STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055677	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Skilled Nursing Center	535 School Street Pittsburg, CA 94565

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46487 Based on observation, interview and record review, the facility failed to treat Resident 10 with dignity and respect when the resident was observed to be eating her pureed (cooked food that had been ground, pressed and blended to the consistency of creamy paste) breakfast in plastic cups. This failure had the potential to cause emotional distress to the resident. Findings: During a review of Resident 10's Admission Record, dated 8/27/24, indicated Resident 10 was admitted to the facility on [DATE] with diagnosis of major depressive disorder (a persistent feeling of sadness). During a review of Resident 10's Physician's Order (PO), dated 6/29/22, the PO indicated Resident 10 had a diet order of pureed consistency. During a concurrent observation and interview on 8/25/24 at 10:08 a.m., Resident 10 sat up in bed in her room and ate pureed food in two plastic cups on top of her bed table with a spoon. When asked about the plastic cups, Resident 10 stated, I don't know why they serve my food in cups. During a concurrent observation and interview on 8/25/24 at 10:11 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 identified the white pureed food in one plastic cup as grits but could not identify the yellow pureed food in second plastic cup. LVN 1 stated Resident 10 ate in plastic cups because Resident 10 was a slow eater. During an interview on 8/25/24 at 10:38. a.m. with LVN 2, LVN 2 stated she was the one who transferred the food from the plates to the plastic cups because the breakfast trays and plates had to be returned to the kitchen. LVN 2 admitted it was not dignified for Resident 10 to eat in plastic cups. During an interview on 8//26/24 12:35 p.m., with the Director of Nursing (DON), the DON stated serving Resident 10's food in cups was not treating the resident with dignity. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P), titled, Dignity, revised August 2009, the P&P indicated, .Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39939 Based on observation, interview, and record review, the facility failed to ensure family representative (FR) of one of three sampled residents (Resident 36) made an informed decision for the use of bed rails for Resident 36. Facility did not share and maintain a record of accurate assessment of medical needs, alternative attempts that failed to meet resident's needs, alternatives considered but not attempted because they were inappropriate, prior to the use of bedrails, with Resident 36's FR. Facility designated a non-licensed professional (Admission Coordinator-AC) to obtain informed consents for use of bed rails during admission process. This failure placed Resident 36's FR to be unaware of the medical necessity, and alternative options available instead of using bed rails. (Cross Reference F 700) Findings: A review of Resident 36's Admission Record printed on 8/25/24 indicated Resident 36 was admitted to the facility on [DATE]. During a record review of Resident 36's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 8/11/24 indicated Resident 36's cognition (mental status) was severely impaired. During a review of Resident 36's Activities of Daily Living (ADL) care plan initiated on 5/6/23, the care plan indicated to use side rails as ord[ered]. During a review of Resident 36's Physician Order (PO) dated 7/7/23, the PO indicated bilateral 1/4 siderails up when in bed every shift for bed mobility. During an observation on 8/25/24 at 9:35 a.m., with Certified Nursing Assistant 2 (CNA 2), Residents 36's 1/4 bed rails were up on both sides while she was lying in bed. CNA 2 stated both side rails were kept up for safety so Resident 36 did not fall out of bed. CNA 2 stated Resident 36 was totally dependent on staff for Activities of Daily Living (ADL) care. During an observation on 8/26/24 at 8:02 a.m. Resident 36 was lying in bed with both 1/4 padded bed rails up. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 8/26/24 at 12:19 p.m., with Licensed Vocational Nurse 6 (LVN 6), Resident 36's document titled Informed Consent for use of Bedrails signed by FR on 5/5/23, was reviewed. (An Informed Consent is defined as the information on assessment of medical needs, benefits, likelihood of benefits, risks, how risks will be mitigated and alternative attempts that failed to meet resident's needs, alternatives considered but not attempted because they were inappropriate). The document indicated, on 5/5/23, Resident 36's Family Representative (FR) opted for I DO voluntarily consent to the use of bedrail(s). I understand that I have the right to refuse the use of bedrail(s) or can revoke this consent at any time. LVN 6 stated he was unable to find which facility staff obtained the informed consent and explained potential risks, negative outcomes, benefits and/or alternatives to Resident 36's FR. During a concurrent interview and record review with Director of Nursing (DON) on 8/27/24 at 7:59 a.m. Resident 36's paper chart and Electronic Health Record (EHR) for progress notes, physician orders, consents, assessments/ evaluations, care plans from 5/5/23 through 8/27/24 were reviewed. The DON stated Resident 36 used bilateral side rails for positioning since her admission to the facility. The DON stated Resident 36 could not hold on to the side rails when prompted and/or voluntarily; and that it was more for her comfort. The DON stated if bed rails were not used as restraints (any device, material or equipment attached or adjacent to the resident's body that they cannot remove easily, which restricts freedom of movement or normal access to one's body), facility was not even required to obtain an informed consent for use of bed rails. The DON then stated the physician was responsible for obtaining an informed consent for use of bed rails. The DON stated Resident 36's Bed rail assessment dated [DATE] and 9/20/23 inaccurately indicated that bed rails assisted Resident 36 from a supine (lying face up) to sitting/standing position as she was not able to perform these activities. The DON stated she was unable to find any documentation in Resident 36's EHR and paper chart since 5/5/23, if facility used any other alternatives and/or a physician obtained an informed consent prior to installing the bed rails on Resident 36's bed. During a phone interview with Resident 36's FR on 8/28/24 at 11:55 a.m. the FR stated she signed the consent to use bed rails upon Resident 36's admission to the facility. FR stated the front desk staff talked to her regarding use of bed rails to prevent Resident 36 from falling out of bed. FR stated she did not recall Resident 36's physician talking to her regarding any alternatives and/or other medical reasons to use bed rails for her. During an interview on 8/27/24 1:46 p.m., in presence of DON, the AC stated she was responsible for obtaining informed consent for the use of bed rails upon residents' admission. AC stated she provided the handouts to residents'/ residents' families upon residents' admission to the facility. AC stated the handout included information about pros and cons of using bed rails. AC stated she did not receive an official training on obtaining an informed consent. AC stated she had a CNA certification, however, was not a licensed medical/health care professional. During a record review of facility's Policy and Procedure (P&P) titled Bed Safety and Bed Rails dated 08/2022, the P&P indicated, Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46487 Based on interview and record review, the facility failed to ensure three of 15 sampled residents' (Residents 4, 8, and 10) Advanced Directives (written statement of a person's wishes regarding the medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed with the residents and/or responsible parties when the Advanced Directive information was unmarked or marked unavailable on the Physician Orders for Life-Sustaining Treatment (POLST, a form designed that records patients' treatment wishes so emergency personnel know what treatments the patient wants in the event of a medical emergency) for Residents 4, 8, and 10. This had potential for the facility to provide treatment and services against the wishes of Residents 4, 8, and 10. Findings: During a review of Resident 10's Minimum Data Set (MDS, MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan)) dated 6/13/24, the MDS indicated Resident 10's cognition was mildly impaired. During a review of Resident 10's POLST dated 8/16/24. Under information and signatures, the POLST indicated no information on the presence of an Advanced Directive. During a concurrent interview and record review on 8/26/24, at 8:15 a.m., with Social Services Director (SSD), SSD reviewed Resident 10's medical records and stated there was no documentation the Advance Directives were discussed with Resident 10's responsible party. 49498 During a review of Resident 4's POLST, dated 4/27/11, the POLST indicated Resident 4's Advance Directive information was marked not available. During a review of Resident 8's POLST, dated 10/26/22, indicated, Resident 8's Advance Directive information was unmarked. During an interview on 8/27/24 at 12:30 p.m. with the SSD, the SSD stated when Advance Directive information was unmarked in the POLST, the SSD assumed the resident did not have one. The SSD stated copies of Advance Directive were followed up during resident's care conference and was documented in the care conference form. The SSD stated the Advance Directive was not documented as followed up in the progress notes for Resident 4 and 8. During a review of Resident 4's Multidisciplinary Care Conference form, dated 11/17/22, the form indicated, Resident 4's Advance Directive copy was not followed up. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's Multidisciplinary Care Conference form, dated 11/8/22, the form indicated, Resident 8's Advance Directive copy was not followed up. During an interview on 8/28/24 at 3:10 p.m. with SSD, the SSD stated Advance Directive for Resident 4 and 8 were not documented. During a review of the facility's policy and procedure (P&P) titled Advanced Directives, the P&P indicated, . During the admission process or shortly after admission, admissions or social service staff informs the resident and/or the responsible party of the advanced healthcare directive . the social service and/or admissions staff will attempt to obtain completed copies of The Advanced Healthcare Directive for the resident's medical record .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51446 Based on the observation, interview, and record review, the facility failed to provide homelike environment to three of 15 sampled residents (Resident 9, 36 and 19) when 1. The wall clock in shared room for Residents 9, 36 and 19 displayed an inaccurate time, with a potential to cause them confusion and disorientation of time, and 2. The overbed tables (a table with metal base with four wheels, a metallic leg on one side and a wooden tray on the top) for Residents 36 and 19 were chipped and unfurnished with rough edges, posing a potential risk for them getting scratched and hurting themselves. Findings: 1. During an observation and interview on 8/26/24 at 8:00 a.m. with Resident 9 inside the shared room of Residents 9, 36, and 19, a round black and white colored wall clock was hung up on the wall next to the television. Resident 9 stated it was 6:50 a.m. on the clock at that time. During an observation and interview on 8/26/24 at 12:13 p.m. with Certified Nursing Assistant (CNA) 2 in shared room of Residents 9, 36 and 19, CNA 2 stated the wall clock displayed 11:50 a.m. CNA 2 took out a personal cell phone from her pocket; and stated the time displayed on the wall clock was not correct and it needed a change of battery. CNA 2 stated the correct time was 12:17 p.m. at that time. During an interview on 8/28/24 at 10:12 a.m. with the Director of Nursing (DON), the DON stated the wall clock in residents' rooms should be working at all times, as otherwise it could cause confusion/disorientation of time among residents. During a record review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, dated 02/2021, indicated, Residents are provided with a safe, clean, comfortable, and homelike environment . 2. During an interview on 8/27/24 at 12:02 p.m., Resident 19 was lying in bed with overbed table at the bedside. The table had chipped, unfurnished, and rough edges. Resident 19 pointed at the table and stated she wanted a new overbed table. During an observation and interview on 8/27/24 at 12:03 p.m. with Environmental Services Supervisor (ESS), in Resident 19 and 36's shared room, their overbed tables were at their bedside. ESS stated both tables had rough and chipped edges and ESS reported the need to replace unfurnished overbed tables to the Administrator (ADM) about a month ago. ESS stated the damage on Resident 19 and 36's overbed tables was not a new damage, and he had been noticing this for over a month. ESS stated it was risky to use a damaged overbed table for residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/27/24 at 12:57 p.m. with ADM, an invoice dated 5/10/24 was reviewed. The ADM stated facility ordered and replaced two overbed tables in 5/2024, but nothing was ordered and replaced since then. The ADM stated overbed table replacements were made when their wheels did not work, the table would not move up and down, and if they had chipped edges. During an interview and record review on 8/28/24 at 8:35 a.m. at nursing station, with Licensed Vocation Nurse 6 (LVN 6- assigned charge nurse for Resident 36 and 19), facility's Maintenance Binder from 7/2024 through 8/2024 was reviewed. LVN 6 stated Resident 36's skin was frail and both Residents 36 and 19 were at risk of getting injured with damaged overbed tables. LVN 6 stated staff checked and reported damaged items in the Maintenance Binder. LVN 6 stated he was unable to find any written services request to replace the overbed tables for Residents 36 and 19. During a record review of the facility's undated P&P titled, Maintenance Service, the P&P indicated, Maintenance service shall be provided to all areas of the building, grounds and equipment .Repairs shall be conducted in a safe and timely manner or as soon as possible if needed .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49498 Based on interview and record review, the facility failed to complete and submit the Death in Facility Tracking Record to Centers for Medicare & Medicaid Services (CMS) for one of one sampled resident (Resident 5) when Resident 5 died in the facility on [DATE]. This failure resulted in Resident 5's specific payment information and quality measure data to be out of date. Findings: During a review of Resident 5's undated Admission Record, the record indicated, Resident 5 was admitted in the facility on [DATE] with a diagnoses of Cervical Disc Disorder, Malignant Neoplasm of Prostate, Combined Systolic and Diastolic Heart Failure and Chronic Obstructive Pulmonary Disease. During a review of Resident 5's Nurses Notes dated [DATE], the record indicated Resident 5 died in the facility on [DATE] at 6:00 p.m. During an interview on [DATE] at 10:58 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 5's Death in Facility Tracking Record was missed and was not completed for submission. During a review of the facility's policy and procedure titled, MDS Submission Timeframes, the policy indicated, The facility will conduct and submit resident assessment in accordance with current federal and state submission timeframes. During a review of the CMS Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual dated [DATE], the manual indicated, Entry and Discharge Reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, . and Death in Facility tracking record . Death in Facility Tracking Record must be completed when the resident dies in the facility, within 7 days after the resident's death and submitted within 14 days after the resident's death.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51446 Based on observation, interview and record review, the facility failed to accurately assess and code one of 15 sampled residents (Resident 36) for diagnosis of Pneumonia (an infection of one or both lungs caused by bacteria, viruses or fungi causing difficulty in breathing, cough, fever, and chills) in the quarterly Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) when the MDS was coded Yes for an active diagnosis of Pneumonia and Resident 36 did not have Pneumonia. This failure resulted in an outdated and inaccurate reflection of Resident 36's medical condition. Findings: A review of Resident 36's Admission Record printed on 8/25/24 indicated Resident 36 was admitted to the facility on [DATE]. During an observation and interview with Certified Nursing Assistant (CNA) 2 on 8/25/24 at 9:35 a.m., Resident 36 was lying in bed. CNA 2 stated Resident 36 was not able to communicate her needs and/or understand others. Resident 36 did not have any signs and symptoms of respiratory distress and was breathing without any difficulty. During an interview on 8/25/24 at 2:37 p.m., Licensed Vocational Nurse (LVN) 2 stated she was the routine charge nurse for Resident 36 for past few months. LVN 2 stated Resident 36 did not have cough and/or a diagnosis of Pneumonia recently. During a concurrent interview and record review on 8/25/24 at 2:59 p.m. with the MDS Coordinator (MDSC), Resident 36's Electronic Health Record for quarterly MDS assessment dated [DATE], and nursing progress notes from 8/5/24 through 8/11/24 were reviewed. MDSC stated Resident 36's MDS assessment dated [DATE] Section I- Active Diagnosis indicated Pneumonia was an active diagnosis during the Look-back period (a time period over which the resident's condition or status is captured in the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD)). MDSC stated look back period for diagnosis of Pneumonia was seven (7) days. MDSC stated she did not recall Resident 36 experiencing any symptoms of Pneumonia during the look back period for MDS assessment dated [DATE]. MDSC also stated she was unable to find any documentation in Resident 36's nursing progress notes to indicate if Resident 36 experienced signs and symptoms and/or diagnosis of Pneumonia from 8/5/24 through 8/11/24. MDSC stated Pneumonia was not an accurate reflection of Resident 36's clinical condition. During a record review of the Centers of Medicare and Medicaid (CMS)'s RAI Version 3.0 Manual dated 10/2023, indicated, Active Diagnosis: Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive [mental] status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7 [seven]-day look-back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's Policy and Procedure (P&P) revised 12/2006, titled, Charting Errors and/or Omissions, the P&P indicated, Accurate medical records shall be maintained by this facility.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50474 Based on interview and record review, the facility failed to ensure one (Resident 15) of one sampled resident completed a Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASRR requires that 1. all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2. be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3. receive the services they need in those settings.) evaluation when Resident 15 had Schizophrenia (a mental condition which makes it difficult to think clearly, have normal emotional responses, act normally in social situations, and tell the difference between what is real and what is not real) and was not screened for PASRR Level II (A Level 2 Evaluation is a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, i.e., serious mental illness, intellectual disability, developmental disability, or related condition evaluation.). This failure had the potential to prevent Resident 15 from receiving appropriate required mental health services. Findings: During a record review of Resident 15's Admission Record, dated 8/27/24, AR indicated Resident 15 was readmitted to the facility on [DATE] with diagnosis of Schizophrenia . During a record review of Resident 15's PASRR, dated 7/23/24, the document indicated Resident 15 was Level I positive for Serious Mental Illness (SMI) with diagnosis of schizophrenia and was prescribed psychotropic medications (medication used to treat mental illnesses). During a record review of Notice of Attempted Evaluation (NAE) letter, dated 7/23/24, the NAE indicated, a Level II (a more comprehensive evaluation) screening was necessary for Resident 15. The document further indicated Level II screening was not scheduled for Resident 15 due to Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of Level I screening. During an interview on 8/27/24 at 9:23 a.m. with the Medical Record Director (MRD), MRD stated she was responsible for processing the PASRR. MRD stated she did not know there was an attempt to screen Resident 15 for Level II evaluation. During a concurrent interview and record review on 8/27/24 at 9:32 a.m. with the DON, the NAE letter was reviewed. The DON stated she was not aware Resident 15 needed a PASRR Level II evaluation. The DON further stated the Level II PASRR evaluation for Resident 15 should have been processed immediately because Resident 15 was Level I positive. The DON stated the risk for not completing the appropriate Level II screening for Resident 15 was risk for safety of Resident 15 and the facility. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the undated policy and procedure (P&P), titled, PASSAR Screening, the P&P indicated, Residents who are admitted from community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for appropriateness and indications for use .a. Complete PASSAR screening (preadmission screening for mentally ill and intellectually individuals .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 50474 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 35 and Resident 23) were administered melatonin (a sleep supplement that helps regulate the sleep-wake cycle) up to safety standards when melatonin was given at 4:00 p.m. to Resident 35 and Resident 23. This failure had the potential to place Resident 35 and Resident 23 at risk for physical harm or injury. Findings: During a record review of Resident 35's hospital Transfer Summary orders, dated 7/25/24, the document indicated, Resident 35 had a medication order of Melatonin (Melanin) 3 milligrams (mg) Oral tablet - Take three tablets by mouth half hour before bedtime as needed for sleep. During a record review of Resident 35's Medication Administration Record (MAR), dated 7/1/24 through 7/31/24 and 8/1/24 through 8/30/24, the MAR indicated Resident 35 received melatonin as a routine supplement daily at 4:00 p.m. During a record review of Resident 23's hospital Transfer Report (TR) dated 5/3/24, the TR indicated Resident 23 had a medication order of Melatonin 5 mg tablet - take two tablets (10 mg total) by mouth nightly at bedtime. During a record review of facility's Medication Review Report (MRR) for Resident 23, dated 8/28/24, MRR indicated Resident 23 had an order of Melatonin Oral tablet 5mg - Give 2 tablets by mouth in the afternoon for supplement since 5/3/24. During a medication pass observation on 8/25/24 at 4:00 p.m. with Licensed Vocational Nurse (LVN) 5, in Resident 35's room, LVN 5 administered three oral tablets of melatonin 3 mg (total of 9 mg) to Resident 35. LVN 5 stated Resident 35 was going to dining room for dinner after giving the melatonin. During a medication pass observation on 8/25/24 at 4:23 p.m. with LVN 5, LVN 5 administered two oral tablets of melatonin 5 mg (total of 10 mg) to Resident 23. Resident 23 was observed in her wheelchair and Resident 23 stated she was going back to the dining room for dinner. During a concurrent interview and record review on 8/26/24 at 3:07 p.m. with the Director of Nursing (DON), MAR for Resident 35 and Resident 23 were reviewed. The DON stated the pharmacy had recommended to give the melatonin to Resident 35 and Resident 23 at 4:00 p.m. The DON stated Resident 35, Resident 23, and their Family Representatives (FR) were informed about it. The DON further stated they administered melatonin as early as 4:00 p.m. because the facility had implemented a sleeping time for all residents at night. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 8/26/24 at 4:07 p.m. with the facility's Consultant Pharmacist (CP), CP stated the pharmacy did not recommend to the facility to give high doses of melatonin at 4:00 p.m. or before dinner to Resident 35 and Resident 23. CP stated melatonin should have been given to Resident 35 and Resident 23 at least around 6:00 p.m. in the evening. CP stated it would have taken two to three hours for melatonin to work and taking it too early was a safety issue and could have potentially caused a fall or injury to Resident 35 and Resident 23. CP stated the manufacturer had also recommended for melatonin to be taken at night to prevent disruption of the sleep-wake cycle. During an interview on 8/28/24 at 11:23 a.m. with Resident 23, Resident 23 stated she was not aware that she was taking melatonin every day at 4:00 p.m. Resident 23 stated, They want me to go to bed early and I don't want it. Resident 23 stated she liked to be in her wheelchair as much as possible because lying down gave her pain on her shoulder. Resident 23 stated she preferred to take the melatonin until around 9:00 p.m. During an interview on 8/28/24 at 12:42 p.m. with Resident 35 and Family Representative (FR), FR stated Resident 35 would have not remembered if he was taking the melatonin at 4:00 p.m. FR further stated she did not know that the facility was administering the melatonin to Resident 35 before dinner. FR stated no one from the facility had informed her about it. During a record review of the facility's policy and procedure (P&P), titled, Administering Medications, dated April 2010, the P&P indicated 3)Medications must be administered in accordance with the orders, including any required time frame .4)If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences .the person preparing or administering the medication shall contact the resident's attending physician or the facility's medical director to discuss the concerns. During a record review of P&P, titled, Physician Medication Orders, dated December 2009, the P&P indicated Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39939 Based on observation, interview, and record review, the facility failed to complete an accurate assessment/evaluation, did not attempt to use any alternatives prior to installing bed rails (adjustable metal or rigid plastic bars attached to the bed) for three of three sampled residents (Resident 36, 24 and 40). Facility did not obtain an informed consent for use of bed rails from Resident 36's Family Representative (FR). This failure placed Residents 36, 24 and 40 at risk of unnecessary use of bed rails and risk of entrapment, hitting against the rail, falling over the side rails, up to and including greater injury or death. Failure to obtain an informed consent placed Resident 36's FR to make an uninformed decision, be unaware of the medical necessity, and alternative options available instead of using bed rails. (Cross Reference F552). Findings: A review of Resident 36's Admission Record printed on 8/25/24 indicated Resident 36 was admitted to the facility on [DATE]. During a record review of Resident 36's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 8/11/24 indicated Resident 36's cognition (mental status) was severely impaired. The MDS assessment indicated Resident 36 was totally dependent for bed mobility including rolling left to right, sit to lying, lying to sitting and for transfers. The assessment indicated activities including sit to stand and walking were not applicable for Resident 36. During an observation on 8/25/24 at 9:35 a.m., with Certified Nursing Assistant (CNA) 2 Residents 36's 1/4 bed rails were up on both sides while she was lying in bed. CNA 2 stated both side rails were kept up for safety so Resident 36 did not fall out of bed. CNA 2 stated Resident 36 was totally dependent on staff for Activities of Daily Living (ADL) care. During an observation on 8/26/24 at 8:02 a.m. Resident 36 was lying in bed with both 1/4 padded bed rails up. During a review of Resident 36's Activities of Daily Living (ADL) care plan initiated on 5/6/23, indicated, to use side rails as ord[ered]. During a review of Resident 36's Physician Order dated 7/7/23 indicated bilateral 1/4 siderails up when in bed every shift for bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/26/24 at 12:19 p.m., with Licensed Vocational Nurse (LVN) 6, Resident 36's Informed Consent for use of Bedrails dated 5/5/23 was reviewed. Informed Consent includes information on assessment of medical needs, benefits, likelihood of benefits, risks, how risks will be mitigated and alternative attempts that failed to meet resident's needs, alternatives considered but not attempted because they were inappropriate. LVN 6 stated informed consent indicated, on 5/5/23, Resident 36's Family Representative (FR) opted for I DO voluntarily consent to the use of bedrail(s). I understand that I have the right to refuse the use of bedrail(s) or can revoke this consent at any time. LVN 6 stated however, the document did not indicate which facility staff representative obtained the informed consent and explained potential risks, negative outcomes, benefits and/or alternatives to Resident 36's FR. During a concurrent interview and record review with DON on 8/27/24 at 7:59 a.m. Resident 36's paper chart and Electronic Health Record (EHR) for progress notes, physician orders, consents, assessments/ evaluations, care plans from 5/5/23 through 8/27/24 were reviewed. The DON stated Resident 36's had been using bilateral side rails for positioning since her admission to the facility. The DON stated Resident 36 could not hold on to the side rails when prompted and/or voluntarily; and that it was more for her comfort. The DON stated if bed rails were not used as restraints (any device, material or equipment attached or adjacent to the resident's body that they cannot remove easily, which restricts freedom of movement or normal access to one's body), facility was not even required to obtain an informed consent for use of bed rails. The DON then stated the physician was responsible for obtaining an informed consent for use of bed rails. The DON stated Resident 36's Bed rail assessment dated [DATE] and 9/20/23 indicated bed rails assisted Resident 36 from a supine (lying face upward) to sitting/standing position as she was not able to perform these activities. The DON stated she was unable to find any documentation in Resident 36's EHR and paper chart since 5/5/23, if facility used any other alternatives and/or a physician obtained an informed consent prior to installing the bed rails on Resident 36's bed. The DON further stated Resident 36's fall risk assessment dated [DATE] indicated Resident 36 was at high risk for falls due to impaired gait and mental status. The DON stated high fall risk posed Resident 36 at risk for falling over the bed rails and sustaining greater injuries. During a phone interview with Resident 36's FR on 8/28/24 at 11:55 a.m. the FR stated she signed the consent to use bed rails upon Resident 36's admission to the facility. FR stated the front desk staff talked to her regarding use of bed rails to prevent Resident 36 from falling out of bed. FR stated she did not recall Resident 36's physician talking to her regarding any alternatives and/or other medical reasons to use bed rails for her. During an interview on 8/27/24 1:46 p.m., in presence of facility's Director of Nursing (DON), the Admission Coordinator (AC) stated she was responsible for obtaining informed consent for the use of bed rails upon residents' admission. AC stated she provided the handouts to residents'/ residents' families upon residents' admission to the facility. AC stated the handout included information about pros and cons of using bed rails. AC stated she did not receive an official training on obtaining an informed consent. AC stated she had a CNA certification, however, was not a licensed medical/health care professional. (Cross reference F552) (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's Policy and Procedure (P&P) titled Bed Safety and Bed Rails dated 8/2022, indicated, 4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: a. roll guards; b. foam bumpers; c. lowering the bed; and/or d. use of concave mattresses to reduce rolling off the bed .6. The resident assessment to determine risk of entrapment includes, but is not limited to: k. mobility (in and out of bed) .7. a. Accident Hazards: (1) The resident could attempt to climb over, around, between, or through the rails .c. Psychosocial outcomes: (1) Creates an undignified self-image and alters the resident's self- esteem; (2) Contributes to feelings of isolation; and/or (3) Induces agitation or anxiety . 50474 During a record review of Resident 40's Admission Record, dated 8/27/24, Resident 40 was admitted to the facility with diagnosis of acute post hemorrhagic anemia (large amount of blood loss). During a record review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/19/2024, MDS indicated Resident 40 needed partial assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) from the staff to roll from lying on back to left and right side and return to lying on back on bed. During a record review of Resident 40's Bed Rail Assessment (BRA), dated 4/13/24, BRA indicated Resident 40 had an unsteady gait and needed the bed rails for bed mobility and safety. BRA further indicated Resident 40 was evaluated for the use of a quarter size bed rails and not half size bed rails. BRA did not indicate the facility provided any alternatives prior to implementing the use of bed rails. During a record review of Resident 40's Care Plan (CP), dated 8/27/24, the CP indicated Side rails as ordered. CP did not have any goals and interventions for Resident 40 on safe bed rail use. During a record review of Resident 40's Hospice Orders, dated 4/12/24, the record indicated Resident 40 May use bed rails as needed for safety and mobility. During a record review of Resident 40's HER, the order created on 8/27/24 indicated Siderails up when in bed every shift for bed mobility. During a record review of Resident 24's AR, dated 8/27/24, Resident 24 was admitted to the facility with diagnoses of cerebral infarction (stroke) with left sided weakness. During a record review of Resident 24's MDS Record dated 7/19/2024, the MDS indicated Resident 24 was totally dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff to roll from lying on back to left and right side and return to lying on back on bed. During a record review of Resident 24's BRA, dated 4/27/24, BRA indicated the resident had poor balance and needed the side rails for bed mobility and safety. The BRA further indicated Resident 24 was evaluated for the use of quarter size bed rails and not half bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 24's undated CP, the CP only indicated Side rails as ordered CP did not indicate goals and interventions for Resident 24 on safe bed rails use. During a record review of Resident 24's Hospice Certification and Plan of Care, dated 7/23/24, the record indicated May use bed rails as needed for safety and mobility. During a record review of Resident 24's Orders in EHR, dated 7/23/24, the order indicated Bilateral Siderails up when in bed every shift for bed mobility. During an observation on 8/25/24 at 9:46 a.m., Resident 40 was observed lying in bed with half side rails raised on both sides. During an observation on 8/25/24 at 9:53 a.m., Resident 24 was observed sleeping in his bed with half side rails on both sides up. During an observation and interview on 8/27/24 at 9:37 a.m. with LVN 6, Resident 40 and Resident 24 were observed lying in their bed with half side rails up. LVN 6 stated the beds with half side rails were provided by the hospice agency (a program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions.) when Resident 40 and Resident 24 were admitted to the facility. During a concurrent interview and record review on 8/27/24 at 10:33 a.m. with MDS Coordinator (MDSC), MDS assessment and Resident 40 and Resident 24's CP were reviewed. MDSC stated she was responsible in doing quarterly assessments and updating the care plan. MDSC stated Resident 40 and Resident 24's MDS assessment did not indicate the use of bed rails because they were not being used as a form of physical restraints. MDSC stated bed rails were not considered a physical restraint if Resident 40 and Resident 24 were able to remove the bed rails on their own. MDSC stated she did not know if using the bed rails to totally dependent residents was a form of physical restraint. MDSC stated Resident 40 and Resident 24's had no specific care plan for bed rails and only indicated side rails as ordered. During an interview on 8/27/24 at 12:21 p.m. with the Director of Nursing (DON), the DON stated Resident 40 and Resident 24 were using the half-sized bed rails instead of the quarter sized bed rails because the hospice did not have any other beds available. The DON was unable to provide documentation that alternatives for use of bed rails were provided. The DON further stated she created and backdated the physician's order for use of bed rails for Resident 40 to four-month prior date because the facility did not have an order in their system. The DON stated she made a mistake, and she should have dated the physician's order on the day she created it. During an interview on 8/27/24 at 2:01 p.m. with LVN 6, LVN 6 stated Resident 24 was unable to turn on his right side on his own due to Resident 24's left sided weakness. LVN 6 stated Resident 40 was able to turn to his sides and grab the bed rails during personal care. LVN 6 stated Resident 40 and Resident 24 were unable to put the bed rails down on their own. LVN stated he did not know why Resident 40 and Resident 24 had a half bed rails instead of the quarter size bed rails. LVN 6 stated the risk of using inappropriate bed rails was potential for entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 8/29/24 at 8:40 a.m. with hospice Case Manager (CM), CM stated the hospice agency provided the beds with bed rails for Resident 40 and Resident 24. CM stated he did not know why the Resident 40 and Resident 24 had half bed rails. CM further stated when Resident 40 and Resident 24 were admitted to the facility, the facility should have re-assessed them for safe and proper use of bed rails according to their policy and procedure. CM stated the order from the hospice doctor was to use bed rails for Resident 40 and Resident 24 on as needed basis for safety and mobility. During an interview on 8/29/24 at 9:45 am with DON, the DON stated the Medical Doctor (MD) did not want Resident 24 and Resident 40 to use the bed rails only as needed and instead the MD wanted it to be always up when Resident 24 and Resident 40 were in bed. The DON stated the facility should have re-assessed Resident 24 and Resident 40 for proper use of bed rails due to inaccurate assessment. The DON stated the risk for not using bed rails properly per doctor's order was risk for accidents such as entrapment. The DON further stated the MDS documentation was coded inaccurately and should have been corrected. During an interview on 8/29/24 at 12:30 p.m. with the DON, the DON stated there were no documentations that MD was informed about the changes the facility implemented for the use of half bed rails for Resident 40 and Resident 24. During a record review of the facility's P&P, titled, Bed Safety and Bed Rails, dated August 2022, the P&P indicated Any device that has effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint . 3) The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives .5) The interdisciplinary team should have an evaluation of the alternatives to bed rails were attempted and how these alternatives failed to meet resident's needs .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46487 Based on interview and record review, the facility failed to provide Registered Nurse (RN) coverage eight hours a day, seven days a week. This failure presents a threat to residents reaching their highest practicable level of well-being and had the potential to endanger the health and safety of residents. (Cross reference F835) Findings: A review on 8/27/24 at 9:19 a.m., the facility's licensed staffing schedules for the month of January 2023 through April 2023 indicated there were no RNs scheduled to work eight hours a day during the following dates: 1. For the month of January: 1/7/23 and 1/30/23, 2. For the month of February: 2/5/23, and 3. For the month of April: 4/22/23, 4/29/23 and 4/30/23. Interview with the Director of Nursing (DON) on 8/28/24 at 11:19 a.m., the DON confirmed there was no RN coverage for eight hours a day on the 1/27/23, 1/20/23, 2/5/23, 4/22/23, 4/29/23, and 4/30/23. During a follow-up interview with the DON on 8/28/24 at 2:11 p.m., the DON stated the risks of no RN coverage for 8 hours a day in the facility was poor oversight of RN supervision.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39939 Based on observation, interview, and record review, the facility failed to monitor and document specific behavior and side effects related to the use of Sertraline (a medication used to treat depression) for one of five sampled residents (Resident 36) being used for a behavior of uncontrollable scratching. This failure placed Resident 36 at risk for not receiving individualized care to address her medical, mental and psychosocial needs. Findings: A review of Resident 36's Admission Record printed on 8/25/24 indicated Resident 36 was admitted to the facility on [DATE]. During an observation and interview with Certified Nursing Assistant (CNA) 2 on 8/25/24 at 9:35 a.m., Resident 36 was lying in bed. CNA 2 stated Resident 36 was not able to communicate her needs and/or understand others. CNA 2 stated Resident 36 had a habit of scratching herself. During a concurrent interview and record review with Director of Nursing (DON) on 8/26/24 at 12:19 p.m., Resident 36's Electronic Health Record (EHR) for Physician orders dated 8/19/24 was reviewed. The EHR indicated to give one tablet of Sertraline HCl Oral tablet 25 mg [milligrams] by mouth one time a day for GAD [generalized anxiety disorder] m/b [manifested by] uncontrollable scratching for 7 [seven] days causing self-inflicted injury. A review of Resident 36's Medication Administration Record (MAR) for 8/2024 indicated, Resident 36 received one tablet of Sertraline 25 mg once a day every day from 8/20/24 through 8/27/24. During a concurrent interview and record review with Licensed Vocational Nurse 6 (LVN 6) on 8/28/24 at 8:35 a.m., Resident 36's EHR for physician orders, nursing progress notes and care plans from 8/19/24 through 8/28/24 were reviewed. LVN 6 stated he was unable to find any documentation for specific behavior monitoring for uncontrollable itching and/or side effects related to the use of Sertraline. LVN 6 stated monitoring the behavior and side effects of the medication should be implemented as soon as Resident 36 was placed on Sertraline on 8/19/24, to evaluate the effectiveness of medication. LVN 6 stated he was the routine morning shift charge nurse for Resident 36, and was not aware if Resident 36 had any changes in behavior of scratching herself since she was placed on this medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's Policy and Procedure (P&P) titled Psychotropic Medication Use dated 7/2022 indicated, A psychotropic medication is any medi[c]ation that effects brain activity associated with mental processes and behavior .Psychotropic medication management includes: a. indications for use; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences .If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50474 Based an observation, interview, and record review, the facility failed to ensure two of 12 sampled residents (Resident 22 and Resident 38) received medications without an error. The facility's medication pass observation during the survey resulted in two errors out of 25 opportunities and indicated a medication error rate of 8 percent (%). This failure placed Resident 22 and Resident 38 at risk for not getting the full therapeutic effect of their prescribed medications and had the potential to result in undesired health outcomes. Findings: During a record review of Resident 22 and Resident 38 Admission Records (AR), dated 8/27/24, AR indicated Resident 22 and Resident 38 had a diagnosis of Type 2 diabetes mellitus (a chronic condition which affects the way body process blood glucose levels). During a record review of Resident 22 and Resident 38's Medication Administration Record (MAR), dated 8/1/2024 through 8/31/2024, the MAR indicated Resident 22 and Resident 38 had orders to administer Metformin (diabetes medication) 1000 milligrams (mg) by mouth two times a day and to administer with meals to prevent gastrointestinal (GI, stomach) upset. During a medication pass observation on 8/25/24 at 4:15 p.m., Licensed Vocational Nurse (LVN) 5 prepared one tablet of Metformin 1000 mg, crushed the medication and mixed with small amount of apple sauce for Resident 22. LVN 5 was observed administering the medication to Resident 22 without offering food or meal. During a medication pass observation on 8/25/24 at 4:38 p.m., LVN 5 prepared one tablet of Metformin 1000 mg for Resident 38.LVN 5 was observed administering Metformin to Resident 38 without offering food or meal. During an interview on 8/25/24 at 4:43 p.m., with LVN 5, LVN 5 stated she gave the medication to Resident 22 without a meal because she was already passing the medication down the hallway. LVN 5 further stated she gave Resident 38 the Metformin because Resident 38 finished personal care and was already sitting up. LVN 5 stated she should have given the Metformin to Resident 22 and Resident 38 with meals. LVN 5 stated it was important to give meals to Resident 22 and Resident 38 prior to administering Metformin because it was a strong medication that regulated the blood sugar and it could have affected their system. During a phone interview on 8/26/24 at 4:07 p.m., with Consultant Pharmacist (CP), CP stated the pharmacy and the manufacturer had always recommended Metformin to be taken with meals to prevent stomach discomfort like diarrhea. During an interview on 8/28/24 10:07 a.m., with the Director of Nursing (DON), the DON stated LVN 5 should have waited for the dinner to arrive prior to giving the Metformin to Resident 22 and Resident 38. The DON stated giving the Metformin without any meal could have affected Resident 22 and Resident 38's blood sugar level. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's policy and procedure (P&P), titled, Administering Medications, dated April 2010, the P&P indicated Medications must be administered in accordance with the orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50474 Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling practices with census of 38 when: 1. Medication refrigerator freezer had multiple ice packs and thick accumulation of ice with yellowish color, 2. Resident 25's glucagon (an injectable emergency medication used to treat very low blood sugar) was stored with eye medications, and 3. an unlabeled bottle of eyewash (a liquid solution used to clean eyes) was stored with liquid oral medications. These failed practices could contribute to unsafe storage of medications and potential for medication error. Findings: 1. During a concurrent observation and interview on 8/25/24 at 10:22 a.m. with Infection Preventionist (IP), the medication refrigerator freezer had multiple ice packs and thick layer of ice buildup. IP stated she did not know why there was so much ice buildup inside the freezer. IP stated the Facility Maintenance Director (FMD), was responsible in cleaning and maintaining the facility's refrigerators including the one they used for medications. During a concurrent observation and interview on 8/25/24 at 10:25 a.m. with FMD, FMD stated the last time he cleaned and maintained the refrigerator was in June 2024. FMD stated he did not have cleaning or maintenance record for the medication refrigerator. FMD stated the medication refrigerator should have been cleaned and maintained every two months. FMD was observed closing the freezer door and FMD stated it was not closing properly because of the ice buildup. FMD further stated if the freezer door was not closing properly, the refrigerator could have had a change in temperature and the medications stored inside could have been affected. During a phone interview on 8/28/24 at 4:10 p.m. with the facility's Consultant Pharmacist (CP), CP stated the facility was responsible in cleaning and maintaining the medication refrigerator. CP stated when the freezer had a thick accumulation of ice buildup, and the door could not be closed properly, it could have caused the freezer to defrost and had a potential to drip on the medications and alter the labels. During a record review of the facility's policy and procedure (P&P), titled, Medication Refrigerator, dated 10/2020, the P&P indicated The refrigerator will be cleaned monthly by housekeeping. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 8/25/24 at 2:47 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 25's glucagon was stored together with the eye medications. LVN 3 stated she did not realize the glucagon was there because it was in the very back of the drawer. 3. During a concurrent observation and interview on 8/25/24 at 2:53 p.m. with LVN 3, an unlabeled bottle of eyewash was stored together with liquid oral medications. LVN 3 stated she did not know who the bottle of eyewash belonged to. During an interview on 8/25/24 at 3:05 p.m. with LVN 3, LVN 3 stated she did not know the facility's protocol for medication storage. During an interview on 8/25/24 at 3:10 p.m., with IP, IP stated the glucagon, and the unlabeled bottle of eyewash should have been stored separately. IP stated storing medications should have been by medication route. IP stated the risk of storing medications with different routes was potential for spread of infection and medication error. During an interview on 8/25/24 at 4:07 p.m. with the facility's Consultant Pharmacist (CP), CP stated the licensed nurses should have stored the medications with different routes separately. CP further stated it had the potential for medication error especially when the unlabeled bottle of eye wash was stored with liquid oral medications. During a record review of the facility's P&P, titled, Storage of Medications, dated April 2007, the record indicated 2) The nursing staff shall be responsible for maintaining medication storage .3) Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 49498 Based on interview and record review, the facility failed to allow one of five sampled residents (Resident 14) to store food brought by family member in the facility's refrigerator. This failure resulted in Resident 14 feeling disappointed. Findings: During an interview on 8/25/24 at 4:13 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the facility does not have a refrigerator to store residents' food brought by family. CNA 1 stated residents who had foods from outside the facility were asked to finish the food if they can and leftovers were thrown away. CNA 1 stated residents were told there was no place to keep leftover foods. During an interview on 8/25/24 at 4:20 p.m. with the Administrator (ADM), the ADM stated the facility does not reheat residents' food brought by family and the food was to be consumed for the day. The ADM stated any remaining food was thrown away and cannot be placed in the kitchen refrigerator. The ADM stated there was no personal refrigerator inside residents' rooms. During an interview on 8/27/24 at 2:01 p.m. with Resident 14 in Resident 14's room, Resident 14 stated her son brought her food sometimes. Resident 14 stated she was told by facility staff that there was no refrigerator to put the leftover food and it made her feel disappointed that if her son brings her something she liked it would be nice to be able to eat it for later. During a review of Resident 14's Minimum Data Set (MDS, an assessment tool used to guide care) dated 6/22/24, the MDS indicated Resident 14 had a Brief Interview for Mental Status (BIMS, a screening tool used to assess cognition) score of 15 out of 15, meaning intact cognition. The MDS indicted Resident 14 was independent with eating. During an interview on 8/28/24 at 9:58 a.m. with the RD, the RD stated there was no refrigerator in the facility to store residents' food brought from outside. During a record review of facility's policy and procedure (P&P) titled, Food For Residents From Outside Sources, dated 2018, the P&P indicated, Food brought in from outside the facility kitchen for resident's consumption will be monitored . Prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the facility kitchen, nursing station's refrigerator or in the residents' personal refrigerator.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46487 Based on interview and record review, the facility administration did not follow their facility policy and procedure when a Registered Nurse's (RN) timecard adjustments for correction for 3 weekend days of April 2023 were done in August of 2024 (after 16 months had passed). This deficient practice had the potential for the residents to not receive the accurate amount of required time of care from an RN. (Cross Reference F727) Findings: Review of the facility's Payroll Based Journal Quarter 3 2023 report dated 4/1/23 to 6/30/23 (facility's staffing information), indicated there was no RN that worked in the facility on 4/22/23(Saturday), 4/29/23(Saturday) and 4/30/23(Sunday), for a minimum of eight hours in a day. During a concurrent interview and record review with Director of Nursing (DON), on 8/27/24, at 9:10 a.m., the RN hours on Skilled Nursing Hours Report records provided by the facility on 8/26/24 dated: 4/22/23, 4/29/23 and 4/30/23 indicated RN 1 worked for four hours on the said dates. DON stated she would confirm if RN 1 only worked for four hours on the dates mentioned. (Skilled Nursing Hours Report or SNHR- are the records of hours worked by the facility licensed nurses and certified nursing assistants for a day) During a review of the second set of SNHR for 4/22/23, 4/29/23 and 4/30/23, provided on 8/27/24 at 11:00 a. m. from the the Director of Staff Development (DSD), the SNHR indicated RN 1's worked hours were changed, from four hours to eight hours on 4/22/23, 4/29/23 and 4/30/23. During an interview with Payroll Director (PD), on 8/27/24, at 11:57 a.m., PD stated she changed RN 1's worked hours from four hours to eight hours on the dates: 4/22/23, 4/29/23 and 4/30/23 on 8/27/24 because she was told by the DSD that RN 1 worked eight hours on the said dates. PD further stated, she did not verify RN 1's worked hours before she changed the SNHR. During a concurrent interview and record review with the DSD, on 8/27/24, at 12:00 p.m., DSD was asked why RN 1's documented worked hours were changed from four hours to eight hours on the dates: 4/22/23, 4/29/23 and 4/30/23 in the SNHR she provided. DSD stated, RN 1 worked for eight hours on the said dates but did not punch in correctly. During a concurrent interview and record review with PD on 8/28/24, at 9:54 a.m., RN 1's employee timecard report dated 4/16/23 to 4/30/23 and paycheck copy for pay period 4/16/23 to 4/30/23 were reviewed. The RN 1's timecard indicated RN 1 worked for 90.50 hours, but RN 1's paycheck copy indicated she was paid 73 hours. PD acknowledged she changed RN 1's timecard hours because she was told by the DSD to change it on 8/27/24. Further stated it was not the practice of the facility payroll to change the employees' timecard after 16 months have passed (time passed from April 2023 until August 2024) for employees' time correction. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent joint interview and record review with DON and DSD on 8/28/24, at 11:29 a.m., the signatures of RN 1 in the missed punch forms for the dates: 4/22/23, 4/29/23 and 4/30/23 were reviewed and were compared to the signatures of RN 1 in her personnel file (a file that stores all the necessary paperwork associated with each staff member's employment). DON acknowledged the signatures in RN 1's personnel file and RN 1's signatures in the missed punched forms dated 4/22/23, 4/29/23 and 4/30/23 did not match. DON stated the DSD found RN 1's missed punch forms from April of 2023 in a binder in the DON's office on 8/27/24. DON denied she recently signed the missed punch forms. DON stated she was aware that the DSD asked the PD to change RN 1's timecard from 4 hours worked to 8 hours worked for the following dates: 4/22/23, 4/29/23 and 4/30/23 on 8/27/24. During a phone interview with RN 1 on 9/3/24 at 4:40 p.m., RN 1 stated she only worked in the facility for one hour on the weekends to administer intravenous antibiotics (IV antibiotics- medications that fight infection and is given through a vein to enter the bloodstream immediately. These medications are ordered by the physician and are given by an RN). RN 1 stated she did not punch in when she worked on the weekends because she only came in for an hour to administer the IV antibiotics to a resident and the facility agreed to pay her for four hours. RN 1 stated she only signed in the facility attendance binder, and she entered four hours worth of time worked. RN 1 stated she did not sign any missed punch forms to correct her time. RN 1 stated she was paid with the correct hours and was paid on time by the facility last year. During an interview with the Administrator (ADM) on 8/28/24 at 12:56 p.m., the ADM stated he was not aware of who made the missed punch forms. A review of the facility's daily attendance sheets with RN 1's signatures dated: 4/22/23, 4/29/23 and 4/30/23 indicated RN 1 signed in for four hours of work during the 7:30 a.m. to 3:30 p.m. shift on 4/22/23, 4/29/23, and 4/29/23. During a review of the facility's policy and procedure (P&P) titled, (Payroll and Paychecks), the P&P indicated, Should an error occur on an employee's paycheck, an adjustment will be made on the next regularly scheduled pay period . Salary adjustments or errors must be reported to the Administrator and Accounting Office within 30 days of their occurrence for corrective action .

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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. 50474 Based on observation, interview, and record review, the facility failed to ensure accuracy of medical record for one of one sampled resident (Resident 40), when a physician order to implement bed rails (a barrier attached to the side of a bed) was created on 8/27/24 for a four-month older date, 4/13/24 without any verification. This failure resulted in inaccurate reflection of physician orders to implement bed rails for Resident 40. Findings: During a record review of Resident 40's Admission Record dated 8/28/24, AR indicated Resident 40 was admitted to the facility with diagnosis of post hemorrhagic anemia (large volume blood loss). During an observation and interview on 8/27/24 at 9:37 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 40 was observed lying in his bed with both half-sized bed rails were raised. LVN 6 stated the half-sized bed rails was provided by the hospice agency (a program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions.). During a concurrent record review and interview on 8/27/24 at 12:21 p.m. with the Director of Nursing (DON), Resident 40's Electronic Health Record (EHR) was reviewed. Resident 40's Audit details showed physician order for bed rails dated 4/13/24 was Created on 8/27/24 at 9:58 a.m. and Created by - DON. The DON stated she created and backdated the physician's order for the use of bed rails for Resident 40 to a four-month prior date because the facility did not have an order in their EHR system. The DON stated she was unable to provide a documentation the Medical Doctor (MD) was informed about creating and backdating the order for the bed rails. The DON stated she should have not backdated a physician's order and should have dated it on the day she received the order. The DON stated back dating an order meant not following the physician orders accurately. During an interview on 8/29/24, at 1:21 p.m., the Administrator (ADM) stated he was not aware the DON created and backdated a physician order for use of bed rails for Resident 40 on 8/27/24 for 4/13/24 start date. The ADM stated the DON should have not backdated the physician's order. The ADM stated the risk of changing a document inaccurately and backdating a physician order could have led to falsification of documents. During a record review of facility's Policy and Procedure (P&P), titled, Charting and Documentation, dated August 2008, the P&P indicated Entries may only be recorded .in accordance with state law and facility policy.

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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. 50474 Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices when: 1. two dryers' lint trap compartments were full of lint, and 2. a glucometer (a device used to check blood sugar level) device was not cleaned and disinfected properly according to the manufacturer's instructions and standards of practice. This failure had the potential to spread infectious diseases to all residents. Findings: 1. During an observation and interview on 8/25/24 at 11:35 a.m. with the Environmental Services Supervisor (ESS) in the facility's laundry room, ESS stated the facility used the two dryers alternatively for drying residents' clothes. ESS was observed opening Dryer #1 and Dryer #2's lint trap compartments and both dryers had thick accumulation of lint inside. ESS stated the lint trap compartments should have been cleaned every two hours by the laundry staff. ESS stated the facility did not have any documentations that the dryers were being cleaned and maintained regularly. ESS stated not maintaining the dryers and having accumulated lint in the trap compartment was potential for fire. During an interview on 8/26/24 at 12:42 p.m., with Infection Preventionist (IP), IP stated having too much lint trapped in the dryers may cause respiratory diseases or infection to the residents. During a record review the Policy and Procedure (P&P), titled, Laundry and Bedding, Soiled, dated September 2022, the document indicated Soiled laundry/bedding shall be handled, transported, processed according to best practices for infection prevention control .Laundry equipment (e.g., washing machines, dryers) is used and maintained according to the manufacturer's instructions for use to prevent microbial contamination of the system. 2. During an observation on 8/25/24 at 3:34 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed placing the glucometer, single use lancet (a small, sharp, needle device used to obtain small blood samples for testing), bottle of test strip, and alcohol pads on top of the medication tray. LVN 4 entered Resident 20's room and placed the medication tray on Resident 20's bed. LVN 4 poked Resident 20's right pointer finger to get blood on the test strip and measured the blood sugar. LVN 4 then placed the used glucometer with contaminated test strip and lancet to the medication tray. LVN 4 returned to the medication cart and was observed wiping the glucometer with a single alcohol pad for less than 5 seconds then placed it immediately inside the medication cart drawer. During an interview on 8/25/24 at 3:55 p.m., with LVN 4, LVN 4 stated she only used alcohol pad to clean the glucometer after using it for Resident 20's blood sugar check because she was in a hurry. LVN 4 stated she should have cleaned and disinfected the glucometer with the facility's approved disinfectant wipes called Micro-Kill Bleach, LVN 4 stated the risk of not cleaning and disinfecting the glucometer appropriately was potential for spread of infection. (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 8/26/24 at 12:38 p.m. with IP, IP stated licensed nurses were expected to clean and disinfect the glucometer after each use with the facility's approved disinfectant wipe called Micro-Kill One Germicidal Alcohol Wipes and not with alcohol pads or bleach wipes. IP stated when cleaning the glucometer, the licensed nurse should have used one wipe to clean all areas, and another wipe to disinfect and wait for one minute to kill the germs. IP stated not cleaning and disinfecting the glucometer properly after each use was potential for infection. During a record review of the facility's P&P, titled, Obtaining a Fingerstick Glucose Level, dated October 2011, the P&P indicated, Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. During a record review of the facility's glucometer Self-Monitoring Blood Glucose System Owner's Manual, the document indicated, With ONLY Super Sani-Cloth Wipes .To Clean .rub the entire outside of meter using 3 circular wiping motions with moderate pressure on front, back, left side, right side, top and bottom. Discard used wipes .To Disinfect .Using a fresh wipe, make sure all the outside surfaces of the meter remain wet for 2 minutes. Let meter air dry thoroughly .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055677	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Skilled Nursing Center	535 School Street Pittsburg, CA 94565

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46487 Based on observation and interview, the facility failed to provide residents with at least 80 square feet (sq. ft.) per resident for rooms occupied by multiple residents for 12 of 20 rooms (Rooms 3, 4, 5, 7, 9, 10, 12, 15, 17, 18, 19, and 20). The failure had the potential for reduced space for staff to deliver care and lack of sufficient space for storage of residents' belongings. Findings: Based on an observation on 8/26/24, at 9:46 a.m., with the Facility's Maintenance Director (FMD), the following rooms and corresponding square footage (sq. ft.) were identified: 1. Room three was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 2. Room four was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 3. Room five was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 4. Room seven was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 5. Room nine was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 6. Room ten was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 7. room [ROOM NUMBER] was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 8. room [ROOM NUMBER] was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 9. room [ROOM NUMBER] was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 10. room [ROOM NUMBER] was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055677	A. Building B. Wing	08/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	11. room [ROOM NUMBER] was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. 12. room [ROOM NUMBER] was a total of 225.36 sq. ft. and had three beds making for 75.1 sq. ft. of space per resident. During observation of care and services from 8/25/24 through 8/28/24, there was sufficient space for provision of care for residents in all rooms. There was no heavy equipment stored in the rooms that could interfere with residents' care, and each resident had adequate personal space and privacy. There were no complaints from residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the 12 rooms. Granting of room size waiver recommended.