patch. The PC stated the lidocaine patch can cause skin irritation if left on for to long and can cause side effects. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/24 at 3:21 p.m. with the Director of Nursing (DON), the DON stated, the nurses should follow the physician order. The DON stated, the nurse should have removed the patch every night. The DON stated the physician order indicated the lidocaine patch should have been removed every 12 hours. The DON stated it was important to remove the lidocaine patch at night to prevent skin irritation. The DON stated, the nurse should have clarified the order with the physician if there was any confusion. During a review of Resident 23's Admission Record (AR), dated 10/12/2024, the AR indicated Resident 23 was admitted to the facility on [DATE]. The ARD indicated Resident 23 had diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a group of lung disease that makes it hard to breath) heart failure (a serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organs) Hypertension (high blood pressure- when the pressure in your blood vessels is too high [140/90 mmHg or higher], and constipation. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 8/15/24, the MDS, indicated Resident 23 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 7 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 23 was severely cognitive impaired. During a review of Resident 23's [Facility Name] Order Summary Report (OSR), dated 10/14/24, the OSR indicated, .Lidoderm Patch 5% (lidocaine) apply to lower back topically every 12 hours for pain remove at bedtime .start date: 09/05/24 . During a review of facility's policy and procedure (P&P) titled, Transdermal Drug Delivery System (PATCH) Application, dated 4/08, the P&P indicated To administer medication through the skin for continuous absorption while the pastch is in place . During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 4/19, the P&P indicated, . Medications are administered in accordance with prescriber orders, including any required time frame .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional standards of practice for three of 14 sampled residents (Residents 18, 51, and 76) when: 1a. Resident 51's Fluticasone Propionate (medication sprayed into the nostrils in order to reduce swelling in the body) was not labeled with its expiration date. 1b. Resident 76's albuterol sulfate (medication used to help open up the airways making it easier to breathe) was not labeled with its expiration date. These failures placed Residents 51 and 76 at risk of being administered medications way past its expiration date which could result in less effective medications. 2. Resident 18's insulin pen (pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge) was missing a label on the pen. This failure had the potential to result for Resident 18 at risk of receiving an incorrect medication. 3. Four medication pills were found on the floor in one of two medication storage room and one and a half pill was found inside a red medication bin. This failure had the potential for an increased risk of medication error to occur. Findings: 1. During a review of Residents 51's Admission Record (AR- a document which provides resident contact details, a brief medical history level of functioning, preferences, and wishes), dated 10/14/24, the AR indicated Resident 51's admitting diagnoses included the following: acute respiratory failure with hypoxia (a condition where someone doesn't have enough oxygen in the tissues of their body) and heart failure (when the heart can't pump enough blood and oxygen to the whole body) During a review of Resident 51's, Order Summary Report, dated 10/14/24 the order summary report indicated, Resident 6 had an order for Fluticasone Propionate every morning for allergies. During a review of Residents 76's AR, dated 10/14/24, the AR indicated Resident 76's admitting diagnoses included the following: acute respiratory failure with hypoxia(a condition where you don't have enough oxygen in the tissues in your body) and heart failure (when the heart can't pump enough blood and oxygen to the whole body) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's, Order Summary Report, dated 10/14/24 the order summary report indicated, Resident 76 had an order for albuterol sulfate every eight hours as needed for shortness of breath. During a concurrent observation and interview on 10/11/24 at 8:42 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 51's Fluticasone Propionate and Resident 76's albuterol sulfate were not labeled with the expiration date. LVN 6 stated the medication should have had the expiration dates written on them, it was the facility's practice to always write the expiration date. During an interview on 10/14/24 at 9:27 a.m. with the Infection Preventionist (IP) the IP stated it was important for the medications to have the expiration date. The IP stated if the expiration date was not on the medications, it could have caused nurses to use the medications after the expiration date. The IP stated using medications past the expiration date would have caused residents to receive medication which did not work as intended anymore. During an interview on 10/14/24 at 10:17 a.m. with the Director of Nursing (DON), the DON stated the medications needed to be labeled with the opened date and the expiration date. The DON stated the staff needed to label Resident 61 and 76's medications in order to know how long the medications were good for. During a review of the facility's policy and procedure titled, Medication Labeling and Storage, dated 2/23, indicated, . 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices 2. The medication label includes, at a minimum .d. expiration date . 49949 2. During a review of Resident 18 's Admission Record (AR-a document with personal identifiable and medical information), dated 10/14/2024 the AR indicated, Resident 29 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2 (disease in which your blood glucose, or blood sugar, levels are too high), hypertension (high blood pressure- is when the pressure in your blood vessels is too high (140/90 mmHg or higher) end stage renal disease, (ESRD- is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), heart failure (when the heart cannot pump enough blood and oxygen to support other organs in the body), dementia (loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anemia (blood disorder that occurs when your body doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to your body's tissues) and pain During an observation on 10/11/24 at 10:45 a.m., in the hallway a medication cart # 2 contained a bag with an insulin pen. The bag contained a label with the Resident 29's name, medication, prescribed dosed, strength, expiration date, route of administration and appropriate instruction. The insulin pen did not contain a label. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/14 at 11:29 a.m. with Registered Nurse (RN) 2, RN 2 stated, the pen was missing a label. RN 2 stated, it was important to make sure the pen contained the 5 rights (the five rights of medication use: the right patient, the right drug, the right time, the right dose, and the right route- generally regarded as a standard for safe medication practices). RN 2 stated, she should have discard it and not use if without the resident name. RN 2 stated, the insulin pen should not be given without resident name. RN 2 stated, insulin pens without labels could be given to the wrong resident without label. During an interview w RN 2 stated, there should be a label on the insulin pen. During an interview on 10/14/24 at 11:32 with Pharmacist Consultant (PC), The PC stated insulin pens are sent out with two labels from the pharmacy. The PC stated, insulin pens should have arrived with a label on the bag and on the pen to the facility. The PC stated, insulin pens had a primary label on the bag and secondary label on the pen. The PC stated, the insulin pen should have a label on the pen to prevent mixing it up with other insulin pens. The PC stated it was important for the two labels on the bag and pen for resident safety. The PC stated, During an interview on 10/14/24 at 3:21 p.m. with the Director of Nursing (DON), the DON stated, the insulin pen should have a label on the pen. The DON stated, when insulin pen was not label it caused confusion. The DON stated the unlabeled insulin pen can be given to someone else. The DON stated unlabeled insulin pen was an infection control. The DON stated, the nurse should contact the pharmacy to get a new label for the insulin pen. During a review of the facility's policy and procedure (P&P) titled, SNF Clinic Medication Labeling and Storage dated revised 2/2023, the P&P indicated, .Medication Labeling .8. If medication containers have missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items . 3. During an observation on 10/11/24 at 9:21 a.m. in the medication storage room, there were four loose pills in the [NAME] of one room and one and a half pill in a red medication plastic bin. During an interview on 10/11/24 at 9:28 a.m. with License Vocation Nurse (LVN), LVN 3 stated thee four loose pills should not be on the ground. LVN 3 stated loose pills on the floor were unacceptable in the medication room. LVN 3 stated, loose pills should be in destroyed bins. LVN 3 stated the medication pills on the floor had the potential to be mixed and administered to other residents which increase the risk of medication error. During an interview on 10/14/24 at 11:32 a.m. with the Pharmacist Consultant (PC), the PC stated, You should never want medication on the ground. The PC stated, all medication should be destroyed in the medication bins. The PC stated license nurses were required to disposal of non-controlled medication in the bins and controlled medication were to go to the Director of Nursing (DON) for disposition. During an interview on 10/14/24 at 3:21p.m. with the DON, the DON stated, loose medication should not be on the floors. The DON stated, the loose pills should have been ion the destruction bin. DON stated the license nurse should have checked the rooms daily and made sure there were not loose pills on the ground. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, SNF Clinic Discarding and Destroying Medications dated revised 10/2022, the P&P indicated, .2. Non-controlled and Schedule V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 28773 Based on observation, interview and review of facility documents, the facility failed to: 1. Comply with Federal regulations related to the oversight of food service operations when the facility did not have a full-time dietitian and the requirements were not met as specified in established State standards (California Code, Health and Safety Code - HSC S 1265.4) for food service managers which required, employment of a full-time, qualified dietetic supervisor when the dietitian was not full-time; and 2. Ensure the Registered Dietitian (RD) provided frequently scheduled consultation to the Food and Nutrition Services department. The lack of a qualified, full-time, competent supervisor to oversee Food and Nutrition Services, and lack of frequently scheduled consultation from the RD, placed the 83 residents who were admitted to the facility at risk for receiving incorrect food items, not receiving a well-balanced diet that was approved by the RD which could result in residents receiving over or under nutrition that can increase their nutrition risk and further compromise their medical condition. It also has the potential to place resident's at risk for the growth of microorganisms and food borne illness (illness caused by food contaminated with bacteria, viruses, parasites or toxins). Findings: 1. According to the California Code, Health, and Safety Code - HSC S 1265.4: A licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor (DSS) who meets the requirements of subdivision (b) to supervise dietetic service operations. Subdivision (b) includes seven different pathways to be qualified. Two of the pathways include being credentialed as a Certified Dietary Manager with 6 hours of in-service training on the specific training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full -time duties as a DSS at the health facility. During an interview with Certified Dietary Manager (CDM) 1 on the initial kitchen tour on 10/8/24 at 8:28 AM, CDM 1 stated he is the CDM that works 32 hours a week at the facility. CDM 1 stated he was a District Manager for the contact food service company, and he has four different facilities. During an interview with CDM 1 on 10/09/24 at 10:37 AM, CDM 2 stated the Kitchen Supervisor (KS) is in a manager in training (M.I.T.) program with the contract food service company and that CDM 1 & CDM 2 (District Managers for the contract company that have three to four facilities each) provide 32 hours of oversight per week. CDM 1 stated they will be there until KS completes the CDM program. CDM 1 stated he provides oversite 16 hours per week while CDM 2 provides oversight for another 16 hours per week. CDM 1 stated KS has approximately two weeks until he is eligible to take the Certified Dietary Manager exam. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with CDM 2 on 10/10/24 at 9:16 AM, CDM 2 stated he and CDM1 split the oversight of KS. CDM2 stated he is usually onsite Thursday and Friday, but his schedule is flexible. CDM 2 stated he started coming here about 3 weeks ago. CDM 2 stated he will recap menu checks and observe the meal tray process, but KS is responsible for meal tray accuracy at the facility. CDM 2 described the meal tray accuracy as a test tray process. CDM 2 stated when he is at the facility he will do a District Manager recap. During a concurrent review of the recap document, it showed there was items pertaining to the budget and a couple items on the food service operation. No documentation was given to the surveyor to show how they were providing guidance to the unqualified KS when they were onsite. During a concurrent interview with the KS, CDM 2 on 10/10/24 at 10:26 AM, KS stated he still has one nutrition class to complete the CDM pathway and then once it is completed, he can take the exam for the CDM. CDM 2 confirmed CDM 1 and 2 are only on site for 32 hours a week. KS stated he was the person who had completed staff competencies on the kitchen staff not the CDMs. Review of the kitchen schedule dated 8/24, 9/24 and 10/24, showed the KS was the Manager and worked five days a week from 8 AM until 5:30 PM. On the bottom of the schedule CDM 1 name and phone number were listed as the District Manager. CDM 1 and CDM 2 were not on the schedule. Review of the KS job description, it showed required credentials to be in States that have established standards for food service managers, meet State requirements. 2. During the Re-Certification survey from 10/8/24 - 10/10/24, multiple issues were identified regarding: kitchen staff competency (Cross Reference F802), not following the planned menu (Cross Reference F803), puree food not the proper form when a whole green bean was found in the puree salad (Cross Reference F805), resident food preferences were not accommodated when they were given food they disliked and there was no alternate food given when residents did not like spinach (Cross Reference F806), and food was not prepared in accordance with professional standards for food service safety when the sanitizer solution was not the appropriate concentration to sanitize food preparation areas and equipment (Cross Reference F812). During an interview with KS and Certified Dietary Manager (CDM) 1 and CDM 2 on 10/10/24 at 11:35 AM, KS stated the RD was remote and had been here once since KS started working here and the RD reviewed the substitution logs. During an interview on 10/10/24 at 2:41 PM, RD stated he works 8 hours a week and on Fridays at the facility. RD stated he was working remotely until about two weeks ago however he was there in person two weeks ago then was sick last week, so he had not been back in person yet. RD stated he was a consultant for the facility. RD stated he does not review or approve the facility menu. He stated he is aware that the KS is not qualified. RD stated the kitchen was going to pick up tray audit tasks but have not yet. RD stated the last time he did a kitchen a sanitation report was sometime in the last quarter of 2023. RD stated most of his time was as a clinician and not in food service. He stated he would dabble in food service but most of the time doing clinical work. RD confirmed he does not evaluate or identify concerns in the food service operations and relies on the KS to let him know what type of in-services may be needed. RD stated KS had not needed any in-services for the food service staff. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Administrator on 10/10/24 at 4:20 PM, Administrator stated he was working with the contractor to ensure the RD was in-person for a couple weeks since the RD had been remote, and he was aware that would not work. During an interview with the Regional Resource RD (REG RD) on 10/11/24 at 11:15 AM, the REG RD stated her role at the facility was doing kitchen sanitation walk-throughs and to work with the facility RD and be their resource. REG RD stated she identifies areas that are not in compliance and brings it to the facilities attention and the facility RD and KS would review her report and do an action plan to address concerns and they will determine the time frame to work on the concerns. REG RD stated she does not have oversight of the kitchen and the facility RD is the oversight of the facility kitchen. REG RD stated she was aware the facility RD was remote and that she thought it was for several months. Review of the RD contract dated 6/29/22, showed the description of the project was the RD services as directed by the facility and the hourly rate. Review of a document titled Contracted RD Tasks, undated, showed the position included completing clinical nutrition assessments, documenting using the Nutrition Care process in the electronic medical record system, collaborating with the interdisciplinary care plan team, completing Section K of the Minimum Data Set (MDS), calculating tube feeding (enteral nutrition - feeding nutrition through tube into the gut), and making recommendations for wounds and significant weight changes. There were no RD responsibilities for the food service operations or to have any oversight or frequently scheduled consultation with the KS. There was no documentation provided to validate the RD provided frequently scheduled consultation to the KS. During an interview with the Administrator on 10/14/24 at 10:16 AM, Administrator stated he had obtained the scope of the RD, and it was a couple bullets on a word document. He stated this contract was in place prior to him being the administrator for the building. Administrator confirmed the RD scope was limited and they would need the RD to do more moving forward.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 51223 Based on observations, interviews and review of facility documents, the facility failed to ensure support personnel was able to effectively carry out the functions of food and nutrition services when [NAME] 1 did not follow menus and recipes. This failure resulted in not accommodating resident preferences which could result in disinterest in meals and decreased meal intake which has a potential to result in weight loss which can compromise the medical condition. This also had the potential to result in increased residents' risk of choking for nine residents. Findings: 1. a. During the review of facility document titled, hcsg1NewGen 2024 Diet Guide Sheet for 10/8/24, showed 1/2 cup of creamed spinach for the following diets: Regular, Dys Adv, Dys Mech, renal, vegetarian. It showed for the puree diet to serve pureed creamed spinach. During a lunch meal observation on 10/08/24 starting at 12:00 PM, in the kitchen, [NAME] 1 prepared the tray line steam table with: puree (steamed) spinach, regular (steamed) spinach. During an interview with [NAME] 1 on 10/8/24 at 12:48 PM, [NAME] 1 stated she prepared 10 pounds (lbs) of frozen spinach, they ran low on spinach and had to make 3-4 more servings to finish the tray line. During an interview with the Kitchen Supervisor (KS) on 10/10/24 at 10:57 AM, KS stated he expects the cook to prepare items on the menu as listed. KS stated he expects the cook to follow recipes. During a review of the facility document titled Census List: 10/8/24 5:54PM, showed there were 81 residents eating at the facility. Review of meal tickets showed there were two residents who disliked spinach (Cross Reference F806), therefore 79 residents eating spinach at the facility. During the review of the facility document titled, Corporate Recipe-Number: 3340 Spinach, Creamed (frz), showed the ingredients: spinach, chopped, frozen; water; margarine, solids; flour, all purpose; spice, pepper, black, ground; and milk 2% reduced fat, gallon. It showed for 80 servings that 16 pounds of spinach was needed. Cross Reference F803. b. During a review of the facility document titled, Week-At-A- Glance menu, dated 10/08/24, showed creamed spinach as the primary vegetable and capri vegetable blend as the alternate; Salisbury steak-brown gravy as an alternate entree to Hawaiian Baked Ham; and Parmesan Noodles as an alternate to Baked Sweet Potatoes. During a review of the facility document titled Production Counts (Day 3: Wk. 1-Tuesday-10/8/2024) Lunch Hot Foods, dated 10/8/24, indicated for the cook to prepare the following food items: Glazed Baked Pork Chop, Hawaiian Baked Ham, two of the three-ounce portions of Salisbury Steak, two servings of 1/2 cup portion of the Capri Vegetable Blend. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the lunch meal observation on 10/08/24 starting at 12:00 PM, in the kitchen, [NAME] 1 would plate residents' trays with food items from the steam table. The steam table contained: Hawaiian Baked Ham, Poppyseed roll, steamed spinach, puree bread, puree spinach, mechanical chopped ham, mashed sweet potatoes, fortified potatoes, buttered noodles, sauce/gravy. The tray line did not include an alternate vegetable to spinach or alternate to ham. Resident #31's tray showed ham, sweet potatoes, and a roll. There was no vegetable on the tray. Resident #31's meal ticket on the tray showed resident was on a regular diet and disliked spinach. Resident #44 tray showed sweet potatoes, ham, spinach, and a roll. Review of Resident 44's meal ticket on the tray showed the resident was on a carbohydrate-controlled diet and that the resident disliked the potato group. Resident #75's tray showed ham, spinach, sweet potatoes, and a roll. Review of Resident 75's meal ticket on the tray, showed regular dysphagia mechanical diet and the resident dislikes ham and pork group. Resident #184's tray showed diced ham, spinach, sweet potatoes, and a roll. Review of Resident #184's meal ticket showed a consistent carbohydrate, dysphagia advanced diet and the resident dislikes ham group. During an observation and concurrent interview when the trays in the meal cart that were ready to leave the kitchen, on 10/08/24 at 12:15 PM. with the Kitchen Supervisor (KS), KS confirmed Resident #75 and Resident #184's dislike of ham group and/or pork group and removed the Hawaiian Baked Ham from the tray. They then served egg salad to the residents. Cross Reference F803. c. During an observation on 10/09/24, at 12:48 PM, food cart 4 arrived at nursing station 2 and the test trays were sampled in the hallway, in conjunction with the Certified Dietary Manager (CDM 1). A whole green bean was identified in the pureed salad. A concurrent interview was conducted at this time with the District CDM, he acknowledged the whole green bean in the puree salad and stated that was not okay. During an interview with the [NAME] 1, on 10/09/24 at 1:02 PM, [NAME] 1 stated she used the handheld blender to prepare the puree green bean salad with Italian dressing. During a record review of Corporate Recipe-Number 4169 Vegetable, the Salad, Marinated Bean (frz) recipe, undated, indicated for pureed: measure out desired number (#) of servings into food processor. Blend until smooth. Cross Reference F805. During an interview with the Registered Dietitian (RD) on 10/10/24 at 2:41 PM, RD stated he has offered to conduct in-services for the kitchen staff, but they had not stated they needed them. RD stated he relies on KS to determine what is needed from him and that he does not evaluate operations to determine what training is needed. Review of the facility document regarding the online in-services for food and nutrition services staff, showed a topic of texture modification and plate presentation dated 9/8/23 and 9/5/24 was completed for [NAME] 1. However, it was unclear what the content of the in-service or outline of education materials and what questions were asked to determine competency. There was no documentation of in-services that were given to food and nutrition services staff regarding following recipes or menu spreadsheets. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of [NAME] 1's Food & Nutrition: Competency Checklist-Food Service Worker, undated, Kitchen Supervisor (KS) signed off on [NAME] 1's competency checklist under Knowledge of Food Practices-prepare mechanically altered foods correctly to recipe, read menu and spreadsheets, and correctly assemble resident meal trays. However, there were observations of concerns with [NAME] 1 competency of the above items during the course of the recertification survey. It is unclear how the evaluation of competency was determined by KS. Review of the facility policy and procedure titled Education and Training HCSG Policy 003, revised 9/15/17, showed all employees will be provided education and training upon hire and ongoing to ensure they have the appropriate competencies and skill sets to carry out the functions of food and nutrition services, taking into consideration the needs of the resident population. It showed that when training materials were not available in the online training library, the KS will maintain records of sessions including the following information: Topic, Outlines of education materials, list of attendees and signature of attendees. The policy did not state an evaluation of competency would be determined after the in-service was given.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51223 Based on observations, interview and review of facility documents, the facility failed to ensure the menu was followed: 1. For the lunch meal on October 8, 2024, when steamed spinach was served instead of creamed spinach for 79 of 81 residents eating spinach at the facility. 2. For the lunch meal on October 8, 2024, when an incorrect scoop size was used for the mechanical (diced) ham given to 24 residents (Resident 34, 185, 1, 16, 33, 51, 42, 22, 24, 43, 46, 26, 60, 2, 29, 186, 27, 40, 21, 30, 76, 184, 18, 35) on the dysphagia advanced (Dys Adv per the National Dysphagia Diet as Level 3-food should be: soft solid, easy-to-cut-meats, fruits and vegetables, requires some chewing ability, meats in soft, bite-size pieces) and the 9 residents (Resident 66, 62, 75, 7, 70, 183, 3, 54, 56) on the dysphagia mechanical (Dys Mech per the National Dysphagia Diet as Level 2-food should be: cohesive, moist semi-solid food, requires some chewing ability, ground or minced meats, moist, ground, soft-textured minced or fork-mashable textured foods) diets; 3. For the lunch meal on October 8, 2024, when fortified mashed potatoes were served instead of whipped sweet potatoes to 9 residents (Residents 25, 53, 17, 11, 68, 6, 12, 48) on a puree diet and 9 residents (Resident 66, 62, 75, 7, 70, 183, 3, 54, 56) on the Dys Mech diets; and 4. For Resident 133 on a vegetarian diet when the resident was given egg salad for lunch and dinner meals on October 8, 2024, and lunch meal on October 9, 2024, and that was not on the planned menu. These failures had the potential for residents' to not meet their nutrition needs which could result in over or under nutrition which can further compromise their medical status. These failures can also result in residents receiving a lack of variety of foods which could lead to a disinterest in eating which could result in residents not meeting their nutrition needs which can further compromise their medical condition. Findings: 1.During an interview during the initial pool process on 10/8/24 at 10:08 AM, unsampled Resident 5 stated the food was terrible, bland and without flavor. At 10:14 AM, unsampled Resident 31 stated the food was like prison food. During the review of facility document titled, hcsg1NewGen 2024 Diet Guide Sheet for 10/8/24, showed 1/2 cup of creamed spinach for the following diets: Regular, Dys Adv, Dys Mech, renal, vegetarian. It showed for the puree diet to serve pureed creamed spinach with a #10 scoop (3/8 cup). During a lunch meal observation on 10/08/24 starting at 12:00 PM, in the kitchen, [NAME] 1 prepared the tray line steam table with: puree (steamed) spinach with a #10 scoop, regular (steamed) spinach with a #8 scoop (1/2 cup). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with [NAME] 1 on 10/8/24 at 12:48 PM, [NAME] 1 stated she prepared 10 pounds (lbs) of frozen spinach, they ran low on spinach and had to make 3-4 more servings to finish the tray line. During an interview with the Kitchen Supervisor (KS) on 10/10/24 at 10:57 AM, KS stated he expects the cook to prepare items on the menu as listed. KS stated he expects the cook to follow recipes and garnish every plate. During a review of the facility document titled Census List: 10/8/24 5:54PM, showed there were 81 residents eating at the facility. Review of meal tickets showed there were two residents who disliked spinach (Cross Reference F806), therefore 79 residents eating spinach at the facility. During the review of the facility document titled, Corporate Recipe-Number: 3340 Spinach, Creamed (frz), showed the ingredients: spinach, chopped, frozen; water; margarine, solids; flour, all purpose; spice, pepper, black, ground; and milk 2% reduced fat, gallon. It showed for 80 servings that 16 pounds of spinach was needed. During an interview with the Registered Dietitian (RD) on 10/10/24 at 2:41 PM, the RD stated he expected staff to follow menus and recipes. 2. During a review of facility document titled, the hcsg1NewGen2024 Diet Guide Sheet dated 10/8/24, the lunch menu noted: Hawaiian Baked Ham ground #10 scoop (3/8 cup) for Dys Adv and Dys Mech diet group. During the lunch meal observation on 10/08/24 starting at 12:00 PM, in the kitchen, the tray line steam table contained mechanical (diced) ham with a #8 scoop (1/2 cup). [NAME] 1 was observed using the # 8 scoop to dish out the diced ham to 24 residents on a Dys Adv diet (Resident 34, 185, 1, 16, 33, 51, 42, 22, 24, 43, 46, 26, 60, 2, 29, 186, 27, 40, 21, 30, 76, 184, 18, 35) and 9 residents (Resident 66, 62, 75, 7, 70, 183, 3, 54, 56) on a Dys Mech diet. During a review of facility document titled Census List: 10/8/24 5:54PM, the following 24 residents had a physician diet order of Dys Adv : Residents 34, 185, 1, 16, 33, 51, 42, 22, 24, 43, 46, 26, 60, 2, 29, 186, 27, 40, 21, 30, 76, 184, 18, 35 and 9 residents had a physician diet order of Dys Mech for Residents 66, 62, 75, 7, 70, 183, 3, 54, 56. During an interview with the Kitchen Supervisor (KS) on 10/10/24 at 10:57 AM, KS stated he expects the cook to prepare items on the menu as listed. KS stated he expects the cook to follow recipes. During an interview with the Registered Dietitian (RD) on 10/10/24 at 2:41 PM, the RD stated he expected staff to follow portion sizes and menus. 3.During the review of facility document titled, the hcsg1NewGen 2024 Diet Guide Sheet dated 10/8/24, showed baked sweet potatoes for regular diet and whipped sweet potatoes for the Dys Adv/Dys Mech/Dys Puree diet group. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the lunch meal observation on 10/8/24 starting at 12:00 PM, in the kitchen, the steam table contained: mashed sweet potatoes and fortified mashed potatoes. There were no whipped sweet potatoes. [NAME] 1 would plate residents' trays with food items from the steam table. [NAME] 1 used a #8 scoop (1/2 cup) of fortified mashed potatoes to the 9 residents (Residents 25, 53, 17, 11, 68, 6, 12, 48) on the puree diet and 9 residents (Residents 66, 62, 75, 7, 70, 183, 3, 54, 56) on Dys Mech diets with the fortified mashed potatoes. During an interview with [NAME] 1 on 10/8/24 at 1:00 PM, at the end of the lunch meal service, [NAME] 1 confirmed that the residents on puree and Dys Mech diets received the fortified mashed potatoes and they did not get sweet potatoes. During an interview with [NAME] 1 on 10/9/24 at 1:02 PM, in the kitchen, [NAME] 1 stated yesterday's lunch served white fortified potato versus the whipped sweet potatoes because she added marshmallows to the sweet potatoes. [NAME] 1 stated the puree potatoes were whipped potatoes and butter which made it fortified. During an interview with the Kitchen Supervisor (KS) on 10/10/24 at 10:57, KS stated he expects the cook to prepare items on the menu as listed. KS stated he expects the cook to follow recipes and garnish every plate. During the review of facility document titled, Census List: 10/8/2024 5:54 PM indicated the following residents were on a physician's order for puree diet for Resident 25, 53, 17, 11, 68, 6, 12, 48 and Dys Mech diet for Resident 66, 62, 75, 7, 70, 183, 3, 54, 56. During an interview with the Registered Dietitian (RD) on 10/10/24 at 2:41 PM, the RD stated he expected staff to follow menus. 4. During an observation on 10/08/24 at 12:07 PM in the kitchen, [NAME] 1 prepared Resident #133's meal tray with egg salad. Review of Resident 133's meal ticket showed she was on a regular diet, and it showed vegetarian. It showed beverages of whole milk and iced tea. There were no other likes or dislikes on the meal ticket. During an interview with KS on 10/08/24 at 4:58 PM, in the kitchen prior to the dinner meal service, KS stated the egg salad sandwich is used for residents who do not eat meat. During a concurrent observation and interview with Resident 133 on 10/09/24 at 1:11 PM, in Resident 133's room, Resident #133 stated yesterday (10/08/24) she had egg salad for lunch and an egg salad sandwich for dinner. Observed Resident 133's entree was egg salad with approximately 25% eaten. Resident 133 stated she is kinda over it as she eats egg salad often. Resident 133 stated she would have like the cheese ravioli that was on the menu for lunch today. Resident 133 stated she met with the KS and informed she is a vegetarian. During an interview with [NAME] 1 on 10/09/24, at 1:16 PM, in the kitchen, [NAME] 1 stated she was told by KS Resident 133 wants egg salad all the time. [NAME] 1 stated KS manages the resident requests and she prepares meals per KS. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with KS on 10/09/24 at 1:18 PM, KS stated Resident 133 was admitted two weeks ago and last week wrote on a meal ticket that she prefers egg salad and fruit. KS stated the preference was not entered in the system and he provided his staff verbal instruction. KS stated he did not enter the dislike on the meal ticket and then stated he may be confusing Resident 133's dislikes with the roommate's information as he interviewed a bunch of residents that day. KS was unable to show documentation of Resident 133's handwritten meal ticket requesting egg salad every day. During an interview with Certified Dietary Manager (CDM) 1 on 10/09/24 at 1:18 PM, CDM 1 stated Resident 133 has a number of special requests, and the food supplier has limited veggie options to purchase. It is unclear why the facility could not purchase vegetarian food items from a local grocery store. During an interview with KS on 10/10/24 at 10:57 AM, KS stated he expects the cook to prepare items on the menu as listed. KS stated he expects the cook to follow recipes and garnish every plate. During a review of Resident #133's meal ticket, dated 10/08/24, the meal ticket indicated the resident is on a regular vegetarian diet. During a review of facility document titled, hcsg1NewGen2024 Diet Guide Sheet, indicated for 10/8/24, the lacto-ovo vegetarian (vegetarian menu for those who eat dairy and eggs) lunch entree listed veggie chicken patty and for the dinner entree. For 10/9/24 for the lunch entree it showed they should get cheese ravioli with marinara sauce and the for the dinner entree it was veggie chicken patty. There was not much variety or variation for these two days on the vegetarian menu. During an interview with the Registered Dietitian (RD) on 10/10/24 at 2:41 PM, the RD stated he expected staff to follow menus and recipes. The RD stated there is a vegetarian menu and that should be followed. The RD stated he has not reviewed or approved the facility menu. During a review of the facility policy and procedure titled Menus - HCSG Policy 004, revised 9/17, showed menus will be served as written and that the RD reviews and approves the menus.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 51223 Based on observation, interview and review of facility documents, the facility failed to ensure pureed food was in the proper form when a whole green bean was served on a pureed diet test tray. This failure had the potential to increase the risk of choking for nine residents who had physician ordered pureed diets due to having severe chewing and/or swallowing problems. Findings: During a lunch meal observation in the kitchen on 10/09/24 at 12:26 PM, meals were placed on trays and put into food cart 4. A regular and puree test tray was ordered by the surveyors. [NAME] 1 plated the test tray for the puree diet test tray with pureed ravioli, pureed bread, pureed salad. During an observation on 10/09/24, at 12:48 PM, food cart 4 arrived at nursing station 2 and the test trays were sampled in the hallway, in conjunction with the Certified Dietary Manager (CDM) 1. A whole green bean was identified in the pureed salad. A concurrent interview was conducted at this time with the CDM 1, he acknowledged the whole green bean in the puree salad and stated that was not okay. During an interview with the [NAME] 1, on 10/09/24 at 1:02 PM, [NAME] 1 stated she used the handheld blender to prepare the puree green bean salad with Italian dressing. During a record review of Corporate Recipe-Number 4169 Vegetable, the Salad, Marinated Bean (frz) recipe, undated, indicated for pureed to measure out desired number (#) of servings into food processor then blend until smooth. During a review of facility document Diet and Nutrition Care Manual, dated 2019, regarding the Dysphagia Puree (Level 1 Diet) indicated all foods must be the consistency of moist, pudding like consistency without particles. Review of the facility document regarding the online in-services for food and nutrition services staff, showed a topic of texture modification dated 9/8/23 was completed for [NAME] 1. However, it was unclear what the content of the in-service consisted of and what questions were asked to determine competency.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 51223 Based on observations, interview and review of facility documents, the facility failed to: 1. Ensure Resident food preferences were accommodated for three residents (Resident 44, 75, 184); and 2. Provide an alternate option when residents disliked a food group for two residents (Resident 31, 39). This failure had the potential to increase residents' refusal of food items due to the facility not following the resident's preferences and potential reduction of meeting the resident's nutritional needs. 3. Resident 52 's dislike of warm food and preference of cold food on his meal ticket (document used to write a resident ' s diet, likes, dislikes, and allergies) was not documented. This failure had the potential for Resident 52 to not receive the caloric intake needed to meet his nutritional needs. Findings: 1. During the lunch meal observation on 10/08/24 at 12:00 PM, in the kitchen, the steam table contained the following food items: Hawaiian baked ham, steamed spinach, mashed sweet potatoes, poppyseed roll. During a review of the facility document titled, hcsg1NewGen2024 Diet Guide Sheet for 10/8/24, showed Hawaiian baked ham, creamed spinach, baked sweet potatoes, poppy seed dinner roll. During the lunch meal observation on 10/8/24 starting at 12:00 PM, in the kitchen, [NAME] 1 would plate residents' trays with food items from the steam table. Resident #44 tray showed sweet potatoes, ham, spinach, and a roll. Review of Resident 44's meal ticket on the tray showed the resident was on a carbohydrate-controlled diet and that the resident disliked the potato group. During an observation on 10/08/24 at 12:07 PM, in the kitchen, Resident #75's tray showed ham, spinach, sweet potatoes, and a roll. Review of Resident 75's meal ticket on the tray, showed regular dysphagia mechanical diet and the resident dislikes ham and pork group. Resident #184's tray showed diced ham, spinach, sweet potatoes, and a roll. Review of Resident #184's meal ticket showed a consistent carbohydrate, dysphagia advanced diet and the resident dislikes ham group. During an observation and concurrent interview when the trays in the meal cart that were ready to leave the kitchen, on 10/08/24 at 12:15 PM. with the Kitchen Supervisor (KS), KS confirmed Resident #75 and Resident #184's dislike of ham group and/or pork group and removed the Hawaiian Baked Ham from the tray. They then served egg salad to the residents. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility document titled Week-At-A-Glance menu, dated 10/8/24, indicated Tuesday lunch regular alternate entree as Salisbury steak-brown gravy. 2. During a review of the facility document titled, hcsg1NewGen2024 Diet Guide Sheet for 10/8/24, showed Hawaiian baked ham, creamed spinach, baked sweet potatoes, poppy seed dinner roll. During a review of the facility document titled, Week-At-A- Glance menu, dated 10/08/24, the menu indicated creamed spinach as the primary vegetables and capri vegetable as the alternate. During the lunch meal observation on 10/08/24 starting at 12:00 PM, in the kitchen, the steam table contained: Hawaiian Baked Ham, Poppyseed roll, steamed spinach, puree bread, puree spinach, mechanical chopped ham, mashed sweet potatoes, fortified potatoes, buttered noodles, sauce/gravy. The tray line did not include an alternate vegetable to spinach or alternate to ham. Resident #31's tray showed ham, sweet potatoes, and a roll. There was no vegetable on the tray. Resident #31's meal ticket on the tray showed resident was on a regular diet and disliked spinach. Resident #39's tray showed there was a divided plate with buttered noodles, diced ham and a roll. Review of Resident 39's meal ticket showed resident was on dysphagia advanced diet and disliked spinach and sweet potatoes. During an interview with KS on 10/10/24 at 10:57 AM, KS stated if a resident has a dislike, then his expectation would be that the cook would prepare the alternate food item that was listed on the menu. During an interview with the Registered Dietitian (RD) on 10/10/24 at 2:41 PM, the RD stated he expects the kitchen staff to follow the resident likes and dislikes. RD stated residents should be offered or served an alternate food item for disliked food. RD stated he thought it would be a learning opportunity for the cook if someone did not like potatoes and they were served sweet potatoes. During a review of the facility document titled Production Counts (Day 3: Wk. 1-Tuesday-10/8/2024) Lunch Hot Foods, dated 10/8/24, indicated for the cook to prepare the following food items: Glazed Baked Pork Chop, Hawaiian Baked Ham, two of the three-ounce portions of Salisbury Steak, two servings of 1/2 cup portion of the Capri Vegetable Blend. Review of the facility policy and procedure titled Dining and Food Preferences, revised 9/17, showed individual dining, food and beverage preferences are identified all residents. It further showed the Registered Dietitian will review food dislikes, and after consultation with the resident, adjust the individual meal plan to ensure appropriate nutritional content for residents that do not consume certain foods or food groups. 51284 3. During a review of Resident 52's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 07/24/2024, the AR indicated Resident 52 was admitted with diagnoses which included (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	palliative care (a medical approach that focuses on improving the quality of life for people with serious illnesses), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), type 2 diabetes mellitus (A disease which result in too much sugar in the blood), and adult failure to thrive (a state of decline in elderly people involving factors such as weight loss, decreased appetite, and poor nutrition). During a review of Resident 52's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 07/31/2024, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 6 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 52 had severe cognitive impairment. During a review of Resident 52's meal ticket, dated 10/8/24, the meal ticket did not list Resident 52's preference for cold food items. During a concurrent interview on 10/08/24 at 11:07 a.m. with Resident 52 and Family Member (FM) 1 in Resident 52's room, Resident 52 was lying in bed with FM 1 next to him. FM 1 stated when Resident 52 was admitted he needed help eating, there had been 2 weeks of not eating because he did not want the hot food, Resident 52 preferred cold food and alternative choices needed to be asked for every time by FM 1. During observation on 10/08/24 at 12:47 p.m. in Resident 52's room, Resident 52 was eating his lunch and no cold food alternatives were provided. During interview on 10/11/24 at 01:50 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the CNAs will pass out the meal trays, but it was the responsibility of the nurses to check the meal tray with the meal ticket for accuracy. CNA 1 stated a residents meal ticket should include their preferences as well. During concurrent interview and record review on 10/11/24 at 2:02 p.m. with Licensed Vocational Nurse (LVN) 6, Resident 52's Progress Notes, dated 8/16/24 at 8:28 p.m. were reviewed. The Progress Notes indicated, . residents family and the resident requested cold food items. [Registered Dietician] recommends that dietary aide should obtain all specific preferences for 'cold food items' and adhere to those preferences/requests as best as possible while resident is at the facility . LVN 6 stated staff use a communication tab to inform the kitchen staff of any resident preferences. LVN 6 stated Resident 52's meal ticket should have included his preferences. During interview with DSD on 10/14/24 at 8:50 a.m., the DSD stated nurses were the ones responsible for checking the accuracy of the meal trays. The DSD stated if the resident did not want food items, CNAs will inform the nurse to ask the kitchen to get something different. The expectation was to fill out a dietary slip and submit it to the kitchen. DSD stated it was important to have an accurate meal ticket with Resident 52's preferences listed because Resident 52 may not eat the food if he did not like it. If Resident 52 did not eat there was a potential, he could lose weight. The DSD stated, additionally, accurate meal tickets ensured resident safety, so they do not choke on food or get an allergic reaction. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 10/14/24 at 9:46 a.m. with the Kitchen Supervisor (KS) and Certified Dietary Manager (CDM) 1, CDM 1 stated the kitchen can communicate with nursing staff for any changes or issues regarding meal tickets for residents. The KS stated he interviews newly admitted residents to understand their preferences. The KS stated if a resident refused to eat or did not like the food provided it was the responsibility of nursing staff to communicate the new preferences to the kitchen in order to update their meal ticket. During interview on 10/14/24 at 10:18 a.m. with the Director of Nursing (DON), The DON stated it was the responsibility of the nurse to communicate meal preference updates to the kitchen staff. The DON stated if a resident kept sending food back the nurse should have written their likes and dislikes in order to update the meal ticket. The DON stated Resident 52's meal ticket should have listed his preferences in order for all nursing staff to be able to check his food for accuracy and dislikes. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preference, dated 7/17, indicated, . Dietary Manager will complete a profile for resident reflecting food preferences . Food preferences will be obtained by meeting with the resident 72 hours of admit, quarterly, annually or as needed . Food preferences can be obtained from the resident . meals will consistent with their preferences, as indicated on their tray card . suitable substitute should be provided .

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 48424 Based on observation, interview, and record review, the facility failed to ensure physician prescribed diets were followed for one of seven sampled residents (Resident 6) when Resident 6 did not receive his ordered double portion meal for lunch on 10/8/24. This failure placed Resident 6 at risk to not receive the full nutritional value of his meal which had the potential for Resident 6 to experience weight loss Findings: During a review of Residents 6's Admission Record (AR- a document which provides resident contact details, a brief medical history level of functioning, preferences, and wishes), dated 10/10/24, the AR indicated Resident 6's admitting diagnoses included the following: sepsis (a serious condition in which the body responds improperly to an infection), gangrene (a serious condition that occurs when tissue in the body dies due to a lack of blood flow), acquired absence of left below knee (surgical removal of the leg). During an observation on 10/08/24 at 1:03 p.m. in the dining room, Resident 6 was served a regular portion for his lunch. During a review of Resident 6's Meal Ticket, undated, the Meal Ticket indicated resident 6 did not have his order for a double portion diet listed. During an interview on 10/11/24 at 1:50 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated if CNAs saw an inaccurate meal, they could have reported it to the nurses or the kitchen staff. CNA 1 stated CNAs check the residents Meal Ticket to see what a residents food order were. CNA 1 stated the meal Ticket for each resident and should reflect the prescribed diet of the resident. During a concurrent interview and record review on 10/11/24 at 1:50 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 6's Order Summary Report, dated 10/11/24 was reviewed. The Order Summary Report indicated, . double portions on all meals. LVN 1 stated Resident 6's diet order was for double portions. LVN 1 stated Resident 6 was slowly declining in his health and could have benefitted from extra calories a double portion meal would have provided. During an interview on 10/14/24 at 8:51 a.m. with the director of staff development (DSD), the DSD stated CNAs could have communicated to the nurses or the kitchen staff if they noticed a resident's provided meal did not match their meal ticket. During an interview on 10/14/24 at 10:22 a.m. with the director of nursing (DON), the DON stated resident 6's order for double portions should have been documented on his meal ticket. The DON stated the kitchen staff should have had the correct order for Resident 6's meals. The DON stated resident 6 had an order for double portions for a reason and he needed to be provided his ordered food portions. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent interview on 10/14/24 at 9:46 a.m. with the Account Manager (AM) and the Certified Dietary Manager (CDM), the AM stated Resident 6's orders for double portions did not get sent to the kitchen until 10/10/24. The AM stated he did not know why it took so long for Resident 6's order to show up on his end. The AM stated the existing diet order should have been followed. During a review of the facility's Policy and procedure titled, Resident Food Preferences, dated 7/17, indicated, . 1. The Dietary Manager will meet with the resident within 72 hours of admission or readmission, quarterly or annually to review the following: . b. the attending physician's dietary order .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51223 Based on observations, interview and record review, the facility failed to prepare food in accordance with professional standards for food service safety when the sanitizer solution was not the appropriate concentration to sanitize food preparation areas and equipment. This failure had the potential to result in cross contamination and the growth of microorganisms which could lead to food borne illness for the 83 residents admitted to the facility. Findings: During an observation in the kitchen on 10/08/24 at 3:36 PM, Food Service Worker (FSW) 1 wiped down a food service cart with a rag from the red bucket sanitation solution. The red bucket sanitation solution concentration was tested with a dip test strip result zero parts per million (ppm). During a concurrent interview at the same time with FSW 1, FSW 1 stated the concentration of the red bucket sanitation solution should be 200 ppm. The sanitation solution in the red bucket was dumped in the sink, replaced, and re-tested with a dip test strip result of 200 ppm. During an observation in the kitchen on 10/08/24 at 4:41 PM, Kitchen Supervisor (KS) wiped the area around the robot coupe (food processor) with a rag from the red bucket with sanitation solution. KS tested the red bucket sanitation solution and the test strip barely changed color. During a concurrent interview at the same time with KS, KS stated acceptable concentration of the red bucket sanitation solution should be 200 ppm. During a review of Healthcare Services Group (HCSG) Policy 028, revised 9/2017, titled Environment, indicated all food preparation areas, food service areas .will be maintained in a clean and sanitary condition . and all food contact surfaces will be cleaned and sanitized after each use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51284 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent infections for three of 21 sampled residents (Residents' 48, 52, and 54) when: 1. Resident 52's oxygen nasal cannula (O2 NC- a tube that directs oxygen into the nose) tubing was observed on top of the oxygen concentrator (medical device that supplies oxygen-enriched air to help people breathe easier) was not stored in a plastic bag. This failure placed Resident 52 at an increased risk to develop respiratory and healthcare associated infections. 2. Resident 48's medication syringe was stored in a wet plastic bag and had some orange liquid substance at the tip of the syringe. This failure placed Resident 48 at an increased risk to develop bacterial infection and gastrointestinal illness. 3. Resident 54 who was on Enhanced Standard/Barrier Precautions (EBP- infection control measures that help reduce the spread of multi drug-resistant organisms [MDROs] in nursing homes) and Certified Nursing Assistant (CNA) 7 did not wear proper PPE (personal protective equipment- a type of equipment worn to reduce exposure to workplace hazards that can cause serious injuries or illnesses) while providing personal care. This failure placed residents and staff at risk to develop healthcare associated infections. Findings: 1. During a review of Resident 52's Admission Record (AR), the AR record indicated, Resident 52 was admitted to the facility on [DATE] with an admission diagnosis of palliative care (specialized care for people nearing the end of life). During a review of Resident 52's Order Summary Report (OSR) dated 7/24/24, the OSR indicated, . oxygen at [3 liters (L-unit of measurement) per minute via nasal cannula as needed for shortness of breath (the uncomfortable feeling of not being able to breathe deeply or normally) . During an observation on 10/8/24 at 11:07 a.m., in Resident 52's room, Resident 52's O2 NC tubing was on top of the oxygen concentrator and was not stored in a plastic bag. During an interview on 10/11/24 at 1:50 p.m. with CNA 1, CNA 1 stated when oxygen tubing was not in use by residents, oxygen tubing was supposed to be placed in a bag to keep it clean. CNA 1 stated placing the O2 NC in a bag was done to stop the spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/11/24 at 2:02 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated Resident 52's O2 NC tubing should have been stored in a bag which protected it from bacteria. LVN 6 stated if Resident 52's O2 NC was not properly stored in a bag when not in use and could result in Resident 52 to develop an infection During an interview on 10/14/24 at 8:50 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 52's O2 NC should have been stored in a protective bag when not in use. The DSD stated having the O2 exposed on top of the oxygen concentrator and touching the wall could placed Resident 52 at risk to develop an infection. During an interview on 10/14/24 at 9:46 a.m. with the Infection Preventionist (IP), the IP stated the O2 NC tubing should have been stored in a bag when not in use. The IP stated if a CNA saw the oxygen tubing not being used by the resident, they should have notified the nurse in order to have the nurse replace the O2 NC and place the new one in a protective bag. The IP stated when a resident did not use their O2 NC, the O2 NC tubing should be labeled, dated and bagged as a standard of practice. During an interview on 10/14/24 at 10:18 a.m. with the Director of Nursing (DON), the DON stated Resident 52 should not have had his O2 NC laying on top of his oxygen concentrator uncovered. The DON stated Resident 52 should have had his O2 NC placed in a protective bag when not in use to prevent Resident 52 from acquiring and infection. The DON stated staff members were expected to identify any oxygen tubing not properly stored in bags and replace them with clean supplies which would then be placed in a protective bag. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control dated 12/2023, the P&P indicated, .The facility adopted P&P to help prevent and manage transmission of diseases and infections .The P&P apply to all personnel, consultants, contractors, residents, visitors, and volunteers . All personal are trained on P&P .including where and how to find and use pertinent procedures and equipment related to infection control .Inquiries concerning infection prevention and control P&P .be referred to the infection preventionist or director of nursing . During a professional reference review, retrieved from https://masvidahealth. com/oxygen-concentrators/maintenance-guide-how-to-clean-a-nasal-cannula-of-an-oxygen-concentrator titled, Maintenance Guide: How To Clean A Nasal Cannula Of An Oxygen Concentrator, undated, indicated, . Always store the nasal cannula in a clean, dry place .Use a dedicated storage container or bag that is also clean and free from contaminants . 40641 2. During a concurrent observation and interview on 10/10/24 at 8:35 a.m. in Resident 48's room, Resident 48 was sitting up in bed watching TV. Resident 48 had a nasal cannula in his nostril connected to an oxygen concentrator. Resident 48 stated he was happy with his care received in the facility. During a review of Resident 48's Admission Record, (AR) dated 10/11/24 the AR indicated Resident 48 was readmitted to the facility on [DATE] with diagnoses which included, encounter for palliative care and hypokalemia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Residents 48's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive [thought process] and physical function) assessment, dated 9/22/24, the MDS indicated Resident 48's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement on a scale of 1-15 with 15 being the highest score) was 00. Resident 40's cognition was assessed as severely impaired. During a concurrent observation and interview on 10/10/24 at 8:42 a.m. with LVN 1 outside of room [ROOM NUMBER] in station 2 hallway, LVN 1 was preparing medications for Resident 48. LVN 1 pulled out the medication bottle and a syringe in a plastic bag. The syringe had orange looking liquid in the tip and was placed in a wet plastic bag. LVN 1 used the syringe to measure medication without rinsing and placed syringe back in the plastic bag without rinsing. LVN 1 stated she was not sure whether she needed to rinse it because she had never done it before. LVN 1 stated, I guess I have to rinse it to prevent contamination, it is an infection control issue . During a review of Resident 48's Order Summary Report, (OSR) dated 10/11/24, the OSR indicated . Potassium Chloride [medication used to treat hypokalemia-low level of potassium in the blood] Liquid 20 MEQ [milliequivalent-unit of measurement]/15ML [milliliter-unit of measurement] 10 %[percent] Give three [3] ml by mouth one time a day . During an interview on 10/10/24 at 10:35 a.m. with the IP, the IP stated, . licensed nurses should have been rinsing the syringe after use and prior to using when the tip of the syringe had discolored liquids in it . The IP stated not rinsing the syringe after use and putting it in the plastic bag could grow bacteria causing resident 48 to become ill. During an interview on 10/14/24 at 2:25 p.m. with the DON, the DON stated Resident 48's syringe was dirty in the plastic bag and it was an infection control issue. The DON stated there was some medication left in the tip of the syringe and the nurse should have rinsed the syringe before she used it to draw out medication from the bottle and rinsed after she used it and placed in a clean plastic bag. During a review of facility's policy and procedure (P&P) titled, Administering Medication, dated 4/19, the P&P indicated, . Staff follows established facility infection and control procedures (e.g handwashing, antiseptic technique, gloves, isolation precaution etc.) for the administration of medications, as applicable . During a professional reference review, retrieved from https://medicina.co.uk/wp-content/uploads/2018/06/LHE-Syringe-Cleaning-Instructions.pdf titled, Cleaning your re-usable syringes undated, the reference indicated, . After use, clean your syringes straight away. Place syringe in warm soapy water. Clean the end of the syringe by drawing soapy water in and out using the plunger until all traces of feed or medication have been removed. Separate syringe and plunger and wash throughly in warm soapy water Rinse both parts of the syringe under the tap, shake off excess water . Store the syringe still separated in a clean dry container with a lid . 49949 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 54's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 8/20/24, indicated the Brief Interview for Mental Status (BIMS) score was 4 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 54 was severely impaired in decision making. During a review of the facility's in -service titled, Class title: Enhanced Standard/Barrier Precautions dated 4/15/24 the in-service indicated, .[Box] staff will be able to identify the correct moment when PPE are required in a room that is on ESP/EBP .[Box] Course Content .When are PPE required when interacting with a resident on ESP/EBP .providing hygiene . During a review of the facility's policy and procedure (P&P) titled, NewGen Administrative Services Enhanced Standard/Barrier Precautions dated No date the P&P indicated, .3.Implementation of Enhanced Barrier Precautions .C. Wear gowns and gloves while performing the following task associated with the greatest risk for MDRO contamination of HCP hands, clothes and the environment .iii. Any care activity where close-contact wit the resident is expected to occur such as bathing, peri-care, providing assistant with personal hygiene, assisting with toileting, changing incontinence briefs, respiratory care, wound care, etc .

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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. 51223 Based on observations, interviews and review of facility documents, the facility failed to provide a comfortable environment in the kitchen for staff. This failure had the potential to increase staff risk of developing heat related illnesses such as heat cramps, heat exhaustion or heatstroke caused by exposure to heat. Findings: During an observation on 10/8/24 at 12:44 PM in the kitchen, the surveyor thermometer read 89.4 degrees Fahrenheit (F) near the hand wash sink. During an observation on 10/8/24 at 3:28 PM in the kitchen, the surveyor thermometer placed on the counter in the center of the kitchen read 90.1 degrees F. During an interview on 10/8/24 at 3:34 PM in the kitchen, [NAME] 2 stated the kitchen is usually this warm. Surveyor thermometer placed on the counter in the center of the kitchen read 90.7 degrees F. During an observation on 10/8/24 at 4:51 PM in the kitchen, the surveyor thermometer placed on the counter in the center of the kitchen read 93.6 degrees F. During an interview with Certified Dietary Manager (CDM) 1 on 10/9/24 at 10:52 AM, CDM 1 stated the air conditioning (A/C) unit next to the dishwasher is not working due to lack of a remote controller. CDM 1 stated the A/C unit above the hand wash sink next to the can opener works and blows cool air. During an observation on 10/9/24 at 3:40 PM, in the kitchen, the surveyor thermometer placed on the counter in the center of the kitchen read 91.2 degrees F. During an interview on 10/9/24 at 4:05 PM, the Facility Maintenance Director (FMD) confirmed he has been here 8 years and the A/C units on the wall in the kitchen have been here before he came. FMD stated there is only one remote for both units and the remote controller display screen is broken so staff cannot verify the A/C setting. FMD stated there is no other A/C units in the building that come into the kitchen. FMD stated the A/C unit brand, and the broken remote is the same brand. FMD stated the ADM is supposed to replace the remote controllers. FMD pointed his temperature gun on the wall above the two compartments sink in kitchen which read 91.2 degrees F and 93 degrees F. During an interview on 10/10/24 at 4:21 PM in the ADM office, ADM stated the A/C unit in the kitchen was assessed this AM, the remote controller display was broken, and staff were unable to assess the A/C setting. ADM stated he ordered a new remote to help the kitchen staff utilize the A/C units correctly. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure titled HCSG Policy 028, revised on 9/2017, indicated, the Kitchen Supervisor (KS) will ensure that the kitchen is maintained in a clean and sanitary manner, including . ventilation. During a review of timeanddate.com website, the recorded high temperature for Kingsburg, CA on 10/8/24 was 97 degrees F and 93 degrees F on 10/9/24. During a review of facility document titled Sanitation and Food Safety Checklist, dated 8/12/24, showed under comments that the kitchen office and emergency food room was hot at 88 degrees F and recommended installing wall a/c unit in office. Document completed by Regional Resource Registered Dietitian (REG RD).