STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055689	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Healthcare	245 E Wilshire Avenue Fullerton, CA 92832

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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 0552 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, and facility P&P review, the facility failed to properly obtain the informed consents (permission granted in the knowledge of the possible consequences) for the use of psychotropic medications (medications affecting brain activity) and treatments from the responsible party (person designated to make decisions on behalf of the residents) for one of 18 final sampled residents (Resident 23). This failure posed the risk for Resident 23 and their responsible parties to not be informed of their medications and the potential side effects. Findings: Review of the facility's P&P titled Care and Treatment, Informed Consents revised 5/19 showed the residents who has a physician's order related for the use of psychotropic medications should not be initiated until an informed consent was obtained. Medical record review for Resident 23 was initiated on 9/25/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Physician Progress Note dated 9/3/24, showed Resident 23 was seen by the physician and the resident appeared more anxious and in visible pain. The physician planned to increase the dose of diazepam (antianxiety medication) medication. Review of Resident 23's Physician's Order dated 9/3/24, showed to increase the dose of diazepam from 10 mg to 15 mg twice a day for anxiety for 14 days. Review of the Facility Verification of Informed Consent for the use of diazepam medication dated 9/3/24, showed the informed consent was obtained for diazepam 10 mg dose; however, there was no documented evidence the informed consent was obtained for the ordered increased dose of 15 mg. On 9/26/24 at 1152 hours, an interview and concurrent medical record review for Resident 23 was conducted with LVN 1. LVN 1 verified Resident 23's physician's order for the use of diazepam medication and verified the increased dose of the medication was ordered. LVN 1 stated the increase of the diazepam medication dose was due to the resident's anxiety. LVN 1 verified the informed consent for the use of diazepam medication should have been obtained when the dose of the medication was increased. On 9/26/24 at 1521 hours, an interview and concurrent medical record review for Resident 23 was conducted with the DON. The DON was informed and verified the above finding.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine if it was safe for one of 18 final sampled residents (Resident 77) to self-administer medications. * Resident 77 was observed to have medications inside a medicine cup at the bedside. Resident 77 did not have an assessment, a physician's order, or a care plan problem addressing the self-administration of medications. This faiure had the potential for Resident 77 to administer medications inaccurately. Findings: Review of the facility's P&P titled Self Administration of Medications dated 2/2021 showed it is the policy of the facility to respect the wishes of alert, competent residents to self-administer prescribed as allowable under state regulations. If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. If the resident is a candidate for self-administration of medications, this will be indicated in the chart. Appropriate notation of these determinations will be placed in the resident's care plan. On 9/23/24 at 0829 hours, an observation and concurrent interview was conducted with RN 1. Multiple medications inside a medicine cup was observed at Resident 77's bedside. RN 1 verified the findings and acknowledged he should not have left the medications at Resident 77's bedside. Medical record review for Resident 77 was initiated on 9/23/24. Resident 77 was admitted to the facility on [DATE]. Review of Resident 77's H&P examination dated 5/25/24, showed Resident 77 had the capacity to understand and make decisions. Review of Resident 77's medical record failed to show documented evidence of the following for Resident 77 to safely self-administer medications: - a physician's order, - assessment, and - a care plan problem addressing Resident 77's self-administration of medications. On 9/24/24 at 1512 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 77 did not have a self-administration of medication assessment, physician's order, or care plan in place.

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F 0578 Level of Harm - Potential for minimal 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to obtain and maintain copies of the advance directive in the medical record for one of 18 final sampled residents (Resident 10). This failure had the potential for confusion or failure to provide care and life sustaining measures in accordance with the residents' treatment wishes. Findings: Review of the facility's P&P titled Advance Directives revised ,d+[DATE] showed it is the policy of the facility that a resident's choice about advance directives will be recognized and respected. Prior to, upon, or immediately after admission, the Social Services staff or through IDT meeting will ask residents and/or their family members, about the existence of any advance directives. Should the resident indicate that he or she has issued advance directives about his/her care and treatment, the facility will require that a copy of such directives be included in the medical record. The care plan team will periodically, at least quarterly, annually, and on any change of condition, review the advance directive and/or preferences regarding treatment options with the resident if his/her representative to ensure that they are still the wishes if the resident. Medical record review for Resident 10 was initiated on [DATE]. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Physician Orders for Life-Sustaining Treatment (POLST) dated [DATE], under Section A- Cardiopulmonary Resuscitation (CPR), showed the option for Do Not Resuscitate/DNR to allow natural death was selected; under Section B- Medical Interventions showed Comfort-Focused Treatment was selected with additional orders to administer oxygen only; and under Section- D Information and Signatures showed advance directive was selected. The form was signed by Resident 10's family member. Review of Resident 10's H&P examination dated [DATE], showed Resident 10 could make some needs known but could not make medical decisions. Review of Resident 10's Order Summary dated [DATE], showed a physician's order dated [DATE], for Resident 10's code status as DNR, comfort treatment, and no tube feeding. Review of Resident 10's annual Social Services Assessment/Evaluation dated [DATE], under the section for Advance Directives- the Resident has issued advance directives about his/her care and treatment, showed Yes was selected. Additionally, a note showed to obtain a copy of such directives to be included in the resident's medical record. Review of Resident 10's readmission Social Services Assessment/Evaluation dated [DATE], under the section Advance Directives- the Resident has issued advance directives about his/her care and treatment, showed Yes was selected with instructions to obtain a copy of such directives to be included in the resident's medical record. (continued on next page)

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 10's medical record failed to show a copy of Resident 10's advance directive. There was no documentation showing the facility had followed up to obtain a copy of Resident 10's advance directive. On [DATE] at 1329 hours, an interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD verified the above findings. On [DATE] at 1017 hours, an interview was conducted with the DON. The DON stated the advance directives were the residents' wishes for health care decisions in the event the resident was no longer capable of making decisions on their own. The DON stated upon admission, the residents were asked if they had formulated an advance directive. If they did, the social worker was responsible to follow-up to obtain a copy and would document their attempts to follow-up. The DON was informed and acknowledged the above findings.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure recommendations from the Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) level II determination was followed up, as per the facility P&P and incorporated into the resident's plan of care for one of two final sampled resident (Resident 8) reviewed for PASARR. This failure had the potential for Resident 8 not receiving the adequate care that was recommended by PASARR level II determination and evaluation report assessed by an appropriate state-designated authority. Findings: Review of the facility's P&P titled PASRR revised 7/22 showed after admission IDT members will review the Level I PASRR assessment for accuracy and the need for PASRR Level II referral. Based upon the assessment, the facility would ensure proper referral to appropriate state agencies for the provision of specialized services to residents with intellectual disabilities or related conditions or serious mental illnesses. Social services shall contact the appropriate State Agency for referral of specialized care and services the resident may require. Review of the facility's P&P titled Comprehensive Resident Centered Care Plan revised 1/21 showed a comprehensive person-centered care plan would be developed and implemented for each resident. Medical record review for Resident 8 was initiated on 9/23/24. Resident 8 was admitted to the facility on [DATE], and readmitted in 12/17/22, with the diagnosis of schizophrenia, anxiety disorder, and major depressive disorder. Review of the letter sent to Resident 8 by the Department of Health Care Services dated 1/9/23, showed the PASARR Level II Evaluation was conducted on 1/7/23. The letter also showed the facility staff would receive the copy of the determination report and discuss the result with Resident 8 and would incorporate the recommendations into Resident 8's care plan. Review of Resident 8's PASARR Individualized Determination Report dated 1/9/23, showed Resident 8 required nursing facility services due to a medical and/or mental health condition. The PASARR Individualized Determination Report further showed special services were recommended. The report showed the Determination Report was based on a review of Resident 8's medical and social history which showed a significant medical condition with mental stressors that require nursing care. Review of Resident 8's H&P examination dated 1/23/24, showed Resident 8 had the capacity to understand and make decisions. Review of the Resident 8's medical record did not show the recommendations from the PASARR Individualized Determination Report was followed up. Review of the Resident 8's plan of care failed to show a care plan problem addressing the recommendations from the PASARR Individualized Determination Report. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 1428 hours, an interview and concurrent medical record review for Resident 8 was conducted with the MDS Coordinator. The MDS Coordinator stated when the Level I Screening was positive, the Department of Health Care Services would contact the facility to conduct a Level II Determination. Once the determination was complete, the facility would obtain and print the determination results and incorporate the recommendations into the resident's plan of care. The MDS Coordinator further stated each resident would have an individualized PASARR care plan to addressed the specific PASARR recommendations. The MDS Coordinator verified the above findings and stated she was unable to find the documentation the results of the determination were discussed with Resident 8, and was unable to find documentation an IDT meeting was conducted to discuss the PASARR level II recommendations for Resident 8. On 9/26/24 at 1034 hours, an interview was conducted with the DON. The DON was informed and acknowledge the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate care and services were provided related to the use of a GT for one of 18 final sampled residents (Resident 65). * The facility failed to ensure Resident 65's GT was checked for placement prior to medication administration, flushed with at least 5 ml of water between each medication as per the facility's P&P, and flushed with 20 to 30 ml of water following medication administration as per the physician's order. This failure had the potential for GT blockage affecting the resident's health and well-being. Findings: Review of the facility's P&P titled Medication Administration - Enteral Tubes dated 1/2019 showed the facility assures the safe and effective administration of enteral formulas and medications. Enteral tubes are flushed before administering medications and after all medications have been administered with at least 30 ml of water. The P&P also showed to verify the tube placement and administer each medication separately, flushing tube with at least 5 ml of water after each dose. On 9/24/24 at 0835 hours, an observation of the medication administration for Resident 65 was conducted with LVN 1. LVN 1 stated Resident 65's medications had to be administered via the GT. LVN 1 prepared and administered Resident 65's medications via the GT. During the observation of the medication administration with LVN 1 for Resident 65, LVN 1 failed to do the following for Resident 65: - check placement of the GT prior to medication administration, - flush the GT with at least 5 ml of water between each medication, and - flush the GT with 20-30 ml of water following medication administration. Medical record review for Resident 65 was initiated on 9/23/24. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 65's Order Summary Report dated 9/24/24, showed a physician's order dated 7/4/24, to check the tube placement before the medication administration and flush the tubing with 20 to 30 ml of water after the medications. On 9/24/24 at 1220 hours, an interview was conducted with LVN 1. LVN 1 verified the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services related to a PICC line for one of 18 final sampled residents (Resident 537). * The facility failed to obtain the measurement of the right upper arm circumference upon admission and dressing changes. In addition, the facility failed to develop a care plan problem to address the use of a PICC line catheter. These failures posed the risk for the resident to development complication such as catheter migration and dislodgement. Findings: According to the literature titled Nursing Advanced Skills dated 2023 in the National Library of Medicine's database, showed if a PICC line is in place, arm circumference is also measured each shift and results compared to previous readings. If arm circumference consistently increases, a deep vein thrombosis may be suspected. Accurate documentation of site assessment and related monitoring are essential. Medical record review for Resident 537 was initiated on 9/23/24. Resident 537 was admitted to the facility on [DATE]. On 9/23/24 at 0817 hours, Resident 537 was observed with a PICC line on the right upper arm covered with a transparent dressing. Review of Resident 537's Order Summary Report dated 9/25/24, showed the physicians orders dated 9/4/24, for PICC catheter, measure the external catheter with the site dressing every day shift every seven days and Meropenem (antibiotic) 1 gram intravenously every 12 hours for leukocytosis (a condition where there are abnormally high levels of white blood cells in the blood). Review of Resident 537's Order Summary Report dated 9/25/24, showed a physician's order dated 9/5/24, for daptomycin-sodium chloride (antibiotic) 700 mg intravenously one time a day for leukocytosis/MRSA of wound. Further review of Resident 537's medical record failed to show the documentation of the measurements of Resident 537's right arm circumference and a care plan problem addressing Resident 537's use of a PICC line catheter in place. On 9/25/24 at 0922 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the above findings and stated they did not measure the arm circumference for the resident's PICC line.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain and maintain the highest well-being for one of 18 final sampled residents (Resident 63). * The facility failed to monitor Resident 63's fluid restriction as per the physician's order. In addition, the facility failed to ensure Resident 63's dialysis access site was assessed prior and after dialysis treatments. These failures had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Dialysis (Renal), Pre and Post Care revised 1/2020 showed it is the policy of the facility to assist resident in maintaining homeostasis pre- and post-renal dialysis, assess and maintain patency of renal dialysis access, and assess resident daily for function related to renal dialysis. Dialysis access should be assessed upon return to the facility for patency, and any unusual redness or swelling. Documentation: assess care given, and condition of renal dialysis access. Medical record review for Resident 63 was initiated on 9/23/24. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease with dependence on renal dialysis with a dialysis accesss site of a right upper chest permacath (a flexible tube that's inserted into a blood vessel in the neck or upper chest and used for dialysis or other medical procedures). Review of Resident 63's Order Summary Report dated 9/25/24, showed a physician's order dated 4/17/24, for dialysis three times a week on Mondays, Wednesdays, and Fridays at the outpatient dialysis center. a. Review of Resident 63's Order Summary Report dated 9/25/24, showed a physician's order dated 10/20/23, to monitor intake and output every shift and on fluid restriction of 1200 ml per 24 hours. Review of Resident 63's Intake and Output Record showed the resident's fluid intake amount was more than 1200 ml on the following dates: - 8/5/24, 1420 ml - 8/6/24, 1220 ml - 8/9/24, 1300 ml - 8/11/24, 1220 ml - 8/15/24, 1220 ml (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/17/24, 1500 ml - 8/18/24, 1500 ml - 8/27/24, 1320 ml - 9/1/24, 1420 ml - 9/3/24, 1320 ml - 9/5/24, 1340 ml - 9/7/24, 1300 ml - 9/8/24, 1300 ml - 9/15/24, 1220 ml - 9/17/24, 1300 ml - 9/18/24, 1300 ml - 9/19/24, 1320 ml Further review of Resident 63's Intake and Output Record failed to show for the documentation of the fluid intake for the following dates and shifts: - 8/20/24, 3-11 shift - 8/21/24, 3-11 shift - 8/22/24, 7-3 shift - 8/23/24, 7-3 shift - 8/25/24, 3-11 shift b. Review of Resident 63's Dialysis Communication Records failed to show an assessment of the dialysis site was done for the following dates: - 7/1/24, pre-dialysis - 7/31/24, post-dialysis - 8/21/24, pre-dialysis - 8/30/24, pre and post-dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/18/24, pre-dialysis - 9/20/24, pre-dialysis - 9/25/24, pre-dialysis On 9/26/24 at 1037 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified and acknowledged the above findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement alternative measures prior to the use of bed rails for two of 18 final sampled residents (Residents 63 and 537). This failure created the potential to put the residents at risk for entrapment and serious injury. Findings: Review of the facility's P&P titled Bedrail Assessment revised 8/2017 showed it is the policy of the facility to attempt to use appropriate alternatives prior to installing a side or bed rail. After the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the resident's assessment needs, the facility IDT will assess the resident for risks of entrapment and possible benefits of using the bed rail. 1. On 9/23/24 at 0800 hours, Resident 63 was observed sitting on the bed with the bilateral bed rails elevated. Medical record review for Resident 63 was initiated on 9/23/24. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 63's Order Summary Report dated 9/25/24, showed a physician's order dated 10/30/23, for bilateral half side rails as enabler for bed mobility and positioning. Review of Resident 63's Bed Rail Safety Evaluation dated 8/22/24, failed to show any alternative interventions were attempted prior to the bed rail use. 2. On 9/23/24 at 0817 hours, Resident 537 was observed lying in bed with the bilateral bed rails elevated. Medical record review for Resident 537 was initiated on 9/23/24. Resident 537 was admitted to the facility on [DATE]. Review of Resident 537's Order Summary Report dated 9/25/24, showed a physician's order dated 9/4/24, for bilateral grab bars as enabler for bed mobility and positioning. Review of Resident 537's Bed Rail Safety Evaluation dated 9/4/24, failed to show any alternative interventions were attempted prior to the bed rail use. On 9/26/24 at 1034 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified and acknowledged the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 18 final sampled residents (Resident 7) was provided the medications as ordered by the physician. * The facility failed to ensure Resident 7 had a physician's order for nasal moisturizing spray. This failure had the potential of not meeting the resident's needs. Findings: Review of the facility's P&P titled Administration of Drugs revised 2/2022 showed it is the policy of the facility that medications shall be administered as prescribed by the attending physician. Medications must be administered in accordance with the written orders of the attending physician. On 9/25/24 at 0930 hours, Resident 7 was observed to have three bottles of Nasal Moisturizing Spray inside her bedside top drawer. Medical record review for Resident 7 was initiated on 9/25/24. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Self-Administration of Medications Evaluation dated 8/23/24, showed the IDT had determined that it was safe for the resident to self-administer medications. Review of Resident 7's MDS Section C dated 8/28/24, showed Resident 7 had no cognitive impairment. Review of Resident 7's Order Summary Report dated 9/26/24, showed a physician's order dated 9/23/24, for resident may self-administer medications and keep medications at bedside. However, further review of Resident 7's Order Summary Report failed to show a physician's order for use of the nasal moisturizing spray. On 9/26/24 at 1300 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified and acknowledged the above findings.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Healthcare	245 E Wilshire Avenue Fullerton, CA 92832

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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** 46787 Based on observation and interview, the facility failed to ensure for the safe storage of the medications and supplies. * The IV Cart was observed to contain the expired supplies along with other supplies without a manufacturing or expiration date. * An opened bottle of Gerilanta (a laxative medication) was observed in Medication Cart 2 with no open date. These failures had the potential to result in unsafe administration of the medications. Findings: a. On [DATE] at 0827 hours, an inspection of the IV Cart was initiated with RN 4. The following items were observed in the IV Cart: - 78 Red Plus Luer Lock Caps with no manufacturing or expiration dates, - five [NAME] Vial Mate Adapter with no manufacturing or expiration dates, - seven BD Vacutainer Luer Lock Access Device with no manufacturing or expiration dates, - two BD Blue Insyte Autoguard Winged Catheters with the expiration dates of [DATE] and [DATE]. RN 4 verified the above findings. b. On [DATE] at 1135 hours, an inspection of Medication Cart 2 was initiated with LVN 2. One opened bottle of Gerilanta was observed without an open date documented on the bottle. LVN 2 verified the findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menus were followed when fortified (additional nutrients added through foods such as butter and cream) diets were not followed for one nonsampled resident (Resident 19). This failure had the potential for Resident 19 to not receive the diet as planned which may lead to compromised nutritional status. Findings: Review of the facility's P&P titled Fortification of Food: Increasing Calories and/or Protein in the Diet dated 2023 showed the enrichment of foods would be done on an individual basis for residents who cannot consume adequate amounts of calories and/or protein to sustain their weight or nutrition status. Identification of the residents in need of fortification would be done by the facility RD or the FNS Director. The physician would then order a fortified diet. Calories and/or protein would be added to selected foods. The facility RD or FNS Director would select the fortification method from the list provided for foods commonly agreed upon to be consumed or utilize the Healthcare Menus Direct, LLC's Fortified Menu Plan. Review of the facility's document titled Fall Menus for Week 4- Tuesday 9/24/24, showed the following items served for lunch on 9/24/24: Pacific Rim Pork Roast with Pacific Rim gravy, red beans and rice, carrots with parsley, tossed green salad, and apple bread pudding. Review of the facility's document titled Healthcare Menus Direct LLC for Week 4-Fall 2024 showed for Tuesday, to add 1/2 oz of melted margarine to the red beans and rice entree, to fortify the entree. Medical record review for Resident 19 was initiated on 9/24/24. Resident 19 was admitted to the facility on [DATE], with a diagnosis of unspecified protein-calorie malnutrition. Review of Resident 19's Order Summary Report dated 9/25/24, showed a physician's order dated 8/5/24, for fortified, puree texture diet with nectar thick consistency. On 9/24/24 at 1245 hours, an observation was conducted of the lunch meal tray line with the DSS. The DSS was asked how the entrees were fortified for fortified diet orders. The DSS stated the butter or margarine would be added to the entrees. The DSS further stated the cooks followed a set menu which was indicated for each specific day and meal, the instructions on how to fortify the entree. An observation of Resident 19's lunch tray was conducted with the DSS. Resident 19's meal ticket showed Resident 19's diet was pureed, fortified, and nectar thick fluid. The DSS verified Resident 19's bean and rice entree did not have the margarine. The DSS stated the cook should have added the margarine prior to the tray being delivered. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 1040 hours, an interview was conducted with the DON. The DON stated the purpose of a fortified diet was because some of the residents required more caloric intake. The DON stated she expected the residents who were ordered a fortified diet to receive a fortified meal trays and the potential risks of not receiving fortified meals as ordered would be not meeting their required caloric intake and weight loss. On 9/26/24 at 1430 hours, an interview was conducted with the Administrator, DON, and DSS. The Administrator, DON, and DSS were informed and acknowledged the above findings.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure dietary texture guidelines were followed as per the facility's P&P, for one nonsample resident (Resident 19) who was on a pureed diet. This failure had the potential to lead to choking or aspiration (a condition in which food, liquids, saliva, or vomit is breathed into the airway) for Resident 19. Findings: Review of the facility's P&P titled Regular Pureed Diet dated 2020 showed the pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape. Medical record review for Resident 19 was initiated on 9/24/24. Resident 19 was admitted to the facility on [DATE], with a diagnosis of dysphagia (difficulty swallowing), oropharyngeal phase (from the oropharynx to the esophagus). Review of Resident 19's Order Summary Report dated 9/25/24, showed a physician's order dated 8/5/24, for fortified, puree (mashed potato consistency) texture diet with a nectar thick consistency. On 9/24/24 at 1245 hours, during the lunch meal tray line, an observation of Resident 19's lunch tray was conducted with the DSS. Review of Resident 19's lunch meal ticket showed Resident 19 was on a pureed, fortified, and nectar thick liquid diet. An observation of Resident 19's lunch tray showed a scoop of pureed pork with gravy and beans and rice. The beans and rice on the plate were observed running into the scoop of the pureed pork with gravy. When asked about the consistency, the DSS stated the pureed entree should hold shape. The DSS further stated the beans and rice was runny. On 9/26/24 at 1430 hours, an interview was conducted with the Administrator, DON, and DSS. The Administrator, DON, and DSS were informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen when: * The facility failed to ensure the thawing process for meats was followed as per the facility's P&P. * The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions. * The facility failed to ensure the food preparation equipment were in good condition. * The facility failed to remove a bag of ham with freezer burns. * The facility failed to ensure a food preparation sink had an air gap for back flow prevention. These failures had the potential to pose the risk for exposure to food-borne illnesses in a medical vulnerable population of 86 that received food prepared in the kitchen. Findings: Review of the facility's document titled Diet Order Tally Report- All Special Diets dated 9/3/24, showed 86 of 90 residents received food prepared in the kitchen. 1. Review of the facility's P&P titled Thawing of Meats dated 2023 showed thawing the meat could be done in a refrigerator at 41 degrees F (Fahrenheit) or colder. Allow two to three days to defrost, depending on quantity and total weight of meat. To label defrosting meat with the pull and use-by date. Further review of the facility's P&P showed once thawed, uncooked meat was to be used within two days. Review of the facility's P&P titled Labeling and Dating of Foods dated 2023 showed once daily, the PM [NAME] and/or PM Diet Aide would be responsible to inspect the refrigerators and discard perishable foods that are TCS in order to ensure food safety. On 9/23/24 at 0800 hours, during the initial kitchen tour, an interview and concurrent observation of Refrigerator 2 was conducted with the DSS. A clear bag of thawed chicken labeled with an out date of 6/21/24, and a use-by date of 6/22/24, was observed. The DSS verified the above finding. The DSS stated the cooks were responsible for checking the items in the refrigerator at the end of each day. The DSS further stated, per the label on the bag, the thawed chicken should have been discarded yesterday. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/24 at 0935 hours, an interview was conducted with [NAME] 2. [NAME] 2 stated the process for the thawing of the meat was to remove the meat from the freezer and label with the date the meat was removed (from the freezer) and the use-by date. [NAME] 2 stated the thawed meat was good for three days from the date it was removed from the freezer. [NAME] 2 further stated the cooks are responsible for checking the refrigerator every day in the morning and at the end of the day. When asked about the thawed chicken found in the refrigerator, [NAME] 2 stated she was the person who labeled and placed the chicken in the refrigerator to thaw. [NAME] 2 stated she had removed the chicken from the freezer on 9/20/24 and verified she incorrectly labeled the date on the chicken. 2. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Review of the facility's P&P titled Sanitation dated 2023, showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. The kitchen staff was responsible for all the cleaning with the exception of ceiling vents, light fixtures, and the hood over the stove, which will be cleaned by maintenance staff. a. On 9/23/24 at 0800 hours, during an initial tour of the kitchen, the following items were observed: - Two large plastic bins were observed storing clean cooking utensils. The bins were observed with multiple dry particles at the inner base. A paper towel was used to wipe the inner bottom of the bins and small particles were observed on the paper towel. - The plate warmer was observed holding plates, however the inner bottom compartment was observed with white debris of various sizes and pieces of a broken plate. The DSS verified the above findings. On 9/26/24 at 1110 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for cleaning the base of the plate warmer, upon notification by the kitchen staff. The Maintenance Director stated he had not been informed to clean the plate warmer in the past week. b. On 9/24/24 at 1115 hours, an observation and concurrent interview was conducted with the DSS. The following was observed: - The fan inside of Refrigerator 1 was observed with brown fuzzy substances. A paper towel was used to wipe the fan and brown residue was observed on the paper towel. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The fan inside Refrigerator 2 was observed with dark brown substances. A paper towel was used to wipe the fan and was observed with brown fuzzy substance on the paper towel. - Two of two fans inside Refrigerator 3 were observed with gray fuzzy substances. The fans were observed directly over the oranges and plastic container of strawberries. - Two of two fans inside Freezer 2 were observed with black fuzzy substances. The DSS verified the above findings. 3. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. The kitchen staff was responsible for all the cleaning with the exception of ceiling vents, light fixtures, and the hood over the stove, which will be cleaned by maintenance staff. a. On 9/23/24 at 0800 hours, during an initial tour of the kitchen, two cutting boards were observed heavily marred with knife marks. The DSS verified the findings. b. On 9/24/24 at 0924 hours, a white spatula was observed with cracks. The DSS verified this finding. 4. Review of the facility's P&P titled Procedure for Freezer Storage dated 2023 showed to store the frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn. On 9/23/24 at 0800 hours, during an initial tour of the kitchen, an observation of Freezer 3 and concurrent interview was conducted with the DSS. A bag of frozen sliced ham was observed with freezer burn (a condition caused by air reaching the surface of the food). The DSS verified the finding. 5. According to the USDA Food Code 2022 5-402.11 Backflow Prevention, (A) a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Accident Prevention- Safety Precautions dated 2023 showed if a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system. An air gap is the most reliable backflow prevention device. All steam tables, ice machines and bins, food preparation sinks, display cases, soda fountains, espresso machines, and other equipment that discharge liquid waste and condensate shall be drained through an air gap into an open floor sink. On 9/23/24 at 0800 hours, during an initial tour of the kitchen, a food preparation sink near Refrigerator 2 was observed without an air gap. The DSS verified the finding and stated the sink was used to wash vegetables and fruits. On 9/26/24 at 1430 hours, the Administrator, DON, and DSS were notified and acknowledged the above findings.

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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. 48882 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the education was provided to the staff and family/visitor on safe food handling of outside food as per the facility's P&P. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from outside sources. Findings: Review of CMS S&C-09-39 dated 5/29/09, showed the residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. The CMS guideline further shows the facility has the responsibility under the food safety regulation to help the visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Review of the facility's P&P titled Foods Brought by Family and Visitor revised 7/21/21, showed foods brought to a resident by family/visitors must be accepted by the resident, inspected before facility storage, and stored and served in accordance with food safety professional standards. The Resident and/or Resident Representative will be informed of the policy and provided safe food handling guidance in the form of RD/Designee education. On 9/23/24 at 1300 hours, an interview was conducted with the DSS. The DSS was asked about her role when the food was brought from outside for the residents to consume. The DSS stated she educated residents, RP, and visitors regarding how long food would be kept in the refrigerator at the facility, and once reheated, food would be discarded if not consumed. When asked about the education provided to the visitors and RP regarding safe food handling, the DSS stated she instructed the family/visitors to ensure proper cool down of food intended for storage. When asked about the specifics of the education provided, the DSS stated she did not address for the proper cooking and cooling temperatures of foods. When asked if she provided the family/visitors with any literature regarding safe food handling practices, the DSS stated she did not. On 9/25/24 at 0955 hours, an interview was conducted with LVN 4. When asked about what education she provided to the resident's family regarding food brought from outside, LVN 4 stated she discussed the policy for outside food and the RD/Designee was responsible for discussing with the visitor/RP about safe food handling guidelines. On 9/26/24 at 0837 hours, an interview was conducted with the DSD. When asked about what education/in-services were provided to staff regarding safe food handling practices, the DSD stated she reviewed the facility P&P for food brought from outside with the staff and reminded the staff to check the resident's bedsides, to ensure food items were labeled properly. The DSD stated she did not provide education to the staff regarding safe food handling practices for the preparation of food or educate about safe cooking and cooling temperatures. The DSD further stated the licensed staff and aides do not reheat food for the residents and reheating was done by the cooks in the kitchen. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 1040 hours, an interview was conducted with the DON. The DON stated the microwave used to reheat the residents' food was located in the kitchen. If the residents wanted to consume food brought by the visitors, reheating of the food would be done by the kitchen staff. The DON further stated the kitchen operated until 2100 hours, daily and if the residents wanted to consume their food brought from outside after that time, the residents were explained the facility was not able to reheat their food. On 9/26/24 at 1430 hours, the Administrator, DON, and DSS were informed and acknowledged the above findings.

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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** 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of infections were implemented as evidenced by: * The facility failed to implement their infection control surveillance program for January through August 2024. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobials. Residents who were not prescribed antimicrobials were not included in the facility's infection control surveillance program. * The facility failed to accurately track and monitor for the infections for February, May, and June 2024. * The facility failed to ensure the infection control practices were implemented on a resident with transmission-based precautions. * The facility failed to ensure the facility staff performed hand hygiene during the GT dressing change for one of 18 final sampled resident (Resident 65). These failures posed the risk for not identifying infections and controlling the transmission of communicable diseases to other residents throughout the facility. Findings: Review of the facility's P&P titled Infection Prevention and Control Program, (undated), showed the Infection Prevention and Control Program is designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Under the Surveillance of Infections and Reporting section, there is an on-going monitoring for infections among resident and personnel and subsequent documentation of infections that occur. Surveillance tools are used to recognize the occurrence of infections, record their number and frequency, detect outbreaks and epidemics, monitor employee infections, and detect unusual pathogens with infection control implications. This also includes reporting of communicable diseases per CDC (Center for Disease Control and Prevention) guidelines. 1.a. Review of the facility's monthly Prevention and Control Surveillance Log from January through August 2024 showed the following surveillance data: - January 2024, total of 11 cases including 5 CAI and 6 HAI - February 2024, total of 20 cases including 9 CAI and 11 HAI - March 2024, total of 11 cases including 6 CAI and 5 HAI - April 2024, total of 20 cases including 8 CAI and 12 HAI (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- May 2024, total of 39 cases including 8 CAI and 31 HAI - June 2024, total of 32 cases including 13 CAI and 19 HAI - July 2024, total of 27 cases including 10 CAI and 17 HAI - August 2024, total of 21 cases including 7 CAI and 14 HAI Review of the facility's monthly Infection Prevention and Control Surveillance Log from January 2024 through August 2024 showed documentation of the residents having an HAI or CAI and prescribed with antimicrobial medications. Further review of the facility's monthly Infection Prevention and Control Surveillance Log from January through August 2024 showed the facility failed to conduct surveillance for all resident infections, specific to the residents who had signs and symptoms of infection, met the McGeer's criteria (method used to retrospectively counting true infection), and were not prescribed antimicrobial medications. b. Review of the facility's monthly Infection Prevention and Control Surveillance Log for February 2024 showed the following: - an onset date of 2/22/24, for Resident 738's cefuroxime (antibiotic) 250 mg every 12 hours. - an onset date of 2/20/24, for Resident 739's azithromycin (antibiotic) 500 mg one tablet by mouth for seven days. :However, the log did not show whether the residents had HAI, CAI or did not meet the McGeer's criteria. Review of the facility's montly Infection Prevention and Control Surveillance Log for May 2024 showed the following: - an onset date of 5/2/24, for Resident 741's doxycycline (antibiotic) 100 mg one tablet by mouth daily for 30 days; and the log showed prophylaxis was documented under the comment section. However, the log did not show whether the resident had HAI, CAI or did not meet the McGeer's criteria. Review of the facility's monthly Infection Prevention and Control Surveillance Log for June 2024 showed the following: - an onset date of 6/23/24, for Resident 742's Keflex (antibiotic) 500 mg one capsule by mouth for seven days; and the log showed prophylaxis was documented under the comment section. However, the log did not show whether the resident had HAI, CAI or did not meet the McGeer's criteria. - an onset date of 6/26/24, for Resident 743's azithromycin (antibiotic) 500 mg one tablet by mouth daily for seven days and vancomycin (antibiotic) 1500 mg intravenously twice daily for seven days. However, the log did not show whether the resident had HAI, CAI or did not meet the McGeer's criteria. (continued on next page)

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	055689	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Healthcare	245 E Wilshire Avenue Fullerton, CA 92832

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/24 at 0826 hours, an interview and concurrent facility document review was conducted with the IP and DSD. The IP and DSD acknowledged and verified the above findings. The IP and DSD verified the monthly Infection Prevention and Control Surveillance Log from January through August 2024 did not include the residents with symptoms of infection who met the McGeer's criteria but were not prescribed with antimicrobial medications. On 9/26/24 at 1600 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 46787 2. On 9/24/24 at 0835 hours, an observation of the medication administration for Resident 65 was conducted with LVN 1. LVN 1 was observed to not don a gown during medication administration. Medical record review for Resident 65 was initiated on 9/23/24. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 65's Order Summary Report dated active as of 9/24/24, showed a physician's order dated 7/9/24, for enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in facilities) for GT. On 9/24/24 at 1220 hours, an interview was conducted with LVN 1. LVN 1 acknowledged she did not don appropriate PPE during medication administration for Resident 65. 50126 3. Review of the facility's P&P titled Infection Control revised 10/2022 showed for the facility to provide the necessary supplies, education and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Procedure: 1. Wash hands with soap and water for the following situations; a. When hands are visibly soiled (e.g., blood, body fluids) b. After caring for a resident with known or suspected Clostridiodes (C.) or Norovirus infection during an outbreak, or if infection rates of C. Difficile Infection (CDI) are high. 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: c. before and after performing any non-surgical invasive procedure g. before handling clean or soiled dressings, gauge pads, etc. i. after contact with resident's intact skin (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. after handling used dressing, contaminated equipment m. after removing gloves. Medical Record review for Resident 65 was initiated on 9/24/24. Resident 65 was readmitted on [DATE]. Review of Resident 65's progress note dated 7/9/24, showed Resident 65 was admitted with a GT. On 9/23/24 at 1130 hours, a GT dressing change observation for Resident 65 and concurrent interview was conducted with LVN 8. LVN 8 sanitized a small gray tray on top of treatment cart and placed the sterile and clean supplies for the GT dressing change. LVN 8 washed hands and entered Resident 65's room to greet Resident 65 and CNA 1. CNA 1 repositioned Resident 65 to her back. LVN 8 placed the small gray tray with the sterile and clean supplies on the mattress at the foot of Residents 65's bed. Residents 65's Family Member 1's purse and cell phone were on the mattress at the foot of the bed. LVN 8 put on gloves and removed Resident 65's GT dressing. LVN 8 removed the gloves and put on new gloves without performing the hand hygiene. LVN 8 opened a sterile gauze poured normal saline on the gauze and cleansed Resident 65's GT site. LVN 8 removed the gloves and put new gloves on without performing the hand hygiene. LVN 8 then placed a new GT dressing on Resident 65's GT site. LVN 8 removed the gloves, taped Resident 65's GT dressing, and removed the supplies from the mattress at the foot of the bed. When LVN 8 was asked about the process for changing gloves and performing hand hygiene during GT dressing change, LVN 8 said the facility used the three-glove change process. LVN 8 said they could remove gloves and put on new gloves 3 times during a dressing change before performing the hand hygiene. On 9/24/24 at 1017 hours, an interview was conducted with the IP. The IP stated hand hygiene needed to be done before and after changing the gloves during the dressing change. The IP further stated LVN 8 did not follow the infection control practices by changing gloves and performing hand hygiene in between steps for changing the GT dressing. On 7/31/24 at 1030 hours, an interview was conducted with the DON. The DON was made aware of the findings and verified the expectation was for hand hygiene to be performed before and after changing gloves during a GT dressing change. The DON further verified the supplies used during the GT dressing change needed to be placed on the sanitized surface.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their antibiotic stewardship program when the facility failed to conduct an assessment for the McGeer's criteria to determine the true infection. This failure had the potential for inaccurately identifying for true infections and potentially inhibited the residents' physicians from discontinuing the unnecessary antimicrobials. Findings: Review of the facility's P&P titled Infection Prevention and Control Program: Antibiotic Stewardship dated 9/2017 showed it is the policy of the facility to implement an Antibiotic Stewardship Program that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post- acute care setting, while improving treatment efficacy and resident safety, and reducing treatment related costs. The Core Elements of stewardship are the same for both acute care setting and nursing homes, as outlined by CDC; however, facilities may have a difference in the implementation of these elements: leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents, and families about antibiotic resistance and opportunities for improvement. Review of the facility's infection control binder showed Surveillance Data Collection Form being used to assess for McGeer's criteria to determine the true infection. Review of the facility's monthly Infection Prevention and Control Surveillance Log from January through August 2024 showed the following surveillance data: - January 2024, 11 infected residents with antibiotics - February 2024, 20 infected residents with antibiotics - March 2024, 11 infected residents with antibiotics - April 2024, 20 infected residents with antibiotics - May 2024, 39 infected residents with antibiotics - June 2024, 32 infected residents with antibiotics - July 2024, 27 infected residents with antibiotics - August 2024, 21 infected residents with antibiotics (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Medical record review for Resident 738 was initiated on 9/24/24. Resident 738 was admitted to the facility on [DATE]. Review of Resident 738's Surveillance Data Collection Form dated 2/22/24, showed Resident 738 was prescribed cefurioxime 250 mg every 12 hours until 3/1/24 and the bottom portion of the form showed the infection was CAI. The form showed two criterion must be present; however, Resident 738 only met one of the criteria. b. Medical record review for Resident 739 was initiated on 9/24/24. Resident 739 was admitted to the facility on [DATE]. Review of Resident 739's Surveillance Data Collection Form dated 2/20/24, showed Resident 739 was prescribed azithromycin 500 mg for respiratory tract infection. However, the bottom portion of the form did not show if the infection was CAI, HAI, or did not meet the criteria. c. Medical record review for Resident 740 was initiated on 9/24/24. Resident 740 was admitted to the facility on [DATE]. Review of Resident 740's Surveillance Data Collection Form dated 2/20/24, showed Resident 740 was prescribed ofloxacin (antibiotic) eye drops. However, the bottom portion of the form did not show if the infection was CAI, HAI, or did not meet the criteria. d. Medical record review for Resident 741 was initiated on 9/25/24. Resident 741 was admitted to the facility on [DATE]. Review of Resident 741's Surveillance Data Collection Form dated 5/2/24, showed Resident 741 was prescribed doxycycline 100 mg by mouth daily for 30 days. However, the bottom portion of the form did not show if the infection was CAI, HAI, or did not meet the criteria. e. Medical record review for Resident 742 was initiated on 9/25/24. Resident 742 was admitted to the facility on [DATE]. Review of Resident 742's Surveillance Data Collection Form dated 6/27/24, showed Resident 743 was prescribed Keflex 500 mg for seven days. However, the bottom portion of the form did not show if the infection was CAI, HAI, or did not meet the criteria. f. Medical record review for Resident 743 was initiated on 9/25/24. Resident 743 was admitted to the facility on [DATE]. Review of Resident 743's Surveillance Data Collection Form dated 6/23/24, showed Resident 743 was prescribed azithromycin 500 mg daily for seven days. However, the bottom portion of the form did not show if the infection treated was CAI, HAI or did not meet the criteria. Review of Resident 743's Surveillance Data Collection Form dated 6/23/24, showed Resident 742 was prescribed vancomycin 1500 mg intravenously twice a day for seven days. However, the bottom portion of the form did not show if the infection treated was CAI, HAI, or did not meet the criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 0826 hours, an interview and concurrent facility document review was conducted with the IP and DSD. The IP and DSD acknowledged the above findings. On 9/26/24 at 1354 hours, an interview and concurrent facility document review was conducted with the DSD and DON. The DON verified the above findings. On 9/26/24 at 1600 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.