STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055649	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tulare Healthcare & Wellness Center, LP	680 East Merritt Avenue Tulare, CA 93274

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46958 Based on observation, interview, and record review, the facility failed to ensure four of 41 sampled resident's (Resident 337, Resident 70, Resident 10, and Resident 41) call lights were within reach. This failure had the potential for residents to be unable to call for assistance and had the potential for delayed care provision. Findings: During a concurrent observation and interview on 10/21/24 at 9:25 a.m. with Certified Nursing Assistant (CNA) 6 in Resident 337's room, Resident 337's call light was on the floor on the right side of her bed. CNA 6 stated Resident 337's call light was on the floor and the call light should be within Resident 337's reach. During a concurrent observation and interview on 10/21/24 at 9:34 a.m. with Director of Nursing (DON), in Resident 70's room, Resident 70's call light was on top of the bed frame behind the head of the bed. Resident 70 was unable to reach the call light. DON stated call light was not within Resident 70's reach and call light should be clipped to the sheet. During a concurrent observation and interview on 10/21/24 at 9:47 a.m. with CNA 7, in Resident 10's room, Resident 10's call light was hanging on the wall behind the bed. CNA 7 stated call light is hanging on the wall and it should be within Resident 10's reach. 51540 During a concurrent observation and interview on 10/21/24 at 9:21 a.m. with LVN 1, in Resident 41's room, Resident 41's call light was on the floor and out of Resident 41's reach. LVN 1 stated Resident 41's call light was on the floor and stated, Call light should be within reach of the resident. During a review of the facility's policy and procedure (P&P) titled, Communication-Call System [P-NP29] dated 10/09/24, the P&P indicated, 2. The call alert device will be placed within the resident's reach. During a review of the facility's P&P titled, Communication-Call System [NP29] dated 10/09/24, the P&P indicated, The Facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 51540 Based on observation, interview and record review, the facility failed to arrange regularly scheduled resident council meetings for three out of three sampled residents (Resident 53, Resident 51 and Resident 29). This failure resulted in the denial of Residents to meet regularly to discuss care and quality of life issues, and for the facility to be unaware of and unable to address residents' concerns. Findings: During a review of the facility's Resident Council Minutes (RCM) dated 7/29/24, the RCM indicated the last resident council meeting was held on 7/29/24. During an interview on 10/22/24 at 8:37 a.m. with Resident 53, Resident 53 stated, We have only met one time. During an interview on 10/22/24 at 8:51 a.m. with Resident 51, Resident 51 stated, I am not aware of resident council at all. During an interview on 10/22/24 at 9 a.m. with Resident 29, Resident 29 stated he is not aware of a resident council. Resident 29 stated, I do not know what that [resident council] is. During an interview on 10/24/24 at 8:52 a.m. with Administrator, Administrator stated, These [Resident Council Minutes dated July 29, 2024] are the last resident council meeting notes I have. During a review of the facility's policy and procedure (P&P) titled, Resident Council, dated 11/1/13, the P&P indicated, The purpose is to promote the exercise of resident rights at the facility. Resident Council meetings are scheduled monthly, or more frequently, if requested by residents or the Administrator.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 51540 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Advance Directive [legal document indicating resident's decision for end-of-life treatment and care] when one of two sampled residents' (Resident 41) request for more information on advanced directives was not provided. Findings: During a concurrent interview and record review on 10/24/24 at 8:56 a.m. with Administrator, Resident 41's AHCD dated 6/7/24 was reviewed. The AHCD indicated, I would like receive more information. Administrator stated, Nothing from social services and nothing in the progress notes for more information on advance directives. During a review of Resident 41's face sheet (provides relevent resident information), dated 5/31/24, the face sheet indicated the facility admitted Resident 41 on 5/31/24. During a review of Residents 41's Brief Interview for Mental Status, (BIMS, cognition assessment tool, 15-point scale: 0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact) dated 5/31/24, Resident 41's Bims Score indicated 13. During a review of Residents 41's BIMS, dated 9/12/24, Resident 41's Bims Score indicated 14. During a review of the facility's P&P titled, Advance Directive, dated 7/31/24, the P&P indicated, If the Resident does not have an Advance Directive and additional information is requested, the Social Services Director or Designee may provide the resident with a copy of the Advance Directive form for their review.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40516 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled Disclosure of PHI [protected health information] for one of one sampled residents (Resident 61) when one of Resident 61's medical diagnoses was disclosed to Resident 61's roommate. This failure resulted in the Former Director of Nursing (FDON) revealing Resident 61's PHI to another resident. Findings: 1. During an interview on 10/21/24 at 4:07 p.m. with Resident 61's family member (FM 1), FM 1 stated Resident 61's roommate (Resident 15) asked FM 1 if Resident 61 had [medical condition]. FM 1 stated he responded by saying no, even though Resident 61 did have the medical diagnosis Resident 15 mentioned. During an interview on 10/23/24 at 8:19 a.m. with Resident 15, Resident 15 stated the old boss (FDON) told him, Resident 61 had [medical condition]. Resident 15 stated FDON was no longer working at the facility and was now working in a neighboring city. During an interview on 10/23/24 at 8:28 a.m. with Administrator, Administrator stated the former Director of Nursing was (same first name given by Resident 15). During an interview on 10/23/24 at 9:14 a.m. with Payroll Clerk (PC), PC stated FDON was employed by the facility from 10/16/23 to 7/12/24. During a review of Resident 61's medical record (MR), the History & Physical Update Evaluation (H&P), dated 3/11/24 indicated Resident 61 was admitted to the facility on [DATE] with medical diagnoses which included the medical condition Resident 15 was made aware of. During a review of FDON Inservice Education, dated 7/2/23, FDON completed the facility's Health Information Portability and Accountability Act (HIPAA- federal law which addresses the privacy and security of individuals' health information) education. The Inservice Education indicated, Protected Health Information (PHI) is information related to a person's health care treatment and to the corresponding payment for those services. PHI includes information that could reasonably identify an individual (patient identifiers) and sensitive health information. Every member of the workforce, even those who don't deal directly with patient information, should have an understanding of what PHI is and the ways in which it must be protected. Patient Rights HIPPA [sic] provides patients with several basic rights that inform and empower them. These include: 1. the [sic] right to inspect and copy his or her PHI used by the organization. 2. the [sic] right to request an amendment to his or her PHI kept by the organization. 3. the [sic] right to restrict the use and disclosure of his or her PHI. During a review of the facility's Policy and Procedure (P&P) titled, Disclosure of PHI dated 12/1/12, the P&P indicated, Purpose: To limit the access, use, and disclosure of Protected Health Information (PHI) to the minimum necessary needed to accomplish the intended purpose of the use, disclosure or request for PHI. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50939

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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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32234 Based on observation, interview, and record review, the facility failed to 1. Follow physician orders (PO) to wrap one of one sampled resident's (Resident 287) left leg daily. This failure resulted in Resident 287's leg to become red and swollen. 2. Complete weekly nursing assessments for two of three sampled residents (Resident 77 and Resident 36). This failure had the potential for residents' physical and emotional care needs to go unmet. 3. Follow its policy and procedure (P&P) titled, Medication-Self Administration, for three of 22 sampled residents (Resident 1, Resident 24, and Resident 43) when the facility did not complete the Assessment for Self Administration of Medications ([NAME]). This failure had the potential for medication to be inaccurately administered by the resident. Findings: 41035 1. During a concurrent observation and interview on 10/23/24 at 10:27 a.m. with Resident 287, on the patio, Resident 287 was alert, oriented, and sitting in her wheelchair. Resident 287's left leg was unwrapped and was red and swollen. Resident 287 stated her left leg should be wrapped but staff had not wrapped her left leg in several days. During an interview on 10/23/24 at 10:31 a.m. with Resident 287's Family Member (FM 2), FM 2 stated, he had not seen his grandmother's leg wrapped since she got to the facility. FM 2 stated, he came to visit Resident 287 every day. FM 2 stated the hospital informed him that his grandmother's leg should be wrapped. During a concurrent interview and record review on 10/23/24 at 10:49 a.m. with Licensed Vocational Nurse (LVN) 8, Resident 287's physician order (PO), dated 10/16/24, was reviewed. The PO indicated, Wrap left leg with ACE bandage once a day for edema (swelling caused by too much fluid trapped in the body's tissues). LVN 8 stated, the PO indicated to wrap Resident 287's left leg. During a concurrent observation and interview on 10/23/24, at 11:55 am, with LVN 8, on the patio, Resident 287 was sitting outside in her wheelchair. LVN 8 stated, Resident 287's left leg had redness and edema. LVN 8 stated Resident 287's leg was not wrapped. LVN 8 stated Resident 287's leg should have been wrapped per PO. During an interview on 10/24/24 at 11:50 a.m. with Administrator, a policy for following physician orders was requested. Administrator stated the facility did not have a policy on following physician orders. 40516 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. During a concurrent interview and record review on 10/24/24 at 8:48 a.m. with DON, Resident 77's medical record (MR) was reviewed. The Admission Record (AR) indicated on 8/23/24, the facility admitted Resident 77. A review of Resident 77's N Adv- Long Term Care Evaluation [LTCE- comprehensive head to toe nursing assessment] indicated the following: 8/30/24 LTCE not done. 9/6/24 LTCE not done. 9/15/24 LTCE not done. DON stated, no LTCE were completed for Resident 77 from 9/15/24 through 10/23/24. DON stated the LTCE was supposed to be completed weekly for each resident. DON stated, The [LTCE] shows if there are any changes and any progress on resident status. During an interview on 10/24/24 at 11:21 a.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated LTCE were supposed to be completed weekly on each resident. LVN 8 stated weekly LTCE give the facility a better understanding of residents' wellbeing and what their needs are. 2b. During a record review on 10/24/24 at 11:26 a.m. with DON, Resident 36's MR was reviewed. A review of Resident 36's LTCE indicated the following: 8/21/24 LTCE not done. 8/28/24 LTCE not done. 9/5/24 LTCE not done. 9/12/24 LTCE not done. 9/19/24 LTCE not done. 9/26/24 LTCE not done. 10/3/24 LTCE not done. 10/10/24 LTCE not done. 10/17/24 LTCE not done. A facility policy for LTCE weekly assessments was requested, none was provided. 3. During an observation on 10/21/24 at 10:07 a.m. in Resident 1's room, an open, single use vial of eye drops with liquid content, was on Resident 1's bed side table. During an observation on 10/21/24 at 10:10 a.m. in Resident 24's room, an open, single use vial of eye drops with liquid content, was on Resident 24's bed side table. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/21/24 at 10:14 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated Resident 1 and Resident 24 had eye drops on their bed side tables. During a concurrent observation and interview on 10/21/24 at 2:55 p.m. with LVN 6, in Resident 43's room, a bottle of eye drops was on Resident 43's bed. LVN 6 stated she saw the eye drops on Resident 43's bed. During a concurrent interview and record review on 10/21/24 at 2:57 p.m. with LVN 6, Resident 43's [NAME], dated 5/8/24 was reviewed. The [NAME] indicated, Capable of administering eye drops/ointments was marked N/A [Not applicable option was marked]. LVN 6 stated, Resident 43 cannot administer her own eye drops. During a concurrent interview and record review on 10/23/24 at 2:04 p.m. with Director of Nursing (DON), Resident 24's medical record was reviewed. DON stated the facility did not complete an [NAME] for Resident 24. During a concurrent interview and record review on 10/23/24 at 2:06 p.m. with DON, Resident 1's medical record was reviewed. DON stated the facility did not complete an [NAME] for Resident 1. During a review of the facility's P&P titled, Medication-Self Administration, dated 1/10/12, the P&P indicated, The Assessment for Self Administration [sic] of Medications will be maintained in the resident's chart.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled Activity Program when: 1. Activity assessments were not completed for five of five sampled residents (Resident 337, Resident 46, Resident 438, Resident 42, and Resident 41). 2. Activity care plan was not completed for one of five sampled residents (Resident 438). These failures had the potential for the facility to not be aware of Resident 337, Resident 46, Resident 438, Resident 42, and Resident 41 activity preferences. Findings: 1. During a concurrent interview and record review on 10/23/24 at 3:55 p.m. with Minimum Data Set Coordinator (MDSC), Resident 337's medical record (MR), undated was reviewed. MDSC stated there was no activity assessment in Resident 337's MR. MDSC stated on 10/10/24, the facility admitted Resident 337. MDSC stated Resident 337's activity assessment should have been completed within seven days of admission. During a concurrent interview and record review on 10/23/24 at 3:59 p.m. with MDSC, Resident 46's MR, undated, was reviewed. MDSC stated there was no activity assessment in Resident 46's MR. MDSC stated the facility readmitted Resident 46 on 3/22/24. MDSC stated Resident 46's activity assessment should have been completed within seven days of admission. 51540 During a concurrent interview and record review on 10/23/24 at 4:03 p.m. with MDSC, Resident 438's MR was reviewed. MDSC stated Resident 438's admitted was 10/12/24. MDSC stated, No [initial] activities assessment was completed yet. It [activities asesssment] should have been completed by the seventh day of admission. During a concurrent interview and record review on 10/24/24 at 10:54 a.m. with Administrator, the Resident 42 and Resident 41's MR were reviewed.Administrator stated, Resident 42's admitted was 8/1/23, no initial assessment as of today [10/24/24]. Administrator stated, Resident 41's, admitted was 5/31/24, the initial activity assessment was 6/10/24, was not completed within seven days [of admission]. During a review of the facility's policy and procedure (P&P) titled, Activities Program, dated 11/1/13, the P&P indicated, The Initial Activity Assessment is completed by the Director of Activities or his or her designee within seven days of admission. 2. During a concurrent interview and record review on 10/23/24 at 4:55 p.m. with MDSC, Resident 438's clinical record was reviewed. MDSC stated, There is no care plan for Resident 438's activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Activities Program, dated 11/1/13, the P&P indicated, After completion of the Initial Activity Assessment and the MDS, an individualized Care Plan will be developed and implemented for each resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32234 Based on observation, interview, and record review, the facility failed to follow their policies and procedure titled Pressure Injury Prevention for one of seven sampled residents (Resident 75) did not receive preventative interventions for a pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). This failure resulted in Wound Care Provider (WCP) performing a surgical excisional procedure to remove non-living tissue in Resident 75's pressure wound and had the potential for Resident 75 to continue to develop further skin breakdown and the Stage 3 pressure injury to worsen. Findings: During an interview on 10/21/24 at 11:19 a.m. with Resident 75, Resident 75 stated, I have wounds on my tailbone both upper and lower. During a review of Resident 75's Wound Evaluation & Management Summary (WEMS), dated 10/15/24, the WEMS indicated, Resident 75's had a Stage 3 (full thickness tissue loss) Pressure Wound for more than 19 days. The wound size was 1 centimeter (cm, unit of measurement) by 0.4 cm by 0.1 cm with a surface area of 0.42 cm squared. This visit's measurements are exactly the same as the previous visit. Full Thickness Slough [dead tissue, usually yellow, tan, gray, or green in color, usually moist and stringy in texture]: 100 %. Wound progress Not at Goal. The WEMS indicated a change in wound care dressings and Recommended Off-Load [reduce pressure on] Wound.Low Air Loss Mattress ; be sure air compressor is set to match patient's weight and not their comfort level. During a concurrent observation and interview on 10/21/24 at 11:57 a.m. with Licensed Vocational Nurse (LVN) 10, in Resident 75's room, Resident 75 was lying in her bed on a regular mattress. LVN 10 stated Resident 75 was admitted to the facility with, a stage 3 pressure injury to her sacrum (a bone at the base of the spine, above the tailbone). LVN 10 stated Resident 75 should be on a Low Air Loss Mattress (alternating pressure mattress to help prevent skin breakdown). During an interview on 10/21/24 at 3:48 p.m. with Certified Nursing Assistant (CNA) 11, CNA 11 stated Resident 75 had a pressure injury on her tailbone. CNA 11 stated Resident 75 was not on a special mattress for her pressure injury. During a review of Resident 75, Admission Record (provides relevant resident information), dated 9/12/24, the Admission Record indicated the facility admitted Resident 75 on 9/12/24. During a review of Resident 75's untitled Plan of Care (POC) for stage 3 pressure wound to coccyx (tailbone), dated 9/13/24, the POC did not indicate any measures to help Resident 75's stage 3 pressure wound to not worsen. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 75's untitled Plan of Care (POC) for risk for skin breakdown, dated 10/16/24, the POC indicated, moderate risk for skin breakdown/pressure ulcer, Braden scale [pressure ulcer assessment tool, score less than or equal to 9 severe risk, High Risk Score 10-12), Moderate risk Score 13-14, Mild Risk Score 15-18] 14. follow facility protocols/policies for the prevention/treatment of skin breakdown. The POC did not indicate any other measures to help Resident 75's stage 3 pressure wound to not worsen. During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention, dated 9/20, the P&P indicated, The nursing staff will implement interventions identified in the care plan which may include but are not limited to, the following: A. Pressure redistributing devices for bed and chair. F. Use of (wedge) pillows for positioning and pressure relief, .I. Devices (bed trapeze bar, draw sheets, mechanical lifts, positioning aides, etc.) to reduce friction and shear when repositioning .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51540 Based on observation, interview, and record review, the facility failed to follow its policies and procedures (P&P) titled, Gait Belt dated 9/16 and Ambulation when Physical Therapy Assistant (PTA) ambulated one of three sampled residents (Resident 438) without a facility provided gait belt, and supported Resident 438 by holding onto her pants waistband. This failure had the potential for Resident 438 to fall and sustain injuries. Findings: During an observation on 10/22/24 at 11:25 a.m. in the hallway, a Physical Therapy Assistant (PTA) was assisting Resident 438 to walk. PTA was holding onto Resident 438's pants' waistband. The gait belt on Resident 438 was fraying (coming apart) During an interview on 10/22/24 at 11:35 a.m. with PTA, PTA stated he did not use a gait belt (transfer belt used to help a resident move safely and maintain their balance). PTA stated, I felt like she (Resident 438) was steady, but the gait belt does help out. The gait belt does reduce falls. PTA stated the facility provides gait belts, but this gait belt was his own. PTA stated the gait belt on Resident 438 was showing its age by fraying. During an interview on 10/23/24 at 10:13 a.m. with Director of Rehabilitation Services (DRS), DRS stated, We should not be holding residents by their pants when ambulating. During a review of Resident 438's Care Plan (CP), dated 10/14/24, the CP indicated, The resident [Resident 438] presents tendency to lose balance during transfers [moving from one surface location to another] and ambulation [walking] related to decreased motor planning [interruption in brain commands], decreased safety awareness, increased loss of balance, leg weakness, pain which places resident at risk for falls. Interventions of gait training, safety measure training, and transfers. During a review of the facility's P&P titled, Gait Belt, dated 9/16, the P&P indicated, Purpose is to provide assistance to clinical staff when moving a resident from one place to another and to increase the safety of resident by allowing clinical staff members to support and keep the resident from falling. During a review of the facility's P&P titled, Ambulation, dated 1/1/12, the P&P indicated, Use an underhand grasp when holding the belt to provide greater safety.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 32234 Based on interview and record review, the facility failed to follow physician orders (PO) for pain management for one of one sampled residents (Resident 75) when: 1. Physician ordered pain medications were not given as ordered for one of one sampled residents (Resident 75). 2. Physician ordered non-pharmacological (not using non-medication) interventions were not implemented for one of one sampled residents (Resident 75). These failures resulted in Resident 75 refusing to eat, pain not being managed and had the potential for more pain medication to be used. Findings: 1. During an interview on 10/21/24 at 11:20 a.m. with Resident 75, Resident 75 stated, I have pain on my knees, feet, and back. Resident 75 stated her pain scale was 8/10 [1 to 10 numeric pain scale. 0 no pain, 1 to 4 = (equal to) mild pain, 5 to 7 = moderate pain, 8 - 9 = severe pain, 10 = excruciating pain]. During an interview on 10/21/24 at 11:32 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated she was covering for LVN 11's lunch break, but she did not have the keys to the narcotic (strong pain medication) drawer in the medication cart, so was unable to give Resident 75 pain medication when she requested at 11:20 a.m. During a review of Resident 75's Medication Administration record (MAR) dated 10/1/24 to 10/21/24, the following was indicated: on 10/7/24 during the night shift (NOC), pain level of 4 on 10/8/24 during the day shift (AM), pain level 3 on 10/11/24 during the NOC, pain level 4 The MAR indicated no tylenol was provided to Resident 75 between 10/1/24 and 10/21/24. During a concurrent interview and record review on 10/22/24 at 11:30 a.m. with the Director of Nursing (DON), Resident 75's MAR dated 10/1/24 to 10/21/24 was reviewed. The MAR indicated the following: Norco (strong pain medication) Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours for chronic pain for chronic pain. Start Date 10/17/24 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tylenol Oral Tablet 325 mg (Acetaminophen) Give 2 tablet[s] by mouth every 8 hours as needed for mild [pain]. Start Date 9/17/24. DON was unable to find documentation for Tylenol 325 mg two tablets was administered to Resident 75 every eight hours as needed for pain. DON stated the Tylenol should have been administered as needed for pain in-between her scheduled Norco 10-325 mg medication every four hours. 2. During a review of Resident 75's Medication Administration Record (MAR), dated 10/1/24 to 10/21/24, the MAR indicated, Assess for pain every shift and chart intensity of pain using 1-10 numeric pain scale. Non-Pharmacological Interventions [NPI - any non-chemical or non-medication treatments performed]: A-Heat, B-Repositioning, C-Relaxation, Breathing, D-Food/Fluids, E-Massage, F-Exercise, G-Immobilizations of Joints, H-Other (Document in Nurses note), N-Not needed every shift. The following dates indicated Resident 75's numeric pain scale and the NPI: 10/7/24 - Night [shift] - NPI - 0 Pain scale 4. 10/8/24 - Day - NPI- y [yes] Pain scale 3. 10/8/24 - Night - NPI - 0 - Pain scale 5. 10/11/24 Night - NPI - NA [not applicable] Pain scale 4. 10/12/24 Night - NPI - 0 Pain Scale 6. 10/13/24 Night - NPI - NA- Pain Scale 5. 10/21/24 Day shift - NPI . n [not needed]. [Resident 75 had a pain scale of 8]. During an interview on 10/22/24 at 9:51 a.m. with Resident 75, Resident 75 stated, I have pain in my right leg, pain level is 8/10. I did not eat my breakfast because of pain. My leg is hurting too bad. During an interview on 10/22/24 at 10:18 a.m. with CNA 12, CNA 12 stated, [Resident 75] refused her whole meal for breakfast. Her leg was hurting her. When I moved her she complained of pain. During a concurrent interview and record review on 10/22/24 at 11:30 a.m. with the Director of Nursing (DON), Resident 75's MAR dated 10/1/24 to 10/21/24 was reviewed. The MAR indicated DON stated the NPI for Resident 75 was not implemented as ordered on 10/7/24, 10/8/24, 10/11/24, 10/12/24, 10/13/24, and 10/21/24 when Resident 25 complained of pain. No additional information was provided. During a review of Resident 75's untitled Plan of Care (POC) dated 10/1/24, the POC indicated, The resident has chronic pain r/t [related to] chronic pain syndrome, generalized weakness, depression. Administer analgesia [pain medication] as per orders. Interventions. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptom, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on observation, interview, and record review, the facility failed to complete Social Service Assessments (SSA) within seven days of admissin for three of seven sampled residents (Resident 388, Resident 438, and Resident 337). This failure had the potential for not meeting residents' psychosocial needs. Findings: During a concurrent interview and record review on 10/23/24 at 4:10 p.m. with Social Services Designee (SSD), Resident 337 medical record (MR), undated was reviewed. SSD stated there was no SSA started within seven days of Resident 337's admission to the facility. Resident 337 was admitted on [DATE] and social service assessment was started on 10/21/24. 50939 During a review of Resident 388's Admission Record (AR), dated 10/8/24, the AR indicated Resident 388's admitted was 10/8/24. During a concurrent interview and record review on 10/24/24 at 10:44 a.m. with Social Services Designee (SSD), Resident 388 SSA dated 10/21/24 was reviewed. SSD stated the Social Services Department has seven days to complete the SSA for new admission. SSD stated, I know I'm late on resident's [Resident 388] Social Service Assessment. SSD stated Resident 388's SSA was completed on 10/21/24 [six days overdue]. 51540 During a concurrent interview and record review on 10/24/24 at 10:44 a.m. with SSD, Resident 438's SSA, dated 10/21/24 was reviewed. The SSA indicated Resident 438's admitted was 10/12/24, and SSA was completed on 10/21/24. SSD stated, it (social services assessment) was late. During a review of the facility's policy and procedure (P&P) titled, Social Service Assessment, dated 12/1/13, the P&P indicated, An initial Social Services Assessment will be completed for new and readmitted residents within seven (7) days of admission.

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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. 46958 Based on observation, interview, and record review, the facility failed to reorder medication timely for one of 13 sampled residents (Resident 28) This failure resulted Resident 28 not receiving his physician ordered medication and had the potential for Resident 28's glaucoma to worsen. Findings: During a review of Resident 28's Order Summary Report (OSR), dated active orders as of 10/22/24, the OSR indicated, on 8/28/24 Brinzolamide [used to treat glaucoma, an eye disease] Ophthalmic [eye] Suspension 1% (Brinzolamide) Instill (drop) 1 drop in both eyes three times a day for glaucoma . During a concurrent observation and interview on 10/22/24 at 11:52 a.m. with Licensed Vocational Nurse (LVN) 6, in D-wing, LVN 6 was administering medication to Resident 28. LVN 6 stated, Resident 28's 12 p.m. dose of Brinzolamide was not available to give. During a review of Resident 28's Medication Administration Record (MAR), dated 10/24, the MAR indicated Resident 28 was not given his Brinzolamide doses on 10/22/24 at 12 p.m. or 5 p.m. During a review of Resident 28's Progress Notes, dated 10/22/24, at 12:43 p.m., the Progress Notes indicated :[Resident 28's] eye medication Brinzolamide missed this morning. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, dated 2013, the P&P indicated, Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46958 Based on observation, interview, and record review, the facility failed to follow its: 1. Policy and procedure (P&P) titled, Medication Storage in the Facility for three of 22 sampled residents (Resident 1, Resident 24, and Resident 43) when medications were found at residents' bedside. This failure had the potential for medication to be accessed by unauthorized staff and residents. 2. P&P titled Medication Storage in the Facility and the Manufacturer's Instructions for use (IFU) for one of one medication. This failure had the potential to result in a loss of medication potency (strength), inaccurate test results and adversely affect the residents' health. 3. P&P titled Medication Storage in the Facility was not followed when two of two medication carts stored topical medications (eye drops, injectable medications, creams, ointments, lotions and patches) with oral medications. This failure had the potential for medications to be cross contaminated. Findings: 1. During an observation on 10/21/24 at 10:07 a.m. in Resident 1's room, an open, single use vial of eye drops with liquid content, was on Resident 1's bed side table. During an observation on 10/21/24 at 10:10 a.m. in Resident 24's room, an open, single use vial of eye drops with liquid content, was on Resident 24's bed side table. During an interview on 10/21/24 at 10:14 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated Resident 1 and Resident 24 had eye drops on their bed side tables. LVN 6 stated patients were not supposed to have any medications at the bedside. LVN 6 stated medications at the bedside gives other residents access to the medications. During a concurrent observation and interview on 10/21/24 at 2:55 p.m. with LVN 6, in Resident 43's room, a bottle of eye drops was on Resident 43's bed. LVN 6 stated she saw the eye drops on Resident 43's bed. During a review of the facility's P&P titled, Medication Storage in the Facility, dated 2/23/20, the P&P indicated, Medications and biologicals (medications made from a biological source) are stored safely, securely and properly .The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications . 2. During a concurrent observation and interview on 10/23/24 at 10:10 a.m. with Licensed Vocational Nurse (LVN) 8 in the A- wing hallway, during an audit of A-wing cart, a package with a vial of Aplisol (testing medication for tuberculosis ,TB) was stored in the cart's top drawer. LVN 8 stated, It [Aplisol] should be in the refrigerator, not in the cart, even after it is open. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Aplisol package's instructions for use/storage (IFU), the IFU the indicated, Precautions .Failure to store and handle Aplisol as recommended may result in a loss of potency and inaccurate test results .Storage .Store between 2 and 8 C [Celsius- temperature scale] (36 and 46 F [Fahrenheit - temperature scale]) and protect from light. During a review of the facility's P&P titled, Medication Storage in the Facility, dated 2/23/20, the P&P indicated, Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. 3. During a concurrent observation and interview on 10/23/24 at 10 a.m. with Licensed Vocational Nurse (LVN) 8, at A-wing hallway, the A-wing medication cart was audited. External and internal medications were stored next to each other in the A-wing medication cart. Erythromycin ointment (used to treat eye infection) was stored next to medications taken by mouth. LVN 8 stated eye ointment should not be stored with medications taken by mouth. During a concurrent observation and interview on 10/23/24 at 10:59 a.m. with LVN 10, in D-wing hallway, the D-wing medication cart was audited. Zofran (medication taken by mouth to treat nausea) stored with Artificial Tears (used to treat dry eyes) and Novolin R Flex Pen (Insulin used to control blood sugar) LVN 10 stated this is how we keep all the medications for one resident together in the same compartment. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 2/23/20, the P&P indicated, Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 32234 Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 27) had a follow-up dental appointment. This failure had the potential to result in decreased appetite and weight loss due to difficulty eating. Findings: During a concurrent observation and interview on 10/21/24 at 10:15 a.m. with Resident 27, in her room, Resident 27 's dentures were found next to her bedside table. Resident 27 stated, My lower denture is loose. I'm not wearing it. During a concurrent interview and record review on 10/24/24 at 10:05 a.m. with Minimum Data Set Coordinator (MDSC), Resident 27's Dental Notes (DN), dated 6/4/24 was reviewed. The DN indicated, doesn't wear dentures, [dentures are] 5-6 years old. MDSC was unable to find follow-up dental notes with Resident 27's dentist since her last dental appointment on 6/4/24. MDSC stated there should have been a follow-up appointment with the dentist regarding realignment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51540 Based on observation and interview, the facility failed to ensure meals were served at a safe and palatable (appetizing) temperature for two of three sampled residents (Resident 41 and Resident 42). This failure had the potential for residents not meeting their nutritional needs. Findings: 1. During an interview on 10/21/24 at 11:20 a.m. with Resident 41, Resident 41 stated, The breakfast was cold this morning, extra cold. The food is bland. During a review of Resident 41's Minimum Data Set (MDS-assessment tool), dated 6/13/24, the MDS indicated Resident 41's Brief Interview for Mental Status (BIMS, cognition assessment tool, 15-point scale: 0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact) score was 13. During an interview on 10/21/24 at 3:07 p.m. with Resident 42, Resident 42 stated, Breakfast is always cold, the sausage and the eggs. The hot food is not hot. During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 had a BIMS score of 15. During an observation on 10/21/24 at 12:18 p.m., in the B-wing hallway, the carts carrying the meal trays were not covered. During an interview on 10/24/24 at 10:49 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated, [Residents] complained of cold food. The food cart is open. It [open food cart] contributes to the temperature of the food that the cart is open. It takes about 10 minutes [to distribute meal trays to residents] for each hallway. During review of the facility policy and procedure titled P-DS16 Food Temperatures dated 2022, the policy indicated 4. Acceptable Serving Temperatures, Meat and Eggs should be served at more than 140 degrees. The policy indicated 5. If temperatures do not meet applicable serving temperatures, reheat the product . 41035 2. During a concurrent observation and interview on 10/22/24 at 12 p.m. in the facility's kitchen, Dietary Aide (DA) 2 was observed putting the dessert bread pudding on the lunch tray. DA 2 stated the lunch tray was ready to be served. During an interview on 10/22/24 at 12:01 p.m. with DA 2, DA 2 stated, she had forgotten to take the temperature of the bread pudding. DA 2 stated, she should have taken the temperature of the bread pudding. During an interview on 10/22/24 at 12:04 p.m. with Dietary Manager (DM). DM stated, all food should have the temperature taken before placing the bread pudding on the tray. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/22/24 at 12:50 pm with DM, a random lunch tray was tested for serving food temperatures. DM stated the pork was 117.8 degrees, the carrots were 121.1 degrees and the rice was 134.9 degrees. During a review of the facility's policy and procedure (P&P) titled, Food Temperatures, dated 2023, the P&P indicated, Food temperature log at the beginning of the tray line making sure to take the temperature of each pan of product before serving. Acceptable Serving TemperaturesMeat entrees required to be higher than 140 degrees and the preferred temperature was 160 to 175 degrees Potatoes, pasta required to be higher than 140 degrees and the preferred temperature was 160 to 175 degrees Vegetables required to be higher than 140 degrees and the preferred temperature was 160 to 175 degrees Pastries, cakes less than 60 degrees. 5. If temperatures do not meet applicable serving temperatures, reheat the product or chill the product to the proper temperature.

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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 ensure meal preferences were honored for two of 41 sampled residents (Resident 55 and Resident 1). This failure had the potential for Resident 55 and Resident 1'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 10/21/24 at 12:17 p.m. with Certified Nursing Assistant (CNA) 10, in Resident 55's room. CNA 10 delivered Resident 55's lunch tray. Resident 55's tray was missing his juice. CNA 10 stated the juice was not on Resident 55's lunch tray. During a concurrent interview and record review on 10/21/24 at 12:18 p.m. with CNA 10, Resident 55's Meal Tray Ticket (MTT), dated 10/21/24 was reviewed. The MTT indicated, Resident 55 should have 4 ounces (oz) of juice on his tray. CNA 10 stated the MTT indicated Resident 55 should have had juice on his tray. During an interview on 10/21/24 at 12:19 p.m. with Resident 55, Resident 55 stated he did not receive the juice he requested. 2. During a concurrent observation and interview on 10/22/24 at 12:40 p.m. in C Wing hallway, Resident 1 was sitting in her wheelchair with her lunch tray placed in front of her on a bedside table. Resident 1 stated, They serve me food that I do not like, and they know I don't like it. Resident 1 stated, I don't like cheese and they gave me cheese. Resident 1's plate contained two cheese Quesadillas. During a concurrent interview and record review on 10/22/24 at 12:42 p.m. with Dietary Manager (DM), Resident 1's MTT, dated 10/22/24 was reviewed. The MTT indicated Resident 1 disliked cheese. DM stated Resident 1 was given cheese quesadillas and she should not have had been given cheese since she disliked it. During a review of the facility's policy and procedure (P&P) titled, Dietary Profile and Resident Preference Interview, dated 2022, the P&P indicated, The Dietary Manager will complete a Dietary Profile for resident to reflect current nutritional needs and food preference .IV. The Dietary Department will provide residents with meals consistent with their preferences and Physician order as indicated on the tray card. A. If a preferred item is not available, a 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. 50939 Based on observation, interview, and record review, the facility failed obtain a therapeutic diet order for one of three sampled residents (Resident 388). This failure had the potential for Resident 388 to not obtain sufficient calories and nutrients. Findings: During a concurrent observation and interview on 10/21/24 at 12:25 p.m. in Resident 388's room, with Resident 388, Resident 388 had no teeth and no dentures. There was a plate with an uneaten half of zucchini. Resident 388 stated the uncut zucchini was difficult to eat. Resident 388 stated he preferred for the zucchini to be cut up. During a review of Resident 388's Care Plan (CP), dated 10/14/24, the CP indicated, The resident [Resident 388] has nutritional problem or potential nutritional problem. Interventions: NAS [No Added Salt] diet, Regular texture, Regular/Thick consistency. During a review of Resident 388's CP, dated 10/22/24, the CP indicated, The resident [Resident 388] has oral/dental health problems r/t [related to] edentulous [having no teeth], no dentures per preference. Interventions: Diet as Ordered. Consult with dietitian and change if chewing/swallowing problems are noted. During an interview on 10/23/24 at 3:05 p.m. with Registered Dietician (RD), RD stated Resident 388's diet order was regular texture. RD stated she did not think Resident 388 had issues with chewing although, Resident 388 had no teeth. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, dated 6/1/14, the P&P indicated, Purpose: To ensure that the Facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders.

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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. 41035 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Dietary Department-Infection Control when one of one Dietary Aide (DA) 1 did not wash his contaminated hands before returning to food service. This failure had the potential to contaminate food and cause food borne illness. Findings: During a concurrent observation and interview on 10/22/24 at 11:30 a.m. with Dietary Aide (DA) 1 in the facility kitchen, DA 1 changed the red bucket sanitizer solution and placed the bucket back on the counter. DA 1 immediately went back to handling the food without performing hand hygiene. DA 1 stated he should have washed his hands before returning to handling the food. During a review of the facility's policy and procedure (P&P) titled, Dietary Department-Infection Control, dated 2024, the P&P indicated, Proper Hand Washing: g. During food preparation, as often as necessary to remove soil and contamination when changing tasks.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32234 Based on interview and record review, the facility failed to follow the facility's policy and procedure (P&P) titled, Completion & Correction when two of 4 sampled residents' (Resident 27 and Resident 36) medical record were not accurate. This failure had the potential to negatively impact the interventions and treatments for Resident 27 and the continuity of care for Resident 36 Findings: 1. During a concurrent interview and record review on 10/24/24 at 10:41 a.m. with Minimum Data Set Coordinator (MDSC), Resident 27's MDS [assessment tool] Assessment (MDSA),was reviewed. The MDSA dated 12/21/23 under the Oral/Dental Status indicated, No natural teeth or tooth fragment(s) [edentulous - all teeth are missing]. No [should have been marked Yes]. MDSC stated Resident 27 was edentulous, the MDS Assessment under the Oral/Dental Status was inaccurate. During a concurrent interview and record review on 10/24/24 at 10:41 a.m. with MDSC, Resident 27's Order Summary Report (OSR), dated 10/24/24 was reviewed. The OSR indicated, Monitor for Adverse Reaction (Zoloft [antidepressant medication]). Antidepressants Adverse Effects: Dry mouth, blurred vision, constipation, urinary retention, tachycardia [a heart rate over 100 beats a minute], fine tremor, postural hypotension [blood pressure drops when going from lying down to sitting up or from sitting to standing], sedation [sleepiness], confusion. MDSC was unable to find the Zoloft medication in Resident 27's OSR. MDSC stated Resident 27 was not on Zoloft medication. MDSC stated Zoloft was discontinued on 10/1/24. MDSC stated Resident 27's OSR physician order for the monitoring of adverse reaction from Zoloft needed to be discontinued. 2. During a concurrent interview and record review on 10/23/24 at 11:06 a.m. with Director of Nursing (DON), DON stated she was unable to find a physician order for Resident 36 to be transferred to the hospital on 10/24/23, but she would check in the Medical Records department. During an interview on 10/24/24 at 10:26 a.m. with DON, DON stated she was unable to find a physician order to transfer Resident 36 to the hospital on 10/24/23. DON stated it is the expectation for the nurse to call the physician, give the physician report on the patient's condition, and let the physician make the decision to or not to transfer a patient to the hospital. During a concurrent interview and record review on 10/24/24 at 11:26 a.m. Resident 36's MR was reviewed. DON stated she was unable to find the History and Physical (H&P) or the Discharge Summary from Resident 36's 10/24/23 hospitalization . During an interview on 10/24/24 at 3:45 p.m. with Regional Quality Management Consultant (RQMC), RQMC stated the facility was unable to get a copy of Resident 36's H&P and Discharge Summary from the hospital because They [hospital] have a EHR [electronic health record] system and they cannot access old records. (continued on next page)

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F 0842 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, Completion & Correction, dated 1/1/12, the P&P indicated, To ensure medical records are complete and accurate. Procedure. 111. Entries will be complete, legible, descriptive and accurate. VII. Documentation will reflect medically relevant information concerning the resident and will be documented in a professional manner.

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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** 50939 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. The facility policy and procedure (P&P) titled Laundry Services was not followed for one of one laundry room not clean and sanitary. 2. The facility P&P titled Housekeeping-General was not followed when a used toilet brush was left on top of the clean area of one of two housekeeping carts. 3. The facility P&P titled Personal Protective Equipment was not followed when two of 19 nursing staff (Licensed Vocational Nurse [LVN] 9 and Certified Nursing Assistant [CNA] 4) did not remove the N95 mask (respiratory protective device) before leaving an transmission based precaution (measures used to protect staff, patient and visitors from infection) room. 4. The posted Centers for Disease Control and prevention (CDC, national health organization) posted signage for required PPE (gown, gloves, face shield, and facemask) inside a transmission based precaution room was not followed by two of two staff (Housekeeper [HK] 3 and Speech Therapist [ST]). 5. The facility P&P titled, Hand Hygiene was not followed when two of 12 Certified Nursing Assistants (CNA 9 and CNA 2) provided resident care while wearing long false nails. 6. The facility P&P titled, Hand Hygiene was not followed when two of 12 CNAs (CNA 9 and CNA 3) did not perform hand hygiene before entering and after exiting residents' rooms. 7. The facility's P&P titled, Housekeeping-Staff Areas, and CDC guideline titled Environmental Cleaning Procedures was not followed when one of one utility room contained both clean patient care items and dirty items. 8. The facility's P&P titled Water Management was not followed for performing water testing to ensure there were no growth of Legionella [bacteria found in [NAME]] in the facility's water system. These failures had the potential to spread infectious diseases to residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 10/22/24 at 10:49 a.m. with Environmental Services Director (ESD), with Housekeeper (HK) 1 and HK 4, in the laundry area, ESD stated he oversees the laundry, housekeeping, and maintenance departments. ESD stated the floor was not clean. ESD stated the crates are dirty. The tops of the laundry machines had dusty debris and cobwebs. Cobwebs were noted behind the laundry machines. Spider webs with spiders were noted on all laundry room walls. ESD stated these areas needed to be cleaned. (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 concurrent observation and interview on 10/22/24 at 10:51 a.m. with HK 1 in the clean area of the Laundry Room, the floor and two crates under the folding counter had thick greyish debris. HK 1 stated she swept the laundry room floor this morning, but did not clean the crates. A fan with thick greyish debris was over the clean folding table. There was a locker in the middle of the two dryers with dark stains. A personal cellphone, a water bottle, a hand sanitizer, a tube of ointment, and a container with food were on top of the shelf above the clean linen folding counter. HK 1 stated those items should not be in the clean laundry area. During a review of the facility's policy and procedure (P&P) titled, Laundry Services, dated 1/1/12, the P&P indicated, I. On-Site Laundry Services . iv. Is maintained in a clean and sanitary condition. 2. During a concurrent observation and interview on 10/22/24 at 11:23 a.m. with HK 2, in the B-Wing hallway, a used toilet brush was on top of the clean housekeeping cart. The used toilet brush was next to a box of clean gloves and clean towels. HK 2 stated the toilet brush was used to clean all the toilets in the facility. During an interview on 10/22/24 at 11:45 a.m. with ESD, ESD stated the toilet brush should be under the cart. During a review of the facility's P&P titled, Housekeeping-General, dated 1/1/12, the P&P indicated, II. The Facility maintains adequate housekeeping supplies and equipment on hand at all times. A. These supplies are stored in a safe and clean manner. 3a. During an observation on 10/23/24 at 8:45 a.m. in the C/D-Wing hallway, there was a sign by a Resident 138's room door indicating how to safely remove PPE, mask or respirator, and to discard in a waste container. LVN 9 walked out of the room and did not remove the N95 mask she was wearing. During an interview on 10/23/24 at 8:46 a.m. with LVN 9, LVN 9 stated, I forgot to take off my N95 and I should have changed to a new N95. 3b. During a concurrent observation and interview on 10/23/24 at 8:53 a.m. with CNA 4, CNA 4 exited an isolation room[separation of residents with an infection from residents without an infection] and removed a N95 mask in the hallway. CNA 4 stated, I did not take my mask off inside the room, I took it off in the hallway. I know I am supposed to take all my PPE off inside the room. During an interview on 10/23/24 at 8:49 a.m. with Acting Infection Preventionist (AIP), AIP stated staff should wear full PPE when they are in the vicinity of COVID (highly infectious respiratory disease) positive areas and remove all PPE and change to a new N95 mask. AIP stated, If the staff is dealing with the COVID positive resident, then they should be changing their N95 mask when leaving the room. During a review of the facility's P&P titled, Personal Protective Equipment, dated 1/1/12, the P&P indicated, C. Masks. ii. A face mask is used only once and then discarded into the appropriate receptacle located in the room in which the procedure is being performed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During an interview on 10/21/24 at 11:06 a.m. with AIP, AIP stated Resident 138, was on Droplet Precaution isolation, for COVID, and staff and visitors had to wear required PPE before entering an isolation room. During a concurrent observation and interview on 10/21/24 at 11:10 a.m. with Speech Therapist (ST), ST entered Resident 138's room wearing only an N95 mask, but was not wearing a gown, gloves, or face shield. ST stated she should be wearing all the required PPE in an isolation room. During a concurrent observation and interview on 10/21/24 at 11:24 a.m. with HK 3, in room [ROOM NUMBER], the signage by the door indicated, Droplet Precaution. HK 3 entered the room wearing gloves and an N95 mask, but was not wearing a gown or face shield. HK 3 stated, I'm not sure who is on isolation. If there is a signage by the door for isolation I should be wearing the [full] PPE when in Resident 138's isolation room. During a review of Resident 138's Care Plan (CP), undated, the CP indicated, Resident is on droplet precautions d/t [due to] [COVID positive]. During a review of the facility's isolation signage outside of Resident 138's room, the isolation signage indicated, STOP Droplet Precautions STOP Everyone Must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. 51540 5. During an observation on 10/21/24 at 10:02 a.m. CNA 9 had long acrylic (false) nails and was providing direct resident care. During a concurrent observation and interview on 10/21/24 at 12:24 p.m. with CNA 2, CNA 2 had long acrylic nails and was providing direct resident care. CNA 2 stated, It is in the policy to not have long nails on. During a review of the facility's P&P titled, Hand Hygiene, dated 1/24, the P&P indicated, For infection control purposes, direct care givers may not wear nail overlays (artificial nails) of any type including, but not limited to, press on nails, silk, linen, acrylic, gels, or any other type of nail overlays. 6. During a concurrent observation and interview on 10/21/24 at 10:02 a.m. with CNA 9, CNA 9 left a resident's room without performing hand hygiene and entered another resident's room to perform resident care, without performing hand hygiene. CNA 9 stated, Sometimes you are in a rush. CNA 9 stated, I forgot to use hand sanitizer During a concurrent observation and interview on 10/22/24 at 12:42 p.m. with CNA 3, CNA 3 entered and exited multiple resident's rooms without performing hand hygiene. CNA 3 stated, I did not gel [hand sanitize] in and out in that room. When I do not do that, I can spread infections to residents. (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 the facility's P&P titled, Hand Hygiene, dated 9/1/20, the P&P indicated, Facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, Residents, volunteers, and visitors. The following situations require appropriate hand hygiene: immediately upon entering and exiting a resident room. 6. During an observation on 10/23/24 at 9:29 a.m. in the utility room, there were peeling red tape on the floor indicated a dirty area in front of a sluice sink (for disposal of body waste) and a second area that roughly divided the room in half and angled over to the cabinets on the opposite side of the room from the sluice sink (for disposal of body waste). The facility had a sign indicating DIRTY on the wall near the hand-washing sink. Two patient lifts (assistive transfer devices) were stored in the middle of the room over the red line dividing the room. The lifts were partially in both the dirty area and the clean area. Neither patient lift was wrapped to indicate it was clean nor did the lifts have a clean/dirty tag attached. The sluice sink did not have any splash guards to minimize the spread of germs onto the clean equipment and supplies in the room. A black floor fan was on the floor next to the sluice sink. Approximately four feet away from the sluice sink was a cabinet inside the designated dirty zone. The cabinet cupboards contained bottles of nutritional feeding formula, feeding tubes, sharps (used needle and syringe) containers, clean medicine cups in a corrugated cardboard shipping box, feeding tubes, spoons. Corrugated cardboard shipping boxes containing patient care supplies and drinking cups were on the dirty cabinet counter. The crash cart (contains emergency medication and supplies for life threatening emergencies) was stored in the utility room near the sluice sink. Staff PPE was stored in corrugated cardboard boxes on top of the clean cabinet. During an interview on 10/23/24 at 9:35 a.m. with AIP, AIP stated the facility does not have a separate clean and dirty utility rooms. AIP stated the utility room has mixed dirty and clean items. During a review of the CDC document titled Environmental Cleaning Procedures 3/19/24, the document indicated 4.7.2 Sluice rooms [utility room, restricted access, dedicated room separated into dirty and clean areas, where noncritical patient care equipment is reprocessed]. Each major patient care area should be equipped with a designated sluice room to reprocess soiled noncritical patient care equipment (e.g., commode chairs, bedpans) . Sluice rooms .should have an organized workflow from soiled (dirty) to clean . The clean area (used for storing reprocessed equipment) should: .be distinctly separate from (by workflow) soiled areas to prevent confusion regarding reprocessing status .be protected from water and soil, dirt, and dust . During a review of the facility's P&P titled, Housekeeping-Staff Areas, dated 1/1/12, the P&P indicated, Purpose. To promote the health of residents and staff by maintaining clean and sanitary conditions. IV. Utility Rooms and Storage Areas. A. Daily. ii. Arrange supplies on the shelves and elsewhere in an orderly manner. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. During a concurrent interview and record review on 10/23/24 at 9:39 a.m. with Administrator, Administrator was unable to provide written documentation of facility water testing for Legionella. Administrator stated, My understanding is that we [facility] only test [water system] if there is a case [of Legionella]. So, there is no testing [for Legionella]. During a review of the CDC document titled Controlling Legionella dated 3/15/24, the document indicated The Centers for Medicate & Medicaid Services (CMS) requires healthcare facilities develop and adhere to ASHRAE [American Society of Heating, Refrigerating and Air-Conditioning Engineers]-compliant water management programs (WMPs). WMPs minimize the risk of growth and spread of Legionella and other pathogens in building water systems . The CDC document referred to CMS Quality, Safety an Oversight (QSO)-17-30. During a review of QSO 17-30, dated 6/2/17, the QSO indicated In manmade water systems, Legionella can grow and spread to susceptible hosts, such as persons who are at least [AGE] years old, smokers, and those with underlying medical conditions such as chronic lung disease or immunosuppression. Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets via aerosolization. Examples of these system components and devices include: Hot and cold water storage tanks Water heaters Water-hammer arrestors Pipes, valves, and fittings Expansion tanks Water filters Electronic and manual faucets Aerators Faucet flow restrictors Showerheads and hoses Centrally-installed misters, atomizers, air washers, and humidifiers Nonsteam aerosol-generating humidifiers Eyewash stations Ice machines Hot tubs/saunas Decorative fountains Cooling towers Medical devices (such as CPAP machines, hydrotherapy equipment, bronchoscopes, heater-cooler units) .CMS expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit. Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. During a review of the facility's P&P titled, Water Management, dated 7/10/23, the P&P indicated, Quarterly measurement of water quality throughout the system to ensure changes that may lead to Legionella growth are not occurring. 32234