STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055601	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Julian Healthcare Center	1801 Julian Avenue Bakersfield, CA 93304

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 - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Informed Consent, for one of two sampled residents (Resident 42) when his informed consent for psychotherapeutic (medication to treat mental disorders) medication was not completed. This failure had the potential for Resident 48 to receive psychotropic medication without knowing the risks and benefits of the medication. Findings: During a concurrent interview and record review on 11/20/24 at 2:15 p.m. with Minimum Data Set Coordinator (MDSC), Resident 42's Informed Consent (IC), dated 11/22/23 was reviewed. Resident 42 was on Amitriptyline (to treat symptoms of depression) 25 mg 1 tablet at bedtime. MDSC stated signature of verification was blank. MDSC stated IC was incomplete. During a review of the facility's P&P titled, Informed Consent, dated 4/1/24, the P&P indicated, The Facility verifies that informed consent was obtained prior to the administration of a medical intervention or change in medical intervention that requires informed consent.

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: 055601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 32946 Based on interview and record review, the facility failed to ensure: 1. Six of 20 sampled residents (Resident 58, Resident 87, Resident 193, Resident 22, Resident 17, Resident 70) had a signed and dated Advance Directive (AD - a legal document that provides instructions for medical care and only go into effect if the individual is unable to make decisions for themselves) 2. Document five of 20 sampled residents (Resident 344, Resident 4, Resident 68, Resident 60, and Resident 45) were informed about their right to complete and Advance Directive or had evidence of declining to complete an Advance Directive. These failures had the potential for responsible parties and/or medical professionals to not honor resident's healthcare wishes and to not provide appropriate treatment in the event of an emergency medical situation. Findings: 1. During a concurrent interview and record review on 11/20/24 at 9:53 a.m. with Social Service Director (SSD), Resident 58's MR was reviewed. SSD stated there was a copy of the AD in Resident 58's MR, but it was not signed and dated. During a concurrent interview and record review on 11/20/24 at 9:56 a.m. with SSD, Resident 87's MR was reviewed. SSD stated there was a copy of AD in Resident 87's MR, but it was not signed. SSD stated, Yes another one [AD] not signed. During a concurrent interview and record review on 11/20/24 at 10:04 a.m. with SSD, Resident 193's MR was reviewed. SSD stated there was copy of the AD in Resident 193's MR, but the copy was not signed and dated. During a concurrent interview and record review on 11/20/24 at 10:08 a.m. with SSD, Resident 22's MR was reviewed. SSD stated, there was a copy of the AD, but it was not dated. During a concurrent interview and record review on 11/20/24 at 10:11 a.m. with SSD, Resident 17's MR was reviewed. SSD stated there was a copy of AD in Resident 17's MR, but it was not dated. During a concurrent interview and record review on 11/20/24 at 10:14 a.m. with SSD, Resident 70's MR was reviewed. SSD stated there was a copy of AD in Resident 70's MR, but it was not dated. During a concurrent interview and record review on 11/20/24 at 10:17 a.m. with SSD, Resident 344's MR was reviewed. SSD stated there was a copy of AD in Resident 344's MR, but it was not dated. 2. During a concurrent interview and record review on 11/20/24 at 10:21 a.m. with SSD, Resident 4's MR was reviewed. SSD stated there was no copy of AD in Resident 4's MR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 11/20/24 at 10:24 a.m. with SSD, Resident 68's MR was reviewed. SSD stated, There's another one who does not have an AD. During a concurrent interview and record review on 11/20/24 at 10:29 a.m. with SSD, Resident 60's MR was reviewed. SSD stated, There was nothing in Resident 60's MR. There was no AD. During a concurrent interview and record review on 11/20/24 at 10:33 a.m. with SSD, Resident 45's MR was reviewed. SSD stated, So he doesn't have one, referring to the AD. During a review of the facility's policy and procedure (P&P) titled, Advance Directive, dated November 04, 2017, the P&P indicated, II. Upon admission Staff or designee will obtain a copy of a resident's advance directive. A copy of the resident advance directive will be included in the resident's medical record . D. If the resident has an Advance Directive, the Facility shall obtain a copy of the document and place it in the resident's medical record .If the resident does not have an Advance Directive, the Admissions Staff or designee will inform the resident can provide the resident with a copy of the Advance Directive form .The interdisciplinary team will annually review the Advance Directive with the resident or responsible party to ensure the directive still reflects the wishes of the resident .Changes to the Advance Directive A. As appropriate, changes or revocations of an advance directive will be communicated to the physician. B If the resident requests to complete a new AD-06-Form A Advance Health Care Directive form . 41035 46958 47734

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32946 Based on observation and interview, the facility failed to provide a homelike environemnt for three of three residents (Resident 17, Resident 62 and Resident 75) when: 1. One of one sampled resident (Resident 17) clothing was not laundered correctly. This failure resulted in Resident 17's personal clothing being damaged and thrown away. 2. Two of two sampled residents (Resident 62 and Resident 75) rooms had patched unpainted wall areas, broken baseboard and peeling wallpaper. This failure resulted in a personal environment that was not homelike for Resident 62 and Resident 75. Findings: 1. During an interview on 11/17/24 at 11:11 a.m. with Resident 17, Resident 17 stated he had to throw away several of his personal shirts in the past due to the items having bleach stains. During a concurrent observation and interview on 11/17/24 at 11:13 a.m. at Resident 17's room closet, one black shirt with light gray stain was observed. A second shirt brown in color, Resident 17 stated it had been black. During an interview on 11/20/24 at 2:55 p.m. with Laundry Services (LS), LS stated, They are probably not sorting them [clothing] right and they got bleach on them. 42148 2. During a concurrent observation and interview on 11/20/24 at 8:53 a.m. with Maintenance Technician (MT) 2 in Resident 62's room, a large patch of white drywall was seen between resident's bed and the wall. MT 2 stated it should have been painted over and looks bad. During a concurrent observation and interview on 11/20/24 at 8:55 a.m. with MT 2 in Resident 75's room, multiple, various sized dry wall patches were seen on the wall, a broken rubber base board was seen in the corner outside of the restroom wall. Wallpaper was peeling away from bottom of wall near the baseboards. MT 2 stated this building is old and needs a lot of cosmetic patch/paint work.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Transfer and Discharge, when the facility did not send a notice of transfer to the ombudsman (representatives who assist residents in long-term care facilities with issues related to day-day care, health, safety, and personal preferences) for two of two sampled residents (Resident 42, and Resident 50). This failure had the potential to result in Resident 42, and Resident 50 not having an advocate who could inform them of their admission, transfer, and discharge rights and options. Findings: During a review of Resident 42's medical record (MR), undated, the MR indicated, Resident 42 was transferred to the hospital on 11/17/23, 2/5/24, and 7/22/24. There was no indication in Resident 42's medical record that Ombudsman was notified. During an interview on 11/20/24 at 3:46 p.m. with Minimum Data Set Coordinator (MDSC), MDSC stated, there was no Ombudsman notification done on hospital transfer. 41035 During a concurrent interview and record review on 11/20/24 at 2:26 p.m with Director of Nursing (DON), Resident 50's transfer forms dated 9/27/24 and 10/19/24 were reviewed. The transfer forms indicated Resident 50 was transfered to the hospital. DON stated the transfer forms were completed. During a concurrent interview and record review on 11/20/24 at 2:26 p.m with SSD, the facility's transfer/discharge binder was reviewed. SSD stated there were no Ombudsman notifications for September and October. During a review of the facility's P&P titled, Transfer and Discharge, dated 4/1/24, the P&P indicated, The facility will also send a copy to the Notice of Proposed Transfer/Discharge to the State Long Term Care Ombudsman for a Facility-initiated discharge. The copy of the Notice of Proposed Transfer/Discharge must be provided to the Ombudsman at the same time the notice is provided to the resident or resident representative. 47734

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled Smoking, for ten of 11 sampled residents (Resident 42, Resident 17, Resident 24, Resident 42, Resident 43, Resident 62, Resident 78, Resident 89, Resident 243, and Resident 245), who smoked independently on the smoking patio, when a smoking assessment was not completed. This failure resulted in residents not being assessed for safety while smoking and the potential residents to be burned while smoking. Findings: During a concurrent interview and record review on 11/20/24 at 2:33 p.m. with Minimum Data Set Coordinator (MDSC), Resident 42's Smoking and Safety undated was reviewed. Reident 42's admission records indicated Resident 42 was readmitted on [DATE] and smoking assessment was done on 1/28/24. MDSC stated there should have been a smoking assessment done upon re-admission. 42148 During a review of Resident 17's Smoking Assessment (SA), dated 11/15/24, the SA indicated, Resident 17 uses tobacco products and will follow the facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 24's SA, dated 9/13/24, the SA indicated, Resident 24 uses tobacco and will follow the facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 42's, SA, dated 9/19/24, the SA indicated, Resident 42 uses tobacco products and will follow the facility's policy on location and time of smoking. Resident will Adhere to the Tobacco/Smoking Policies of the Facility. During a review of Resident 43's SA, dated 8/13/24, the SA indicated, Resident 43 uses tobacco and will follow the facility's policy and location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 62's SA, dated 11/6/24, the SA indicated, Resident 62 uses tobacco products and will follow the facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 78's SA, dated 11/13/24, the SA indicated, Resident 78 uses tobacco and will follow facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 89's SA, dated 11/4/24, the SA indicated, Resident 89 uses tobacco and will Adhere to the Tobacco/Smoking Policies of the Facility. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 243's SA, dated 11/11/24, the SA indicated, Resident 243 uses tobacco and will follow the facility's policy on location and time of smoking and will Adhere to the Tobacco/Smoking Policies of the Facility. During a review of Resident 245's, SA, dated 10/23/24, the SA indicated, Resident [Resident 245] does not utilize any smoking products. During a review of the facility's P&P titled, Smoking, dated 2/1/22, the P&P indicated, All smokers shall be assessed related to smoking safety at the time of admission and then at least quarterly as outlined by OBRA assessment timeframes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

47734

Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Dialysis Care for two of two sampled residents (Resident 67 and Resident 69) when:

1. One of two sampled residents (Resident 69) did not have an order to monitor dialysis access site.

2. Two of two sampled residents' (Resident 67 and Resident 69) dialysis access sites were not assessed according to access type.

These failures had the potential for dialysis access sites to not be assessed for correct care and monitoring.

Findings:

1. During an interview on 11/19/24 at 8:48 a.m. with Resident 69, she stated her dialysis access was a catheter on her chest.

During a concurrent interview and record review on 11/20/24 at 8:27 a.m. with Registered Nurse (RN) 2, Resident 69's Order Summary Report (OSR) dated November 2024 was reviewed. The OSR indicated, there was no order for dialysis access monitoring or what type of dialysis access Resident 69 had. RN 2 stated there should have been an order for monitoring her dialysis access site and there was no order.

2a. During a concurrent interview and record review on 11/20/24 at 8:31 a.m. with RN 2, Resident 69's Progress Notes, (PN) dated November 2024 were reviewed. The PN indicated the following:

Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/20/2024 4:01 a.m.Access site: . Bruit [sound heard on a dialysis access in arm through a stethoscope]: positive. Thrill [vibration felt when palpating dialysis access in arm]: Yes .

Treatment Information: Post-Dialysis Evaluation. Time out of the facility: 11/18/2024 8:05 a.m Access site: . Bruit: positive. Thrill: Yes .

Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/15/2024 4:00 a.m Access site: . Bruit: positive. Thrill: Yes .

Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/13/2024 4:00 a.m Access site: . Bruit: positive. Thrill: Yes .

Treatment Information: Post-Dialysis Evaluation. Time out of the facility: 11/11/2024 9:00 a.m Access site: . Bruit: positive. Thrill: Yes .

Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/11/2024 4:00 a.m Access site: . Bruit: positive. Thrill: Yes .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/08/2024 4:05 a.m Access site: . Bruit: positive. Thrill: Yes . Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/06/2024 4:00 a.m Access site: . Bruit: positive. Thrill: Yes . Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/01/2024 4:59 a.m Access site: . Bruit: positive. Thrill: Yes. RN 2 stated staff should not check for bruit and thrill because Resident 69 had a dialysis catheter on her chest not a dialysis access on her arm. 2b. During an interview on 11/19/24 at 10:34 a.m. with Resident 67, she stated she had a dialysis catheter as her dialysis access. During a concurrent interview and record review on 11/20/24 at 8:34 a.m. with RN 2, Resident 67's PN dated November 2024 were reviewed. The PN indicated the following: Treatment Information: Post-Dialysis Evaluation. Time out of the facility: 11/11/2024 12:45 p.m Access site: . Bruit: positive. Thrill: Yes . Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/11/2024 9:01 a.m Access site: . Bruit: positive. Thrill: Yes . Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 11/06/2024 7:45 a.m Access site: . Bruit: positive. Thrill: Yes. RN 2 stated staff should not check for bruit and thrill because Resident 67 had a dialysis catheter on her chest and Resident 67 does not have a dialysis access on her arm. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care dated 11/1/2017, the P&P indicated, D. Ateriovenous (AV) Shunt/Fistula .a. Place your fingertip slightly over the vein and feel for the thrill. b. Place the stethoscope over the vein and listen for the buzz or bruit. Resident 67 and Resident 69 does not have an AV Shunt/Fistula.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Pre-Admission Screening and Resident Review (PASRR [federal requirement to help ensure that individuals are not incorrectly placed in nursing homes or long-term care instead of a psychiatric setting]), to accurately complete the annual Pre-Admission Screening Assessment and Resident Review for two of six sampled residents (Resident 68 and Resident 69). This failure had the potential for Resident 68 and Resident 69 to be placed in an inappropriate setting and not receive required services. Findings: During a review of Resident 68's Pre-Admission Screening and Resident Review (PASRR) Level I screening, dated 9/9/24, the PASRR indicated, Level I-positive for SMI [Serious Mental Illness]/Negative for ID [Intellectual Disability]/DD [Developmental Disability]/RC [Related Condition]. During a concurrent interview and record review on 11/20/24 at 1:39 p.m. with Minimum Data Set Coordinator (MDSC), Resident 68's Notice of Attempted Evaluation letter was reviewed. The letter indicated, Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. MDSC stated PASRR 1 was positive, and facility never called back so assessment was not completed and PASRR was not resubmitted. During a review of Resident 69's Preadmission Screening and Resident Review (PASRR) Level I screening, dated 4/1/24, the PASRR indicated, Positive Level I Screening Indicates a Level II Mental Health Evaluation is Required. During a concurrent interview and record review on 11/20/24 at 1:45 p.m. with MDSC, Resident 69's PASRR dated 4/1/24 was reviewed. MDSC stated PASRR I was positive and there was no PASRR II evaluation done on Resident 69. During the review of facility's policy and procedure (P&P) titled, Pre-Admission Screening and Resident Review (PASRR), dated 12/1/21, the P&P indicated, A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASRR Level II, which must be conducted prior to admission to a nursing facility. 42148

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763 Based in interview and record review the facility failed to: 1. Ensure medications were administered according to physicians' order for one of two sampled residents (Resident 82). This failure had the potential for Resident 82's infection to worsen. 2. Ensure three of eight sampled employees (Registered Nurse [RN] 1, Director of Staff Development [DSD], and Director of Nursing [DON]) had current educational training and demonstrated knowledge in cardiopulmonary resuscitation (CPR-life saving intervention during medical emergency). This failure had the potential to staff would not be able to perform life-saving procedures in the event of a heart or respiratory emergency. 3. Provide 57 of 57 Certified Nursing Assistants (CNA) and 27 of 27 Licensed Nurses the required Personnel Educational Program (required employee competencies). This failure had the potential for staff to not have the knowledge and skills necessary to perform their jobs, which could be detrimental to patient safety and patient care. 4. Ensure one of one Maintenance Technician (MT) 2 was knowledgeable of facility policies and procedures. This failure resulted in two residents having an unapproved space heater in their room. Findings: 1. During an interview on [DATE] at 2:46 p.m. with Registered Nurse (RN) 2, RN 2 stated she tries to administer IV (Intravenous- administration of fluids, medications or nutrients directly into a vein) medications on time. RN 2 stated she documents on IV Medication Administration Record (MAR) once she administered the medication. RN 2 stated for refusals or other reasons IV medications cannot be administered, she calls and informs the physician. RN 2 stated she documents refusal or other reason medications were not administered on the IV MAR and in the progress note. During a concurrent interview and record review on [DATE] at 3:03 p.m. with Director of Nursing (DON), Resident 82's IV MAR, dated [DATE], was reviewed. DON stated the IV MAR indicated the following: Normal Saline Flush . Use 10 ml intravenously every 6 hours . -Start Date- [DATE] 0000 [12 a.m.] The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's flush was administered. The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's flush was administered. The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's flush was administered. The IV MAR indicated, on [DATE] for the 6 a.m. administration time, no documentation Resident 82's flush was administered. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's flush was administered.

The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's flush was administered.

The IV MAR indicated, on [DATE] for the 6 a.m. administration time, no documentation Resident 82's flush was administered.

The IV MAR indicated, on [DATE] for the 12 p.m. administration time, no documentation Resident 82's flush was administered.

Unasyn (medication used to treat infection) .Use 3 grams intravenously (administering medications directly into a vein using a needle or tube) every 6 hours for right foot osteomyelitis (inflammation of bones) until [DATE] 23:59 (11:59 p.m.) -Start Date-[DATE] 0000 -D/C (discontinued) Date-[DATE] 1412 (2:14 p.m.)

The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's Unasyn was administered.

The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's Unasyn was administered.

The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's Unasyn was administered.

The IV MAR indicated, on [DATE] for the 6 a.m. administration time, no documentation Resident 82's Unasyn was administered.

The IV MAR indicated, on [DATE] for the 12 p.m. administration time, no documentation Resident 82's Unasyn was administered.

Unasyn .Use 3 grams intravenously every 6 hours for right foot osteomyelitis until [DATE] 23:59 -Start Date-[DATE] 1800 (6 p.m.)

The IV MAR indicated, on [DATE] for the 12 p.m. administration time, no documentation Resident 82's Unasyn was administered.

The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's Unasyn was administered.

The IV MAR indicated, on [DATE] for the 12 a.m. administration time, no documentation Resident 82's Unasyn was administered.

The IV MAR indicated, on [DATE] for the 12 p.m. administration time, no documentation Resident 82's Unasyn was administered.

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NAME OF PROVIDER OR SUPPLIER Parkview Julian Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Julian Avenue Bakersfield, CA 93304	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IV MAR indicated, on [DATE] for the 6 a.m. administration time, no documentation Resident 82's Unasyn was administered. The IV MAR indicated, on [DATE] for the 12 p.m. administration time, no documentation Resident 82's Unasyn was administered. DON stated there was no documentation of IV flush or Unasyn administration on Resident 82's MAR on these dates. During a review of the facility's policy and procedure (P&P) titled, Medication- Administration, revised [DATE], the P&P indicated, I. Medications will be administration by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. V. Medication may be administered one hour before or after the scheduled medication administration time. XVI. The licensed Nurse will chart the drug, time, administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR. XVII. Holding Medications A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason the medication was held on the back of the MAR. XIX. Documentation A. The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment. B. Recording will include the date, the time, and the dosage of the medication or type of treatment. 46958 2. During a concurrent interview and record review on [DATE] at 4:25 p.m. with DSD, RN 1's personnel file was reviewed. DSD stated CPR certification expired ,d+[DATE]. DSD stated facility should have current CPR certification on file. During a concurrent interview and record review on [DATE] at 4:35 p.m. with DSD, DSD's personnel file was reviewed. DSD stated there was no current CPR certification on file for the DSD. DSD stated facility should have current CPR certification on file. During a concurrent interview and record review on [DATE] at 8:24 a.m. with DSD, DON's personnel file was reviewed. DSD stated there was no current CPR certification on file for the DON. DSD stated facility should have current CPR certification on file. During a review of the facility's provided policy and procedure (P&P) titled, Cardiopulmonary Resuscitation (CPR) Nursing Manual-Sub-Acute dated [DATE], the P&P indicated, To ensure all clinical staff respond and provide adequate ventilation to an advanced airway during an emergency such as dyspnea, respiratory arrest and asystole.IV. Dedicated subacute nursing staff are required to be certified in basic CPR and must maintain active certification. 3.During a concurrent interview and record review on [DATE] at 1:37 p.m. with Director of Staff Development (DSD), the Calendar of Education for 2024, was reviewed. DSD stated the facility employed 57 CNAs and 27 licensed nurses. The Calendar of Education indicated the following: Problems and needs of the aged, chronically ill, and disabled patients: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility was unable to provide a sign-in sheet indicating the facility provided this education. Prevention and control infection: The sign-in sheet dated [DATE] indicated Topic Infection control, Side rails, and Residents dietary requests lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 31 of 57 CNAs attended. The sign-in sheet dated [DATE] indicated topic Linen Handling/Customer Service/Shower Team/ Emergency Shut Offs/Abuse Reporting and Prevention lasted one hour. The in-service sheet indicated 16 of 57 CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. The sign-in sheet dated [DATE] indicated Topic Hydration/HIPPA (sic) [Health Insurance Portability and Accountability Act personal health privacy information]/Linen Extra lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 16 CNAs attended. The sign-in sheet dated [DATE] indicated Topic Hand Washing/Peri-care [private area hygiene]/Brief [disposable underwear]/CPR[cardiopulmonary resuscitation, lifesaving procedure] lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 8 CNAs attended the in-service. DSD was unable to provide additional in-service documentation. Interpersonal relationship and communication skills: The sign-in sheet dated [DATE] indicated Topic Communication Skills/Linen/Trash lasted one hour. The sign-in sheet indicated 27 CNAs attended the in-service. The sign-in sheet indicated 0 of 27 licensed nurses attended. The sign-in sheet, dated [DATE], indicated Topic Communication Skills with the Elderly lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 22 of 57 CNAs attended. The sign-in sheet dated [DATE] indicated Topic Communicating with elderly with dementia lasted one hour. The Sign-in sheet indicated 33 staff: two of three activity staff, one of one Receptionist, six of 27 Licensed Nurses and 24 of 57 CNA attended the in-service. DSD stated a total of 96 staff attended communication in-services. DSD was unable to provide additional in-service documentation. Fire prevention and safety: The sign-in sheet dated [DATE] indicated Topic Linen Handling/Customer Service/Shower Team/ Emergency Shut Offs/Abuse Reporting and Prevention lasted one hour. The in-service sheet indicated 16 of 57 CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. The sign-in sheet dated [DATE] indicated Topic Earthquake/Fire lasted one hour. DSD stated 19 of 57 CNAs attended the in-service. The sign-in sheet indicated one staff from Central Supply and 18 of 57 CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD was unable to provide additional in-service documentation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Accident prevention and safety measures: The sign-in sheet dated [DATE] indicated Topic Infection control, Side rails, and Residents dietary requests lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 31 of 57 CNAs attended. DSD was unable to provide additional in-service documentation. Confidentiality of patient information: The sign-in sheet dated [DATE] indicated Topic Hydration/HIPPA (sic) [Health Insurance Portability and Accountability Act personal health privacy information]/Linen Extra lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 16 CNAs attended. DSD was unable to provide additional in-service documentation. Preservation of dignity and privacy: The sign-in sheet dated [DATE] indicated topic Linen Handling/Customer Service/Shower Team/ Emergency Shut Offs/Abuse Reporting and Prevention lasted one hour. The in-service sheet indicated 16 pf 57 CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. The sign-in sheet dated [DATE] indicated Topic Hydration/HIPPA (sic) [Health Insurance Portability and Accountability Act personal health privacy information]/Linen Extra lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 16 CNAs attended. The sign-in sheet dated [DATE] indicated Topic Hand Washing/Peri-care/Brief/CPR lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 8 CNAs attended the in-service. DSD was unable to provide additional in-service documentation. Patient rights and civil rights: The sign-in sheet dated [DATE] indicated Topic Abuse/Dignity/COC [change of condition] Reporting Change lasted one hour. The sign-in sheet indicated 27 of 57 CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. The sign-in sheet dated [DATE] indicated Topic Resident Rights lasted one hour. The sign-in sheet indicated 36 of 57 CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. The sign-in sheet dated [DATE] indicated Topic Linen Handling/Customer Service/Shower Team/Emergency Shut Offs/Abuse Reporting and Prevention lasted one hour. The sign-in sheet indicated 14 CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. The sign-in sheet dated [DATE] indicated Topic Infection control, Side rails, and Residents dietary requests lasted one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated 31 of 57 CNAs attended. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The sign-in sheet dated [DATE] indicated Subject: Turning-Repositioning/Resident Rights-theft, loss, missing clothes; telephone system lasted one hour. The sign-in sheet indicated 36 CNAs attended. The sign-in sheet 0 of 27 licensed nurses attended. DSD was unable to provide additional in-service documentation. Signs of cardiopulmonary [heart and lung] distress: The in-service sign -in sheet dated [DATE] indicated Title Peri care/CPR. End of life Brief last one hour. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated a total of 35 CNAs attended the in-service. DSD was unable to provide additional in-service documentation. Choking prevention and intervention: The in-service sign -in sheet dated [DATE] at 6 a.m. indicated Topic Choking Prevention lasted one hour. The Sign-in sheet indicated seven CNAs attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. The in-service sign -in sheet dated [DATE] at 2 p.m. indicated Topic Choking Prevention lasted one hour. The sign-in sheet indicated 18 CNAs and one staff from Central Supply attended. The sign-in sheet indicated 0 of 27 licensed nurses attended. DSD stated a total of 26 staff attended Choking Prevention. DSD was unable to provide additional in-service documentation. DSD stated not all staff have received the required educational programs. During a concurrent interview and record review on [DATE] at 2:55 p.m. with DSD, CNA 1, DSD and DON's educational training files were reviewed a. DSD was unable to provide documented evidence the Certified Nursing Assistant (CNA) 1 was provided educational training on the elimination and prevention of discrimination related to LGBT challenges in medical care. b. DSD was unable to provide documented evidence the DSD was provided educational training on the elimination and prevention of discrimination related to LGBT challenges in medical care. c. DSD was unable to provide documented evidence the Director of Nursing (DON) was provided educational training on the elimination and prevention of discrimination related to LGBT challenges in medical care. DSD was unable to provide documented evidence of employees' individualized certificate of attendance received from either LGBT in-person training or online-based training. During an interview on [DATE] at 2:55 p.m. with DSD, DSD stated the facility did not provide any in-services on LGBT to all staff within the last year. DSD stated the staff should be trained on LGBT upon hire and annually. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Non-Discriminatory Practices, dated [DATE], the P&P indicated, No person (i.e., resident, Staff, or visitor) on the grounds of race, color, creed, religion, national origin, age, sex, disability, sexual orientation, pregnancy, gender identity, sex stereotype or source of payment shall be denied benefits or be subjected to discrimination under any admission programs, activities, financial assistance programs, training programs or employment practices. During a review of the facility's policy and procedure (P&P) titled, Mandatory In-Service Training for Nursing Staff, dated [DATE], the P&P indicated, During a review of the facility's policy and procedure (P&P) titled, Mandatory In-Service Training for Nursing Staff, dated [DATE], the P&P indicated, Policy All nursing staff at [facility name] must complete the mandatory in-service training requirements annually, as prescribed by Title 22 regulations to promote competency, safety, and compliance. The facility will provide ongoing education in areas essential to quality care delivery and patient safety .1. Annual Training Requirements 1. Certified Nurse Assistants (CNAs): a. Must complete 24 hours of in-service training annually. 2. Specific Mandatory Training Topics Include: a. Infection prevention and control (minimum 2 hours). b. Fire prevention and safety. c. Accident prevention and safety measures. D. Confidentiality of patient information (HIPPA compliance). e. Preservation of patient dignity and rights. f. Recognizing signs and symptoms of cardiopulmonary distress. g. Choking prevention and intervention. h. Prevention and reporting of abuse (minimum 4 hours every two years). i. Dementia care (5 hours annually). j. Disaster preparedness. k. Universal precautions for infection control. 4. During a concurrent observation and interview on [DATE] at 8:40 a.m. with Maintenance Technician (MT) 2, in Resident 17's room, a space heater was at the Resident 17's bedside. MT stated, he was not aware of the facility policy on residents having a personal space heater. During a concurrent observation and interview on [DATE] at 8:52 a.m. with MT 2, in Resident 62's room, a space heater was at the Resident 62's bedside. MT stated, I don't think the resident's here [at the facility] are allowed to have them. During the facility's P&P titled, Electrical Appliances, dated [DATE], the P&P indicated, Only authorized electrical appliances are permitted in resident living areas. I. Residents may maintain electrical appliances in their living area only if approved by the Administrator or designees . III. Any violation of this policy may result in the removal of such items from the resident's living area.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42148 Based on observation, interview, and record review, the facility failed to maintain an environment free of accident hazards for 12 of 22 sampled residents when: 1. One of one sampled resident (Resident 58), at risk for choking, was unsupervised in the dining room. This failure resulted in Resident 58 putting sugar packets into her mouth and chewing on them. 2. 10 of 16 residents that smoke (Resident 17, Resident 24, Resident 42, Resident 43, Resident 48, Resident 62, Resident 78, Resident 89, Resident 243, and Resident 245) were not monitored with smoking materials and supervised during smoking times. This failure had the potential for residents to be burned while smoking. 3. Two of two sampled residents (Resident 17 and Resident 62) had space heaters in their rooms without authorized approval. This failure had the potential for an electrical failure or fire. 4. One of one sampled residents (Resident 58) who was at risk for wandering/elopement (leave a medical facility without permission), had an unlocked and unalarmed screened door in her room. this failure had the potential for Resident 58 to leave the facility unnoticed. Findings: 1. During a concurrent observation and interview on 11/17/24 at 11:32 a.m. with Certified Nursing Assistant (CNA) 1 in the dining room. Multiple paper packets of sugar were on the table in front of Resident 58. Resident 58 was putting paper packets of sugar in her mouth and chewing on them. CNA 1 came over and put her gloved finger in Resident 58's mouth and pulled a ball of the chewed-up paper sugar packets out of her mouth and stated she [Resident 58] shouldn't of had access to them [paper sugar packets]. During a review of Resident 58's Minimum Data Set [MDS-an assessment tool] section C-Cognitive Patterns (MDSCP), the MDSCP indicated, C1000. Cognitive Skills for Daily Decision Making: code of 3 indicated, Severely Impaired- never/rarely made decisions. During a review of Resident 58's Care Plan (CP), the CP indicated, Behavior of eating non-food items per family. Interventions: Remove unnecessary paper items from meal trays. 2. During a concurrent observation and interview on 11/17/24 at 10:05 a.m. with CNA 1 in the smoking area of the facility, Resident 43 and Resident 48 were smoking outside on the patio. No staff were observed monitoring residents smoking on the patio. Resident 48 stated, We can come out to this patio to smoke whenever we [residents] want. Resident 48 stated residents were not made to wear smoking aprons it is a choice. Resident 48 stated staff do not come outside to supervise the smoking residents. Resident 48 stated he lights Resident 43's cigarettes for him because Resident 43 isn't allowed to have a lighter because he might set something on fire. CNA 1 stated, They [residents] are allowed to smoke unsupervised and whenever they want. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 11/18/24 at 9:30 a.m. on the outside patio, Resident 48 smoking cigarettes unsupervised. Resident 48 had both cigarettes and lighter in his shirt pocket. During a concurrent observation and interview on 11/18/24 at 3:30 p.m. with Resident 43 in the dining room, Resident 43 had cigarette ashes all over his lap and pants. Resident 43 was confused and unable to answer questions appropriately. During a concurrent observation and interview on 11/19/24 at 10:14 a.m. with Activities Director (AD). AD stated she only holds cigarettes for Resident 43. AD stated, All the other smokers in the facility keep their own cigarettes and lighter. They [smoking materials] should all be locked up. AD stated Resident 17 had two electronic cigarette in his bedside table, Resident 42 had a pack of cigarettes on his nightstand, Resident 62 had a pack of cigarettes on the back pocket of his wheelchair, Resident 24 had a pack of cigarettes in her purse, Resident 48 had a pack of cigarettes in his shirt pocket, Resident 78 had an electronic cigarette on bedside table. Resident 243 had a pack of cigarettes on his nightstand. AD stated all smoking materials should be locked up. During an interview on 11/19/24 at 9:06 a.m. with Resident 24, Resident 24 stated she smokes daily and keeps her cigarettes in her purse and stated, My son buys them and brings them to me. During a concurrent observation and interview on 11/20/24 at 11:21 a.m. with Resident 245 in the dining room, a cigarette lighter was found on the floor next to Resident 245. Resident 245 stated it was hers and stated, I haven't given it back yet. I get it from the staff in the front office when I need it and return it whenever I get a chance to. Residents are responsible to taking them out and giving them back. Resident 245 stated staff does not give them smoking materials or collect them in the smoking area. During an observation on 11/20/24 at 2:45 p.m. in Resident 48's room, a bag of loose tobacco was seen in resident's wheelchair at the foot of his bed. During a review of facility document titled, Smoking Schedule for Residents Safety (SSRS), (undated), the SSRS indicated, All smoking activity will be scheduled and supervised by facility staff on the designated patio. All cigarettes, matches and lighters are to be kept in a lock box in the Nurses cart or Activities room. No cigarettes, matches or lighter are to be kept by resident or stored in residents' room. During a review of Resident 17's Smoking Assessment (SA), dated 11/15/24, the SA indicated, Resident 17 uses tobacco products and will follow the facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 24's SA, dated 9/13/24, the SA indicated, Resident 24 uses tobacco and will follow the facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 42's, SA, dated 9/19/24, the SA indicated, Resident 42 uses tobacco products and will follow the facility's policy on location and time of smoking. Resident will Adhere to the Tobacco/Smoking Policies of the Facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 43's SA, dated 8/13/24, the SA indicated, Resident 43 uses tobacco and will follow the facility's policy and location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 43's Care Plan-Tobacco Use (CPTU), dated 5/13/24, the CPTU indicated, Conduct Smoking Safety Evaluation on admission and PRN [as needed]. Ensure Eyeglasses on. Utilize cigarette holder. Utilize Smoking Apron. During a review of Resident 48's SA, dated 8/5/24, the SA indicated, Resident 48 uses tobacco and will follow the facility's policy on location and time of smoking and will adhere to the Tobacco/Smoking Policies of the Facility. During a review of Resident 62's SA, dated 11/6/24, the SA indicated, Resident 62 uses tobacco products and will follow the facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 78's SA, dated 11/13/24, the SA indicated, Resident 78 uses tobacco and will follow facility's policy on location and time of smoking. The rest of the smoking assessment was incomplete. During a review of Resident 89's SA, dated 11/4/24, the SA indicated, Resident 89 uses tobacco and will Adhere to the Tobacco/Smoking Policies of the Facility. During a review of Resident 243's SA, dated 11/11/24, the SA indicated, Resident 243 uses tobacco and will follow the facility's policy on location and time of smoking and will Adhere to the Tobacco/Smoking Policies of the Facility. During a review of Resident 245's, SA, dated 10/23/24, the SA indicated, Resident [Resident 245] does not utilize any smoking products. During a review of the facility's Policy and Procedure (P&P) titled, Smoking, (undated), the P&P indicated, Purpose- to maintain a safe healthy environment for both smokers and non-smokers. Policy- III. The facility discourages smoking by residents and ensures that those residents who choose to smoke do so safely. IV. Residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke independently in these areas. V. Resident who are not able to smoke independently and safely will be accompanies by facility staff while smoking. VI. This policy applies to the use of both cigarettes and e-cigarettes [Vapes]. Procedure- Smokers shall be identified at the time of admission. IX. Resident who smoke shall wear a smoking apron if they are found not to be safe. X. All smoking material will be stored in a secure area to ensure they are kept safe. XII. All smoking sessions will be supervised by facility staff members. 3a. During a concurrent observation and interview on 11/20/24 at 8:40 a.m. with Maintenance Technician (MT) 2, in Resident 17's room, a space heater was at the Resident 17's bedside. MT 2 asked Resident 17 where he got the space heater and how long he had it [the space heater]. MT stated, I don't know the policy, but I don't think the resident's here [at the facility] are allowed to have them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3b. During a concurrent observation and interview on 11/20/24 at 8:52 a.m. with MT 2, in Resident 62's room, space heater was at the bedside of Resident 62. MT 2 asked Resident 62 where he got the space heater and how long he had it [the space heater]. MT stated, I don't know the policy, but I don't think the resident's here [at the facility] are allowed to have them. During an interview on 11/20/24 at 3:29 p.m. with Administrator, Administrator stated, Space heaters require my approval, and I don't want any space heaters in my facility due to the risk of fire. I have not authorized residents at this facility to have a space heater in their room. During the facility's P&P titled, Electrical Appliances, dated 11/1/17, the P&P indicated, Only authorized electrical appliances are permitted in resident living areas. I. Residents may maintain electrical appliances in their living area only if approved by the Administrator or designees . III. Any violation of this policy may result in the removal of such items from the resident's living area. 4. During a concurrent observation and interview on 11/21/24 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 3 and CNA 2 in Resident 58's room, Resident 58's sliding glass door was unlocked. An alarm case was seen attached with the batteries missing along with the cover. CNA 2 opened the sliding glass door and stated she didn't know if Resident 58 was a wanderer or an elopement risk. LVN 3 stated Resident 58 can walk or use a wheelchair and is at risk for wandering and elopement. During an interview on 11/21/24 at 10:03 a.m. with Director of Nursing (DON), DON stated Resident 58 was a wanderer and was at risk for elopement. DON stated Resident 58 was at risk for elopement and was supposed to have a functioning alarm on her sliding glass door. During a review of Resident 58's MDS- Behavior (MDSB), dated 10/9/24, the MDSB indicated, Wandering-Presence & Frequency code 2 indicating behavior of this type occurred 4 to 6 days. During a review of Resident 58's Care Plan (CP), dated 10/224/24, the CP indicated, [Resident 58] is wanderer related to confusion and disorientation and impaired safety awareness. The resident will not leave facility unattended. The resident's safety will be maintained. During a review of the facility's P&P titled, Wandering & Elopement, dated 11/1/17, the P&P indicated, The facility will identify residents at risk for elopement and minimize any possible injury because of elopement.

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NAME OF PROVIDER OR SUPPLIER Parkview Julian Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Julian Avenue Bakersfield, CA 93304	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39763 Based on interview and record review, the facility failed to ensure adequate numbers of staff with certain skill set were available to meet one of two sampled resident (Resident 82) care plan needs. This failure resulted in Resident 82 not receiving needed medications. Findings: During a review of Resident 82's care plan with the focus on (Resident 82) is on IV [Intravenous - administration of fluids, medications or nutrients directly into a vein] antibiotics [medication used to treat infections] for Osteomyelitis [inflammation of bones] r/t [related to] Right foot/ankle, initiated 8/20/24. The care plan indicated one of the interventions were to Administer antibiotic per md (medical doctor) orders. During a concurrent interview and record review on 11/6/24 at 3:03 p.m. with Director of Nursing (DON), Resident 82's IV Medication Administration Record, (IV MAR) for October 2024 was reviewed. DON reviewed the following: Unasyn (medication used to treat infection) .Use 3 grams (unit of measure) intravenously (administering medications directly into a vein using a needle or tube) every 6 hours for right foot osteomyelitis until 10/17/2024 23:59 - Start Date -10/16/2024 1800 (6 p.m.) The IV MAR indicated, on 10/27/24 for the 6 a.m. administration time, no documentation Resident 82's Unasyn was administered. The IV MAR indicated, on 10/27/24 for the 12 p.m. administration time, no documentation Resident 82's Unasyn was administered. DON stated two doses of Unasyn were missed. DON stated the facility had a mix up in the schedule and could not get registered nurse coverage for 10/27/24 day shift. During a review of the facility's policy and procedure (P&P) titled, Nursing Department - Staffing, Scheduling & Postings, revised 6/1/19, the P&P indicated, To ensure an adequate numbers of nursing personnel are available to meet resident needs. Policy I. The Facility will employ sufficient Nursing Staff on a 24-hour basis that meets the appropriate competencies, skill set, and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well -being for each resident. i. The Facility will employ sufficient nursing staff as determined by resident and individual plans of care .

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

41035

Based on observation, interview, and record review, the facility failed follow their policy and procedure (P&P) titled, Food Preparation when one of one sampled cooks (Cook 1) did not follow the facility's standardized recipe for puree (smooth texture) food preparation to maintain nutritive value. This failure had the potential for residents on a pureed diet to be at risk for nutritive impairment.

Findings:

During a concurrent observation and interview on 11/18/24, at 9:40 a.m. with [NAME] 1, in the kitchen, [NAME] 1 prepared the puree meat sauce for lunch. [NAME] 1 stated she was using the 12 servings portion in the recipe book for the meat sauce. [NAME] 1 stated 10 residents were on a puree diet. [NAME] 1 stated she would put three cups of water to blend into the meat and sauce. [NAME] 1 stated she was using the casserole menu from the recipe book. [NAME] 1 put in three (3) cups of water into the food processor with the meat and sauce. [NAME] 1 then added 3/4 of a cup of thickener. [NAME] 1 proceeded to use the food processor to blend the above items into a puree texture. [NAME] 1 completed the puree meat sauce. [NAME] 1 stated she had completed the puree meat sauce and it was ready to be put in warmer to be served to residents with a puree diet order.

During a concurrent interview and record review on 11/18/24, at 9:55 a.m. with [NAME] 1, the Pureed Casserole recipe was reviewed. The recipe indicated, Fluid such as milk, gravy, or low sodium broth, use 3 cups. gradually add warm liquid (low sodium broth, milk or gravy). [NAME] 1 stated she used water and should have used either milk or broth as the recipe indicated.

During a review of the facility's policy and procedure (P&P) titled, Food Preparation, dated 2023, the P&P indicated, food shall be prepared by methods that conserve nutritive value, flavor and appearance. 1. The facility will use approved recipes, standardized to meet the resident census.2. Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. 2. Recipes are specific as to portion yield, method of preparation, quantities of ingredients .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 41035 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled, Food Preference, when two of six sampled residents (Resident 24 and Resident 43) meal preferences were not honored. This failure had the potential for Resident 24 and Resident 43's nutritional needs to not be met and the potential for unintended weight loss due to the food not meeting their nutritional needs. Findings: 1. During a concurrent observation and interview on 11/17/24, at 12 p.m. with Resident 24, in the facility's dining room, Resident 24 was sitting in her wheelchair at the dining room table. Resident 24 was served Mac and Cheese for lunch. Resident 24 stated she does not like pasta. During a concurrent interview and record review on 11/17/24 at 12:05 p.m. with Certified Dietary Manager (CDM), Resident 24's Meal Tray Ticket (MTT), dated 11/17/24 was reviewed. The MTT indicated, Resident 24 disliked pasta. CDM stated Resident 24 was given Mac and Cheese. CDM stated Resident 24 should not have had been given Mac and Cheese since it was pasta and Resident 24 disliked it. 2. During a concurrent observation and record review on 11/17/24, at 12:07 p.m. with Resident 43, in the facility's dining room, Resident 43 was sitting in his wheelchair at the dining room table. Resident 43's MTT was reviewed. The MTT indicated Resident 43 disliked pasta. Resident 43 had Mac and Cheese on his plate, this caused Resident 43 to have a shouting and angry outburst. During a concurrent interview and record review on 11/17/24 at 12:09 p.m. with CDM, Resident 43's MTT, dated 11/17/24 was reviewed. The MTT indicated Resident 43 disliked pasta. CDM stated Resident 43 was given Mac and Cheese. CDM stated Resident 43 should not have had been given Mac and Cheese since it is pasta and the Resident 43 disliked it. During a review of the facility's policy and procedure (P&P) titled, Food Preference, dated 2023, the P&P indicated, Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 42148 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations and follow the care plan for one of one sampled resident (Resident 48) to prevent symptoms of dehydration, poor oral (mouth) moisture and skin elasticity (turgor) This failure had the potential to negatively affect the well-being and the hydration status for Resident 48. Findings: During an interview on 11/19/24 at 9:08 a.m. with Resident 48, Resident 48 stated, The staff will never give me a cup of coffee. They [staff] will either tell me the kitchen is closed or that I am not allowed to have it. I like to drink coffee all day. It is my favorite beverage. During a concurrent observation and interview on 11/19/24 at 2:05 p.m. with Resident 48 and Dietary Supervisor (DS) at the kitchen entrance. Resident 48 stated staff won't let him have a cup of coffee. Resident 48 rang the doorbell at the kitchen entrance. DS came to the door and told him she couldn't give him a cup of coffee, and that he would have to tell his Certified Nursing Assistant (CNA). Resident 48 stated he has been asking his CNAs all day and staff won't bring him any. DS stated, We won't give resident's coffee just anytime they want it. During an interview on 11/19/24 at 2:18 p.m. with Registered Dietician (RD), RD stated, the kitchen staff doesn't know the residents well and dining staff won't give resident coffee. RD stated, We don't have a process or lists that states resident's choice or preferences for beverages outside of meal times and kitchen staff don't know what resident is allowed which beverage. RD stated, Residents are provided coffee in the morning, but not just whenever they want it, because we don't know who can/can't have it. During a review of Resident 48's, Care Plan (CP), dated 7/31/24, the CP indicated, The resident has potential fluid deficit and will be free of symptoms of dehydration and maintain moist [mouth] and good skin turgor [skin elasticity] with interventions including educate the resident/family/caregivers on importance of fluid intake. During an interview on 11/19/24 at 2:56 p.m. with Director of Nursing (DON), DON stated providing beverages should be a resident choice and a case-by-case situation. DON stated if a resident was independent with a BIMS of 15, and if coffee was their beverage of choice, resident should be allowed to have it whenever they want. During a review of Resident 48's, MDS - Section C Cognitive Patterns [MDSC-an assessment tool that scores how a resident mentally understands thought processes.], the MDSC indicated, Resident has a BIMS (Brief Interview for Mental Status) of 15 meaning he does not have impairment mentally understanding his thought processes. During a review of the facility's policy and procedure (P&P) titled, Food Preference, dated 2023, the P&P indicated, Resident's food preferences will be adhered to within reason.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41035 Based on observation, interview, and record review, the facility failed to store, prepare, and maintain food in a sanitary manner when: 1. Food items were expired in one of one dry storage room. 2. One dented can was not stored separately in one of one dry storage room. 3. Food items in one of one dry storage room were unlabeled and undated. 4. Food item in the one of one freezer was unlabeled and undated. 5. Food items in one of two Refrigerator's were unlabeled and undated. Findings: 1. During a concurrent observation and interview on [DATE] at 10:07 a.m. with [NAME] 1 in the kitchen's dry storage room, 11 boxes of baking soda were on the shelf with an expiration date of [DATE]. [NAME] 1 stated the baking soda boxes were expired and they should not have been on the shelf for use. 2. During a concurrent observation and interview on [DATE] at 10:10 a.m. with [NAME] 1 in the kitchen's dry storage room, a dented can of Pork and Beans was on the shelf with other canned foods. [NAME] 1 stated the dented cans should not have been with the regular cans. [NAME] 1 stated the dented can should have been put with the other dented cans. During a review of the facility's policy and procedure (P&P) titled, Food Storage-Dented Cans dated 2023, the P&P indicated, All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and place in a specified labeled area. 3. During a concurrent observation and interview on [DATE] at 10:15 a.m. with [NAME] 1 in the kitchen's dry storage room, an unlabeled and undated plastic bag of dry pasta noodles was on the shelf. [NAME] 1 verified the pasta was unlabeled and undated and stated the bag should have been labeled with product name and date that it was opened. 4. During a concurrent observation and interview on [DATE] at 10:19 a.m. with [NAME] 1 in the kitchen, freezer #1 had an undated and unlabeled bag of hash browns. [NAME] 1 stated the bag was unlabeled and undated and the bag should have been labeled with product name and date it was opened. 5. During a concurrent observation and interview on [DATE] at 10:25 a.m. with [NAME] 1 in the kitchen, a pitcher with red liquid and a pitcher with brown liquid were in the refrigerator and were unlabeled and undated. [NAME] 1 stated the pitchers were unlabeled and undated and should have been. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 10:27 a.m. with [NAME] 1 in the kitchen, 5 glasses of milk, 8 glasses of red juice, and 2 glasses of prune juice were on the kitchen counter in a blue basket. All glasses of liquid were unlabeled and undated. [NAME] 1 stated all glasses containing various liquids were unlabeled and undated and should have been. During a review of the facility's P&P titled, Labeling and Dating of foods dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated .All prepared foods need to be covered, labeled, and dated .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32946 Findings: 1. During a concurrent observation and interview on 11/19/24 at 10:47 a.m. with Licensed Vocational Nurse (LVN) 2 inside Resident 70 and Resident 29's bedrooms, the ceiling above Resident 29's bed had water stain larger than a dinner plate with black stains in the center about the size of a silver dollar. LVN 2 examined the water stain on the ceiling and stated, I think there's a leak, it looks like water damage. During a concurrent interview and record review on 11/20/24 at 3:19 p.m. with Maintenance Supervisor (MS), MS stated he had seen the visible signs of water damage. MS reviewed the maintenance binder and stated he could not find documentation where staff had notified him of water damage to Resident 70 and Resident 29's bedroom ceiling. During a review of the Division of Occupational Health and Safety (DOHS) Mold and Water Intrusion Program Manager's Standard Operating Procedures [SOP] titled Moisture and Mold Remediation Standard Operating Procedures dated 2023, the SOP indicated The presence of excessive moisture in buildings has been linked with occupant illnesses and deterioration of building material . 42148 2a. During a concurrent observation and interview on 11/20/24 at 8:40 a.m. with Maintenance Technician (MT) 2, in Resident 17's room, a space heater was at the Resident 17's bedside. MT stated, I don't know the policy, but I don't think the resident's here [at the facility] are allowed to have them. 2b. During a concurrent observation and interview on 11/20/24 at 8:52 a.m. with MT 2, in Resident 62's room, a space heater was at the Resident 62's bedside. MT stated, I don't know the policy, but I don't think the resident's here [at the facility] are allowed to have them. During an interview on 11/20/24 at 3:29 p.m. with Administrator, Administrator stated, Space heaters require my approval, and I don't want any space heaters in my facility due to the risk of fire. I have not authorized residents at this facility to have a space heater in their room. During the facility's P&P titled, Electrical Appliances, dated 11/1/17, the P&P indicated, Only authorized electrical appliances are permitted in resident living areas. I. Residents may maintain electrical appliances in their living area only if approved by the Administrator or designees . III. Any violation of this policy may result in the removal of such items from the resident's living area. 3. During a concurrent observation and interview on 11/21/24 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 3 and CNA 2 in Resident 58's room, Resident 58's sliding glass door was unlocked. An alarm case was attached with the batteries missing along with the cover. CNA 2 opened the sliding glass door and stated she didn't know if Resident 58 was a wanderer or an elopement risk. LVN 3 stated Resident 58 can walk or use a wheelchair and is at risk for wandering and elopement. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 10:03 a.m. with Director of Nursing (DON), DON stated Resident 58 was a wanderer and was at risk for elopement. DON stated Resident 58 was at risk for elopement and was supposed to have a functioning alarm on her sliding glass door. During a review of Resident 58's MDS- Behavior (MDSB), dated 10/9/24, the MDSB indicated, Wandering-Presence & Frequency code 2 indicating behavior of this type occurred 4 to 6 days. During a review of Resident 58's Care Plan (CP), dated 10/224/24, the CP indicated, [Resident 58] is wanderer related to confusion and disorientation and impaired safety awareness. The resident will not leave facility unattended. The resident's safety will be maintained. During a review of the facility's P&P titled, Wandering & Elopement, dated 11/1/17, the P&P indicated, The facility will identify residents at risk for elopement and minimize any possible injury because of elopement.