STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: Oakwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 375 Cohasset Rd Chico, CA 95926	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to provide showers twice a week and nail care as indicated on the residents Activities of Daily Living (ADL's refers to dressing, bathing, grooming, toileting and hygiene) record, for 3 of 18 residents who were sampled for ADL care. (Residents 5, 7, and 41) when: 1. Resident 5 missed two of his Saturday showers which were important to him, because he e attended Spiritual Meetings on Sundays. This had the potential to negatively impact Resident 5's emotional well-being. 2. Resident 7 had unwanted body odor. This had the potential for Resident 7 to experience embarassment and skin irritation. 3. Resident 41 had long fingernails with jagged sharp edges and thick dark brown substances under each nail. This had the potential to cause infection and skin tears from long sharp nails. Findings: During a review of the facility's policy revised 1/1/2012, titled, Showering and Bathing, indicated a tub or shower bath is given to the resident to provide cleanliness, comfort, and to prevent body odors. The policy indicated residents are given tub baths or showers, unless contraindicated. Observing the skin is performed during bathing and to update the resident's care plan as needed. During a review of the facility's policy revised 10/21/21, titled, Grooming Care of Fingernails and Toenails, indicated the purpose of this procedure is nail care is given to clean the nail bed and keep the nails trimmed. Fingernails are trimmed by Certified Nursing Assistants (CNAs), except for Residents with diabetes (too much sugar in the blood) or circulatory impairments, this includes all toenails for high-risk residents. Note: A licensed Nurse (LN) will trim those residents' nails. Document the procedure in the Resident's medical record and update the resident's care plan as needed. 1. A review of Resident 5's clinical record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included fracture of left tibia (broken shin bone) and left fibula (broken calf bone), protein calorie malnutrition (the body does not get enough protein or energy from food), hyponatremia (too little sodium or too much water in the blood), Rheumatoid Arthritis (long term, painful condition, that causes joint pain, stiffness, and swelling of the joints), embolism (blocks blood flow, often a blood clot), and high blood pressure. (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 5 dated 11/3/24, indicated that Resident 5 was cognitively intact (ability to think, reason and make decisions), with a brief interview for mental status (BIMS) score of 15 out of 15, and was totally dependent on staff to provide ADL care. During an interview on 2/17/25 at 9:12 am, Resident 5 stated, I did not get my shower this past Saturday and this happens a lot on Saturday. I have my spiritual meetings on Sunday mornings, and I need my showers. My showers are important to me, and they did not make them up. During a review of a facility document revised 10/21/24 titled, Shower Schedule AM Shift, indicated Resident 5 was scheduled for showers/bathing every Wednesday and Saturday. During a record review of Resident 5's clinical record, a document dated February 2025, titled, Documentation Survey Report v2, indicated Resident 5 had not been showered twice a week for three weeks in February 2025 and two of those missed showers were on a Saturday. 2. A review of Resident 41's clinical record indicated Resident 41 was admitted to the facility on [DATE] with diagnoses that included aphasia (language disorder that affects how you communicate, having trouble finding words), dementia, atrial fibrillation (irregular heart rate), diabetes (too much sugar in the blood), and depression. A review of the most recent MDS, for Resident 41, dated 1/3/25, indicated that Resident 41 had a severe ability to think, reason and make decisions, and a BIMS score of 00. Resident 41 was totally dependent for staff to provide all ADL care. During an observation on 2/18/25 at 7:51 am, Resident 41 had long fingernails with sharp jagged edges and a thick dark brown substance under each nail. During an interview on 2/18/25 at 7:55 am, CNA L confirmed Resident 41's nails were long, with sharp jagged edges and had a thick dark brown substance under each nail. During an interview on 2/18/25 at 10:15 am, the Director of Nursing (DON) and the Admin confirmed resident showers and/or nail care had not been completed twice a week and should have been for Residents 5 and 41. DON stated, We know this is a problem. 43739 3. During a review of Resident 7's admission record, the record indicated that she was originally admitted to the facility on [DATE], and was readmitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), diabetes (high blood sugar), difficulty in walking, and need for assistance with personal care. Resident 7 was not her own health care decision maker. During a review of Resident 7's MDS, dated [DATE], the MDS indicated that Resident 7 had severely impaired decision making skills and a poor memory and a BIMS score of 3. The MDS section GG (how a resident can perform ADLs), indicated that Resident 7 was dependent on the staff to perform all of her ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's Activities of Daily Living (ADL) flowsheets from 11/1/2024 to 2/17/25, at the section, Bed Bath/Shower: on Tuesday & Friday afternoon shift (PM shift), indicated that Resident 7 had not been showered twice a week for four months. During a concurrent observation and interview on 2/17/25 at 9:18 am, in Resident 7's room, Resident 7 was observed lying in bed with notable body odor. Resident 7 confirmed that she was not getting showered twice a week, Since I was admitted to the facility. During a concurrent interview and record review on 2/19/25 at 2:38 pm, with the Director of Staff Development (DSD), in the DSD's office, Residents 7's ADL flowsheets were reviewed. The DSD confirmed with the above findings, and stated, Showers are to be provided twice a week, and should indicate if the resident refused .When the resident refused, they should notify the nurse, and the nurse would document in the resident's progress notes.

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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. 40903 Based on interview and record review, the facility failed to ensure safe use and accountability of narcotic controlled medications (prescription narcotic drugs of abuse), when: Resident 61's Norco (Hydrocodone-APAP; an opioid/narcotic pain medication) was removed from Controlled Drug Record (CDR, an accountability sheet that tracked narcotic removal with nurses initial, date, and time), without the corresponding administration documentation in Resident 61's MAR (Medication Administration Record- a legal document that listed the drugs given to Resident 61). This failure could contribute to unsafe drug handling, poor pain control, and risk of drug diversion (drug loss). Findings: During a record review of Resident 61's MAR, dated 2/2025, the record indicated a doctor's order for PRN (as needed) use of pain medication called Norco as follows: Hydrocodone-Acetaminophen oral tablet 5-325 MG (. Same as Norco a combination of opioid drug pain reliver; MG stands for Milligram, a unit of measure); Give 1 tablet by mouth every 6 hours as needed for Moderate to Severe pain . Start Date 1/9/25. The same order was renewed again on 2/6/25 by the doctor as noted in the MAR. During a record review of Resident 61's Controlled Drug Record (CDR) for Norco, with date range of 2/1/25 to 2/19/25, the record listed Norco removal for PRN (as needed) use. A comparative review of Resident 61's CDR with Medication Administration Record (MAR) record for the same time period, indicated the following: 2/3/25 at 7:30 am; the CDR removal not documented in the MAR 2/3/25 at 8:13 pm; the CDR removal not documented in the MAR 2/10/25 at 8:30 am; the CDR removal not documented in the MAR 2/16/25 at 800 am; the CDR removal not documented in the MAR The record indicated Norco removal from CDR with no corresponding documentation in the MAR. During a concurrent observation and interview with Licensed Nurse (LN) C, on 2/17/25 at 12:12 pm, LN C removed two Norco 5/325 pills from CDR for Resident 44 and immediately documented the use in the MAR. LN C stated controlled drug use or waste were documented and/or co-signed in both MAR and CDR per facility policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent interview with Director of Nursing (DON) and record review of Resident 61's CDR and MAR records, in her office, on 2/19/25, at 1:45 p.m., the DON stated she had to further review the record to confirm the findings. DON on the same day confirmed the finding of missed documentation of Norco use in Resident 61'a MAR and was not able to explain why the medication was not documented as given on Resident 61's MAR. Review of the facility's policy titled, Medication Administration, dated 1/1/12, the policy indicated The Licensed Nurse will chart the drug, time administered and initial his or her name with each medication administration and sign full name and title on each page of Medication Administration Record . When a PRN medication is given, it will be charted on Medication Administration Record. The nurse will document the reason given, reason for the drug, route of administration, date, and time. Review of the facility's policy, titled Medication Orders: Controlled Substance Prescription, date 1/2018, the policy indicated Each controlled substance (narcotic opioid) prescription is documented in the residence medical record with date, time and signature of the person receiving the prescription. The prescription is recorded in the patients' health record and recorded on the Medication Administration Record.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40903 Based on interview, observation, and record review the facility failed to ensure safe use of psychotropic medications (medication that alters mood, behavior and cognition (thinking, learning and understanding)), on one out of five residents (Resident 42) reviewed for unnecessary drug use with census of 75 when: Resident 42's PRN (as needed) use of phenobarbital (an anti-seizure medication also used to treat mood and behavior problems), was not evaluated and assessed by the facility and medical doctor for duration of use based on facility's policy. These failures could contribute to unsafe use of psychotropic medications that could have placed resident at risk for adverse consequences. Findings: Review of Resident 42's electronic medical record titled, Admission Record indicated Resident 42 was admitted to the facility with diagnosis of heart disease including heart rhythm disease, depression, recurrent falls, and on 12/24/24 was started on palliative care (specialized medical care that helps people with serious illnesses manage symptoms and improve quality of life). Review of Resident 42's electronic medical record, titled Medication Administration Record (or MAR, a record that listed medications ordered by doctor and administered by nursing), dated 2/2025, the record indicated an order for phenobarbital as follows: Phenobarbital oral (by mouth) tablet 30 MG (MG, same as milligram, a unit of measure); Give 1 tablet by mouth every 8 hours as needed for delirium (a temporary state of mental confusion and disorientation that can develop rapidly) M/B (Manifested By) calling out after all needs have been met .; Start Date- 2/3/25. The MAR order did not have a duration for PRN use and there was no documentation that it was used by the Resident 42. Review of the Resident 42's medical record progress notes, written by a telehealth (the use of electronic information and telecommunications technologies to provide healthcare remotely) mental health doctor, dated 1/8/25, the record indicated a recommendation to discontinue the phenobarbital. Review of the Resident 42's medical record titled, IDT Progress Notes (IDT stands for Interdisciplinary Team, a group of care givers and clinicians), dated 1/13/24, the record indicated [Resident 42] has a PRN order used for phenobarbital PRN for delirium and has not been used or needed at this time. IDT reviewed with physician and order to D/C (discontinue) phenobarbital . The record did not show a reason or indication for the PRN phenobarbital ordered on 2/3/25. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with Licensed MDS nurse (MDS, stands for Minimum Data Set, a standardized assessment tool mandated by federal government), and review of Resident 42's medication orders, on 2/20/25 at 10:29 a.m., MDS nurse stated the order for phenobarbital was written for PRN use and she did not see any doses of the drug given to the resident since started on 2/3/25. During a concurrent review of Resident 42's medical record, and interview with Infection Prevention Nurse (IP), on 2/20/25 at 10:51 a.m., the IP nurse indicated the medication orders were reviewed by a medical doctor and entered in the facility's computer system. IP nurse stated the PRN medications used for behavior or mood control should have had a 14-day duration to assess the use and effectiveness. IP nurse could not locate any doctors note to address the duration of use in Resident 42's electronic medical record. Review of the facility's policy titled, Behavior/Psychoactive Medication Management, dated 6/4/2024, the policy on section 5 indicated, Any psychoactive medication ordered on a PRN basis, must be ordered not to exceed 14 days. If the physician feels the medication needs to be continued, he/she must document the reason(s) for the continued usage and write the order for the medication; not to exceed a 90-day time frame.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater.

40903

Based on observation, interview, and record review the facility failed to ensure safe medication administration practices when medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with resident census of 75. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of three errors out of 31 opportunities which resulted in a facility wide medication error rate of 9.68% in 2 out of 9 residents (Resident 19 and Resident 71) observed for medication administration as follow:

1. The facility failed to ensure Resident 19 received food with the potassium (an essential electrolyte needed by all tissues in the body) administration.

2. The facility failed to ensure Gastric-tube (G-tube, a small tube that's surgically inserted into the stomach through the abdomen for feeding, hydration, and medicine to be delivered directly to the stomach) medications were administered one at a time for Resident 71.

These failures may result in unsafe medications use affecting residents' health and well-being.

Findings:

Review of the Institute for Safe Medication Practices (ISMP, a nationally recognized medication and patient safety organization) safety alert, dated November 17, 2022, last access on 2/25/25, via https://www.nutritioncare.org/uploadedFiles/Documents/Guidelines_and_Clinical_Resources/ISMP%20Safety%20Alert_Medications%20and%20Enteral%20Feeding%20Tubes.pdf, the document indicated wrong tube feeding administration technique including 1) mixing multiple medications together to give at once; 2) neglecting to flush the tube prior to and after medication administration; and 3) mixing medications with enteral feedings Could lead to incompatibility issues with other medications and feedings. The safety alert additionally indicated Prepare each medication separately. Avoid mixing two or more medications together, whether solid or liquid formulations, as this can create a new unknown entity with an unpredictable release and bioavailability.

Review of National Library of Medicine or NLM (a federal government information website), titled Nursing Skills: Chapter 15 Administration of Enteral Medications, last accessed on 2/25/25, via https://www.ncbi.nlm.nih.gov/books/NBK593215/, and https://www.ncbi.nlm.nih.gov/books/NBK593210/pdf/Bookshelf_NBK593210.pdf, the document indicated Liquid medication, or appropriately crushed medication dissolved in water, is administered one medication at a time. Medication should not be mixed because of the risks of physical and chemical incompatibilities, tube obstruction, and altered therapeutic drug responses. Between each medication, the tube is flushed with 15 mL of water, keeping in mind the patient's fluid volume status.

1. During review of Resident 19 electronic medical record and physician order, dated on 1/9/25, it indicated an order for Potassium tablet 10 milliequivalent (mEq, a unit of measure) by mouth one time a day. ***Take with food and a 4-8-ounce glass of water***.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation with Licensed Nurse (LN) B, on 2/18/25 at 9:15 am, LN B administered potassium pill to Resident 19. LN B did not administer food with the potassium. During a concurrent interview with LN B on 2/19/25 at 11:50 am, and record review of Resident 19's MD order for potassium pill, LN B confirmed potassium tablet was supposed to be given with food. 2. During a medication administration observation with LN B on 2/18/25 at 2:30 pm, for Resident 71, LN B combined two crushed medications and administered via G-tube at the same time. One medication was hydrocodone/acetaminophen pill (or Norco, for severe pain medications) and a Buspar pill (anxiety medication). In an interview with LN B, at facility's Station 2, on 2/18/25 at 3:00 pm, LN B stated she forgot she should not have mixed the crushed pills together and given via G-tube. LN B stated she had seen issues with G-Tube clogging up because of this. During an interview with Director of Nursing, (DON) on 2/19/25 1:31 pm, the DON confirmed the nurse should have given the potassium tablet with food and the gastric-tube medication administration should have been given one medication at a time with a flush in between.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51253 Based on interview, observation, and record review, the facility failed to ensure safe medication storage practices in the medication room (a locked room used to store medications and supplies) and two out of 5 medication or treatment carts (a mobile cart stored medication and supplies for immediate use) based on manufacturer specifications with census of 75 when: 1. Medication Cart 3 at Station 2 stored an unopened and unused eye drop called latanoprost (or Xalatan- used to treat eye disease) that required refrigeration based on manufacturer specification. An undated glucometer (a device that measure blood sugar) test strips bottle (testing supply inserted in the glucometer to measure blood sugar) based on manufacturer specification. 2. Medication room at Station 1 stored expired test tube (blood test tube is a sterile, vacuum-sealed tube used to collect and store blood samples for medical testing) and throat culture swab kit (a kit used to swab the throat and check for infection) in the active storage areas. 3. Treatment Cart at Station 1 stored multiple opened and partially used wound care supplies marked as sterile per manufacturer labeling. These failed practices could contribute to unsafe medication and wound care supply use in the facility. Findings: A review of the facility's policy titled, Medication Storage in The Facility, revised [DATE], indicated, Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The policy further indicated When the original seal of the manufacturer's container or vial is initially broken, the container or vial will be dated. 1. During a concurrent observation of the Medication Cart 3 at Station 2, and interview with Licensed Nurse (LN) F on [DATE] at 3:43 p.m., the latanoprost the eye drop medication had a manufacture's label that indicated, Refrigerate until opened. The eye drop bottle was not opened, and it was not refrigerated. LN F confirmed the finding. During a concurrent observation and interview, on [DATE], at 3:46 p.m., with LN A blood sugar test strips were opened and not dated. The manufacturer of these test strips indicated, Use within 90 days of first opening. There is no way of knowing the expiration date of these test strips as it was not marked once they were first opened. LN A confirmed the finding. 2. During a concurrent observation and interview on [DATE] at 1:43 p.m., with LN E in the medication room at Station 1, all of the blood test tubes were expired with the expiration date of [DATE]. The culture swabs were all expired with dates on them of [DATE]. LN E acknowledged the findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a concurrent observation of the facility's treatment cart in Station 1, and interview with LN G on [DATE] at 10:21 a.m., the treatment cart stored multiple sterile wound dressings that were cut in different sized pieces and placed throughout treatment cart. There were also several single use and individually wrapped wound dressings that were cut in pieces and placed throughout the treatment cart that were marked as Do Not Reuse and Sterile on the outer labeling. LN G acknowledged the findings and stated the staff should have used smaller size products and discarded the un-used products. During an interview with Director of Nursing (DON) on [DATE], at 1:45 p.m., the DON stated not refrigerating eye drop medication such as Latanoprost, according to manufacturer's labeling was not in accordance with the facility's policy or to her expectations for nursing staff. DON stated not dating blood glucose test strips upon opening was not in accordance with the facility's policy or her expectations. DON stated having expired blood test tubes and culture swabs was not in accordance with the facility's policy or her expectations. DON stated that having cuttings of individually wrapped wound dressings that were sterile and single use was not in accordance with the facility's policy or her expectations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49934 Based on observation, interview, and record review, the facility failed to maintain professional standards of practice to ensure food service safety for the residents of the facility when during the initial tour food preparation equipment was not clean. These failures had the potential for risk of contaminating food with germs and causing a food born illness. Findings: A review of the Food and Drug Administration (FDA- federal agency that protects and promotes public health by regulating various products, such as drugs, devices, food, cosmetics, and tobacco) Food Code, 2022, section 4-601.11, indicated, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, indicated, (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During a concurrent observation and interview with the Dietary Manger (DM) in the kitchen on 02/17/25 at 8:43 am, observed were four baking sheets with a black charred substance at the edges and sides. The DM confirmed that this burnt substance could cause cross contamination (a process where bacteria are transferred from one surface to another). The DM stated that they needed to be replaced.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review, the facility failed to maintain medical records that were complete for one out of 18 sampled residents (Resident 46) when Restorative Nursing Assistant (RNA, trained in providing residents with range of motion exercises [ROM, exercises that assist with movement of the arms or leg]) did not document care that was provided. This failure caused medical records to be incomplete which caused an inability to know of physician care ordered was provided or not. Findings: A review of the facility's policy and procedure titled, Completion and Correction, revised 1/1/12, indicated, treatments provided to residents would be documented in the resident's medical record as they occurred and that medical records would be complete. A review of Resident 46's Admission record, dated 10/12/20, indicated, admission to the facility on [DATE] with the diagnoses of dementia (memory loss) and trigger finger (a condition where the finger gets stuck in a bent position then snaps straight), left middle finger. Resident 46 was his own responsible party (made own decisions). During a concurrent interview and record review on 2/19/25 with RNA, a review of Resident 46's tasks tab, where RNA documented care that was provided to residents, dated 2/18/25 and 2/19/25 was reviewed. Both days were highlighted in red, and RNA stated, red meant no one documented care. RNA confirmed, there was missing documentation for Resident 46 but was not able to verbalize understanding of questions that were asked during the interview or how to locate the records in the electronic medical record (EMR). During a concurrent interview and record review on 2/19/25 at 3:10 pm, with Director of Staff Development (DSD), Resident 46's Physician Order, dated 1/6/25 was reviewed. DSD stated, the Physician Order, indicated, Resident 46 would receive PROM (passive range of motion, when another person provided the exercise with little to no help from the resident) to the left hand and fingers three times a week. DSD reviewed, the intervention/tasks section of the EMR, dated 1/1/25 through 2/19/25, and confirmed, the intervention/task section indicated, RNAs were not documenting care that was provided and should have. DSD confirmed, four weeks of documentation (1/6/25 through 2/2/25) was missing one out of three entries a week, and there was no documentation present from 2/3/25 through 2/19/25.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility did not follow their Arbitration Agreement (a binding contract that explained how a resident would resolve disputes against the facility) policy and procedure (P&P) for three of three residents (Residents 27, 42, and 48) that were sampled for arbitration when: 1. Resident 27 did not fully understand the terms and conditions of the arbitration agreement, stated it was not explained in a manner that was understood, and felt rushed during the process; and 2. Resident 42's responsible party (RP, decision maker/representative) stated, facility staff did not discuss the arbitration process or agreement with RP and was not aware RP had signed a binding arbitration agreement; and 3. The facility's Interdisciplinary Team, (IDT, a group of facility staff that discuss, monitor, and coordinate care that a resident received) acted as Resident 48's surrogate (representative/RP) and entered Resident 48 into a binding arbitration agreement with the facility. These deficient practices resulted in residents and resident decision makers to enter into an agreement for binding arbitration without fully understanding what they were signing. Findings: 1. A review of the facility's policy and procedure (P&P) titled Arbitration Agreement, revised 5/25/23 indicated, when facility staff presented the arbitration agreement to the resident or the resident's RP, the agreement would be explained in a manner that was understood. The P&P indicated, Residents should be given the opportunity to ask questions and clarify their understanding of the implications [the significance] of signing the agreement. A review of Resident 27's Admission record, dated 4/10/23, indicated, Resident 27 was admitted to the facility on [DATE] with the diagnoses of hypertension (high blood pressure) and primary open-angle glaucoma, bilateral, mild stage (when the eyes drainage system is not functioning properly and could cause trouble seeing in both eyes). Resident 27 was her own responsible party (RP, decision maker). A review of Resident 27's Minimum Data Set (MDS, a resident assessment tool), Section C, dated 8/9/23, indicated, Resident 27 had a BIMS (Brief Interview for Mental Status, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15, which indicated Resident 27's memory was intact. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/19/25 at 12:17 pm, Resident 27 was observed sitting up in bed. Resident 27 was asked if Resident 27 remembered signing an arbitration agreement with the facility. Resident 27 stated, what was explained to me was, I wouldn't call an attorney and get them (the facility) in trouble. Resident 27 stated, I was told to sign it and I didn't know I had a choice. Resident 27 confirmed, not fully understanding what the arbitration agreement meant and stated she was rushed through the forms. Resident 27 stated, facility staff told me to sign here, sign here, and sign here. Resident 27 was observed acting out the scenario. Each time Resident 27 stated, sign here, Resident 27 pointed to a place on the bedside table and demonstrated signing her name. During a concurrent interview and record review on 2/19/25 at 1:46 pm, with Admissions Coordinator (AC), Resident 27's Arbitration Agreement, dated 4/11/23 was reviewed. AC stated, Resident 27 was admitted prior to AC stepping into the role and did not present Resident 27 with the arbitration agreement. AC confirmed, residents should not be rushed into signing the arbitration agreement and residents should fully understand the agreement prior to signing the form. 2. A review of Resident 42's Admissions Record, dated 10/7/24, indicated Resident 42 was admitted to the facility on [DATE] with the diagnoses of moderate dementia with psychotic disturbance (memory loss with difficulty recognizing what was real or not). Resident 42's family member was his RP. A review of Resident 42's MDS, Section C, dated, 1/2/25, indicated Resident42 had a BIMS score of 2, which indicated, Resident 42 had poor memory and judgement. During an interview on 2/17/25 at 2:32 pm, Resident 42's RP confirmed signing all the admission paperwork for Resident 42 and stated, I don't remember being talked to about an arbitration agreement or signing it. During a concurrent interview and record review on 2/19/25 at 11:51 am, with AC, Resident 42's Arbitration Agreement, dated 10/11/24, was reviewed. AC confirmed, Resident 42's RP signed the arbitration agreement and stated, residents and their RPs should be notified of the agreement prior to signing the form. 3. The facility's Arbitration policy indicated, If the resident lacks capacity [understanding] at the time of admission, or if a family member signed on their behalf, the director of admission will request documentation regarding the authority of the person signing, such as durable power of attorney [person legally responsible for making decisions or signing forms] and/or orders of conservatorship. [court appointed RP]. The P&P indicated, the documentation that named the residents power of attorney or other legal documentation that indicated the resident was conserved, would be uploaded into the medical records with the arbitration agreement. A review of Resident 48's Admission Record, dated 5/14/20, indicated, Resident 48 was admitted to the facility on [DATE] with the diagnoses of anoxic brain damage (lack of oxygen to the brain) and aphasia following cerebral infarction (a stroke that affected the ability to speak or understand) and the facility's IDT acted as Resident 48's RP. A review of Resident 48's MDS, Section C, dated, 5/21/20, indicated, Resident 48 was rarely or never understood, and the BIMS assessment could not be conducted. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 48's medical records, there was no documentation that indicated Resident 48 was conserved or had a legal power of attorney. Subsequently, there was no documentation of authority present with the signed arbitration agreement. During a concurrent interview and record review on 2/19/25 at 1:46 pm, with AC, Resident 48's Arbitration Agreement, dated, 9/29/22 was reviewed. AC stated, Resident 48's arbitration agreement was signed by the facility's IDT [Interdisciplinary Team, managers and clinicians that oversee the facility] team. During an interview on 2/20/25 at 8:19 am, the facility's Administrator (Admin) confirmed, prior to signing the arbitration agreement, residents and the resident's RP should be fully informed and understand the arbitration agreement prior to signing. Admin confirmed, IDT signed Resident 48 into a binding arbitration agreement and stated, the IDT was allowed to make medical decisions for Resident 48 and IDT cannot sign the arbitration agreement for anyone.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review the facility failed to ensure safe infection prevention practices with resident census of 75 according to standards of practice and the facility's policy when: 1. Facility staff did not perform hand hygiene (cleaning hands) for three of three residents (Residents 32, 35, and 36) that were sampled for infection control while being served their lunch trays; and 2a. Bags that contained clear liquid were not labeled for three out of three gastrostomy (g-tube, a tube surgically inserted through the abdomen that delivered liquid hydration and nutrition) sampled residents (Residents 20, 36, and 48); and 2b. A plastic bottle that contained g-tube feeding was missing information for one of three sampled g-tube residents (Resident 36); and 3a. The facility failed to ensure the pill cutter (a small cutting device used to divide the pills) were cleaned after each use and a safe system of cleaning was in place to prevent cross contamination when the pill cutter in Medication Cart 3 at station 2 had white powder residues; and 3b. The facility failed to ensure safe infection control practices with use of shared Blood Pressure (BP) devices (a device that measured rate of blood flow using the arm or the wrist) in-between resident care when the BP device was not cleaned and sanitized when used on Resident 19 and Resident 54 during medication administration; and 3c. The facility failed to ensure hand hygiene and sanitization in-between resident care on Resident 19 and Resident 54 during medication administration. These failed practices could contribute to unsanitary medical device use and the spread of infection in the facility. Findings: 1. A review of the facility's policies and procedures (P&P) titled, Infection Control, revised 1/1/12, indicated, The Facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/17/24 at 12:22 pm, Certified Nurse Assistant (CNA) M was observed touching Resident 32's food items on the meal tray with bare hands. CNA M was observed holding the cheeseburger down with a bare hand while cutting the cheeseburger in half. CNA M then walked out of Resident 32's room, cleansed hands with an alcohol gel-based hand sanitizer and removed a resident's meal tray from the cart and took the meal tray to Resident 45. Upon entry to Resident 45's room, Nurse Assistant (NA) was observed setting Resident 36 up for lunch. NA was observed touching Resident 36's cheeseburger with bare hands. CNA M asked NA for assistance with moving Resident 45 up in bed, NA wiped hands on scrub pants, walked over to Resident 45's bed. Both CNA M and NA used their bare hands to pull Resident 45 up in bed, utilizing the bed linen that Resident 45 was lying on. Immediately after, CNA M began touching food items on Resident 45's meal tray with bare hands, without performing hand hygiene. NA walked back over to Resident 36 and began opening food containers on the meal tray, bare handed. NA had not performed hand hygiene in between resident care or before touching Resident 36's food and food containers. NA stopped opening Resident 36's food containers and stated, I should put gloves on. NA put gloves on, without performing hand hygiene, touched a few more food items, removed gloves, and walked out of the room. During an interview on 2/17/25 at 12:46 pm, CNA M confirmed touching Resident 32 and 45's food with bare hands and stated, CNA M was not aware if CNA M had to wear gloves while handling resident food. During an interview on 2/17/25 at 12:49 pm, NA confirmed touching Resident 36's food with bare hands, wiping own hands-on pants, assisting CNA M to move Resident 45 up in bed, returning to Resident 36's meal tray, and touching food containers. NA confirmed during the entirety of the observation, NA did not perform hand hygiene in between resident care and stated, NA was not aware if NA had to wear gloves while handling resident food. During an interview on 2/19/25 at 3:21 pm, Director of Staff Development (DSD) stated, facility staff should not be using bare hands-on resident food and facility staff was required to perform hand hygiene in between each resident. The observations made on 2/17/25 that involved CNA M and NA were described, and DSD confirmed, lack of hand hygiene between each resident and touching resident food items with bare hands was considered an infection control concern and had the potential to spread illness. During an interview on 2/20/25 at 7:27 am, with the facility's Infection Preventionist (IP), the observations of CNA M and NA that were made on 2/17/25 were discussed. IP confirmed, lack of hand hygiene between each resident and touching resident food items with bare hands was considered an infection control concern and had the potential to spread illness. 2a. A review of the facility's P&P titled, Enteral Feedings, revised 8/2/23, indicated, facility staff would label g-tube feeding .bag and tubing with date and time hung. Hang time is for no more that 24 hours. During an observation on 2/17/25 at 9:53 am, located in Resident 36's room, an unlabeled bag full of clear liquid was observed hanging on a pole, next to Resident 36's bed. During an observation on 2/18/25 at 10:59 am, located in Resident 36's room, an unlabeled bag full of clear liquid was observed hanging on a pole, next to Resident 36's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/25, with the Director of Nursing (DON) and the facility's IP, photos of the bags found in Resident 36's room, that contained clear liquid, were reviewed. Both DON and IP stated, the clear liquid was water and the bag of water should have been dated by the Licensed Nurse (LN) who prepared it. DON and IP confirmed, the bags of water should have been labeled with a date and stated, not labeling the water bottles were considered an infection control issue due to not knowing how long the water had been in the bag. 2b. During a concurrent observation and record review on 2/18/25 at 10:59 am, located in Resident 36's room, a plastic bottle that contained liquid nutrition was observed hanging on a pole near Resident 36's bed. The label on the plastic bottle was dated 2/18/25 and indicated, the plastic bottle contained liquid nutrition for Resident 36. The label did not include the time that the liquid nutrition had been prepared. During an interview on 2/20/25, with DON and the facility's IP, a photo of the plastic bottle that contained liquid nutrition was reviewed. DON and IP stated, the plastic bottle that contained liquid nutrition should be filled out completely, and should include the time it was prepared, because the liquid nutrition was only good for use for a 24-hour period after it was placed in the plastic bottle. DON and IP confirmed, the label for liquid nutrition was missing the time that it had been prepared. DON and IP stated, this was considered an infection control issue due to not knowing how long the liquid nutrition had been hanging in the plastic bottle. 43739 2a. During a review of Resident 20's admission record, indicated that she was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses which included cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to damage or death of brain tissue), dysphagia (difficulty swallowing) following cerebral infarction, aphasia (a disorder that makes it difficult to speak) following cerebral infarction, and gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). Resident 20 was not her own health care decision maker. During a review of Resident 20's MDS, dated [DATE], the MDS indicated that a Brief Interview for Mental Status (BIMS) shouldn't be conducted, because Resident 20 was rarely/never understood. During a concurrent observation and interview on 2/19/25 at 7:41 am, with LN B, in Resident 20's room, an unlabeled bag full of clear liquid was observed hanging on a pole, next to Resident 20's bed. The LN B stated, They are a whole set together, the bag did not need to be labeled. During a review of Resident 48's admission record, indicated that she was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses which included cerebral infraction, dysphagia following cerebral infarction, aphasia following cerebral infarction, and gastrostomy status. During a review of Resident 48's MDS, dated [DATE], the MDS indicated that a Brief Interview for Mental Status (BIMS) shouldn't be conducted, because Resident 48 was rarely/never understood. During an observation on 2/19/25 at 8:17 am, in Resident 48's room, an unlabeled bag full of clear liquid was observed hanging on a pole, next to Resident 48's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51253 3a. A review of the facility's Policy, titled Cleaning and Disinfecting Resident Care Equipment, last revised on January 1, 2012, indicates, Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturer's instructions. During a concurrent observation and interview on 2/14/25 at 3:44 pm with a LN A, a pill cutter stored in medication cart 3, station 2 had white powder residue and was not clean. LN A confirmed it had pill powder on it. During an observation on 2/17/25 at 3:54 pm, with LN A, bleach wipes were used to clean inside of pill cutter stored in medication Cart 3 at Station 2. The labeling on the bleach wipes indicated in bold lettering, It is a violation of Federal law to use this product in a manner inconsistent with its labeling. A potable [drinkable] water rinse is required for food contact surfaces. The pill cutter was wiped with this bleach product, and it was placed back into the cart. No potable water source was used after bleach was placed on the pill cutter blade. There were no other wipes located in the medication cart, only the bleach wipes. LN A acknowledged using the wrong wipe to clean the pill cutter. 3b. During an observation with LN B on 2/18/25 at 9:15 am, LN B did not disinfect the resident blood pressure cuff equipment after taking the blood pressure for Resident 19. During an observation with LN B, on 2/18/25 at 10:01 am, LN B did not disinfect the resident blood pressure cuff and equipment after taking the blood pressure for Resident 54. 3c. A review of the facility's policy, titled Hand Hygiene (cleaning the hand with soap and water or use of alcohol-based hand sanitizer), last revised on September 1, 2020, indicates hand hygiene is to be performed before donning and doffing personal protective equipment, and immediately upon entering and exiting a resident room. During an observation with LN B, on 2/18/25 at 9:15 am, LN B did not perform hand hygiene for medication administration for Resident 19. There was no hand hygiene performed while entering and exiting resident's room. During and observation with LN B on 1/18/25 at 10:01 am, LN B did not perform hand hygiene for medication administration for Resident 54. There was no hand hygiene performed while entering and exiting resident's room. During an interview with LN B on 2/19/25 at 11:50 am, LN B confirmed not performing hand hygiene for residents 19 and 54 and that was not following the facility's policy. LN B also confirmed not disinfecting blood pressure cuff and equipment while taking blood pressure for Resident 19 and 54 and this did not follow the facility's policy. During an interview with facility's IP, on 2/20/25 at 11:02 am, IP confirmed not disinfecting blood pressure cuff and not performing hand hygiene in between residents is against facility policies on infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 2/19/25 1:31 pm, the DON stated not disinfecting blood pressure cuff and not performing hand hygiene in between residents is against facility policy.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to ensure an electrical outlet cover in room [ROOM NUMBER], located near a privacy curtain (a fabric curtain that hung from the ceiling and provided privacy to the residents), was maintained when the electrical outlet cover was loose and there was an exposed gap between the electrical outlet cover and the wall. The failure to maintain an electrical outlet and it's cover could be considered a safety hazard. Findings: A review of the facility's policy and procedure (P&P) titled, Maintenance Service, revised 1/1/12, indicated, the maintenance department was responsible for maintaining all areas of the facility and the purpose of the (P&P) was To protect the health and safety of residents, visitors, and Facility Staff. During an observation on 2/17/25 at 9:46 am, located in room [ROOM NUMBER], an electrical outlet cover was observed to have a gap between it and the wall and was loose. The electrical outlet cover was located near a privacy curtain, and was close enough, that when the privacy curtain was fully closed, it almost touched the electrical outlet cover. During a concurrent observation and interview on 2/20/25 at 10:38 am, with Maintenance Supervisor (MS), an electrical outlet cover, located in room [ROOM NUMBER] was observed. MS confirmed, the electrical outlet cover was loose and there was a gap between it and the wall. MS stated, the electrical outlet cover needed to be fixed and shouldn't be that way.