STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055775	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orinda Care Center, LLC	11 Altarinda Road Orinda, CA 94563

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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** 40968 Based on observation, interview, and record review, the facility failed to provide care with dignity for one of three sampled residents (Resident 18) when two facility staff did not provide privacy for Resident 18 during nursing care. This deficient practice resulted in not ensuring resident 18's right to be treated with dignity and respect. Findings: During a review of Resident 18's admission record, dated, 1/23/25, the admission record indicated Resident 18 was admitted to the facility on [DATE] and was readmitted on [DATE]. During a review of Resident 18's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/17/24, indicated Resident 18 had multiple diagnoses which included progressive neurological conditions (type of illness that affects the nervous system like brain, spinal cord, or nerves and gets worse over time) that included cerebral palsy (condition that affects posture and movement), quadriplegia [(condition characterized by the loss of impairment of movement and sensation in all four limbs (arms and legs)], seizure or epilepsy (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, loss of consciousness), muscle wasting and atrophy (loss of muscle mass and strength). The MDS, revealed, Resident 18 had functional limited in range of motion in the upper and lower extremities on both sides. The MDS also revealed, Resident 18 was dependent on two or more helpers with upper and lower body dressing and with rolling on left and right side. During an observation on 1/22/25, at 9:58 a.m., in Resident 18's room, Licensed Vocational Nurse (LVN) 2, provided wound care treatment to Resident 18's left ischium (lower back part of hip bone) while Certified Nursing Assistant (CNA) 1 helped. Resident 18's buttocks were fully exposed. LVN 2 performed wound care treatment while window blinds were left open, and curtain was not drawn to provide privacy. LVN 2 stated, Resident 18 was not treated with dignity during treatment. CNA, acknowledged Resident 18's rights were violated when not provided privacy during nursing care. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/25, at 11:25 a.m., with the Director Of Staff Development (DSD), DSD stated, she was aware LVN 2 and CNA 1 did not provide privacy to Resident 18 during nursing care. DSD further added, the expectation was for the staff to draw curtain to provide privacy during wound care because Resident 18 can be seen exposed by other residents. DSD also stated, LVN 2 and CNA 1 will be given one-on-one in-service training on resident rights. A review of the facility's policy and procedure (P&P) titled, Resident Rights, dated, 2/2021, indicated, Employees shall treat all residents with kindness, respect, and dignity. The P&P also indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; .t. privacy .

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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** 40968 Based on observation, interview and record review, the facility failed to ensure an assessment and/or an evaluation for self-administration of medications was completed for one of 46 sampled residents (Resident 11) when the following were observed on Resident 11's bedside table: a. a bottle of Nystatin (antifungal antibiotic topical treatment) powder b. one cup filled with Pepto Bismol (oral medication used for heartburn, indigestion, diarrhea, and nausea) c. Sudafed (allergy) Nasal Spray This facility failure increased the potential for the unsafe self-administration of medications. It also had the potential to result in the use of the medications by other residents, who could come into the room and obtain the treatment from the bedside table where it was stored. Findings: During a review of Resident 11's admission record, dated 6/23/25, the admission record indicated, Resident 11 was admitted to the facility on [DATE], with multiple diagnoses that included, mild cognitive impairment of uncertain or unknown etiology (problems with memory or thinking). During a review of Resident 11's Minimum Data Set (MDS- a federally mandated assessment tool) dated, 12/27/24, the MDS indicated Resident 11 had a progressive neurological condition (continual deterioration of neurological function). During a concurrent observation and interview on 1/21/25 at 10:33 a.m., with Resident 11, stated, the bottle of Nystatin powder, cup of Pepto Bismol, and Sudafed Nasal Spray has been stored on the bedside table. Resident 11 further added, staff were aware she was using these medications on her own. During a concurrent observation and interview on 1/21/25 at 10:44 a.m. with Licensed Vocational Nurse (LVN) 3, in Resident 11's room, LVN 3 acknowledged seeing the medication on Resident 11's bedside table. LVN 3 stated, Resident 11 had been keeping medications on her bedside. LVN 3 further added, she was not aware if Resident 11 had an assessment or evaluation for self-administration of medication. During a concurrent interview, and record review on 1/24/25 at 10:38 a.m. with the Director Of Nursing (DON), in the DON's office, the DON confirmed there was no Interdisciplinary Team (IDT) assessment completed for Resident 11. DON stated, Resident 11 had not been assessed by the IDT to determine whether Resident 11 can self-administer medications/treatments. DON added, the IDT assessment will determine whether the medication stored by the resident can have undesired interaction with her prescribed medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Self-Administration of Medications, dated, 2/21, indicated 1. As part of the evaluation, comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents . 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40968 Based on interview and record review, for eight of 31 sampled residents (Residents 2, 11, 14, 18, 37, 38, 46 and 249), the facility failed to offer or ensure an advance directive (a written instruction for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated) was on file, when the facility did not offer to locate or help the residents/representatives complete the document. This failure had the potential for Residents 2, 11, 14, 18, 37, 38, 46, and 249's wishes regarding provision of health care to not be honored. Findings: During a record review of the Resident 2's Admission Record, printed 1/23/25, it indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), paranoid schizophrenia (a mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior), epilepsy (a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior such as bodily movements), amnestic disorder (a condition that causes memory loss, making it difficult to learn new information or recall past events), and cognitive communication deficit (a difficulty with communication caused by an impaired thinking). Review of Resident 2's clinical record indicated there was no documentation that Resident 2 or her representative were asked about the existence of any advance directives. During a record review of Resident 14's Admission Record, printed 1/23/25, it indicated Resident 14 was admitted to the facility on [DATE] with diagnoses including epilepsy, hypertensive heart disease (heart conditions caused by long-term high blood pressure. It occurs when the heart must work harder to pump blood through narrowed arteries, which can thicken the heart muscle over time), delusional disorders (a mental health condition that involves having fixed false beliefs that are not based in reality. People with delusional disorder can have delusions about their relationships, their bodies, or the world around them), dementia, and congestive heart failure (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs). Review of Resident 14's clinical record indicated there was no documentation that Resident 14 or his representative were asked about the existence of any advance directives. During a record review of Resident 37's Admission Record, printed 1/23/25, it indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including multiple rib fractures (broken bones), depression (a mental disorder that involves a long-lasting low mood and loss of interest in activities. It can affect how a person feels, thinks, and behaves), psychoactive substance abuse (the harmful or hazardous use of mind-altering substances, including alcohol and illicit drugs), and alcohol abuse. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 37's clinical record indicated there was no documentation that Resident 37 or his representative were asked about the existence of any advance directives. During a record review of Resident 46's Admission Record, printed 1/23/25, it indicated Resident 46 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis), hypertension (a chronic condition where the force of blood in your arteries is consistently too high), suicidal ideations (thoughts of suicide or taking your own life), and anxiety. Review of Resident 46's clinical record indicated there was no documentation that Resident 46 or his representative were asked about the existence of any advance directives. During an interview on 1/23/25 at 1:00 p.m., Medical Records (MR) staff stated the facility does not have advance directives on file for Residents 2, 14, 37, and 46. During a phone interview on 1/24/25 at 8:39 a.m., Resident 14's responsible party (RP) stated since the facility did not have an advance directive on file, the RP felt worried because the facility might not care for Resident 14 appropriately if there was a sudden health decline. During an interview on 1/24/25 at 9:56 a.m., the Social Services Director (SSD) stated both the admitting nurse and the SSD are responsible for ensuring advance-[NAME] directives are on file, or residents are offered help in making one. The SSD stated this issue should also be reviewed at each interdisciplinary team (IDT- refers to a meeting where healthcare professionals from different disciplines within a long-term care facility, such as doctors, nurses, physical therapists, social workers, and nutritionists, come together to discuss and coordinate the care plan of a resident, considering their holistic needs including physical, mental, and social aspects, to ensure the best possible care delivery) conference, and should be documented in the residents record to prove it was done. The SSD stated if the resident did not have an advance directive, their wishes may not be followed in case of incapacitation. During a record review of the facility's policy and procedure titled, Advanced Directives, revised 2013, it indicated, 1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including right to accept or refuse medical or surgical treatment, and the right to formulate advanced directives .5.If the resident indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. The resident will be given the option to accept or decline the assistance, and the care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist, and the resident's decision to accept or decline. 2. a. During a review of Resident 11's admission record, dated 1/23/25, indicated Resident 11 was admitted to the facility on [DATE]. During a review of Resident 11's Minimum Data Set (MDS, a federally mandated assessment tool) dated, 12/27/24, indicated Resident had multiple diagnoses that included, Asthma (lung condition that causes inflammation and narrowing of airways), Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that cause long-term breathing problem). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 18's admission record, dated, 1/23/25, the admission record indicated Resident 18 was admitted to the facility on [DATE] and was readmitted on [DATE]. During a review of Resident 18's MDS, dated [DATE], indicated, Resident 18 had multiple diagnoses which included progressive neurological conditions (type of illness that affects the nervous system like brain, spinal cord, or nerves and gets worse over time) that included cerebral palsy (condition that affects posture and movement) quadriplegia [(condition characterized by the loss of impairment of movement and sensation in all four limbs (arms and legs)] seizure or epilepsy (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, loss of consciousness), muscle wasting and atrophy (loss of muscle mass and strength). During a concurrent interview and record review on 1/23/25 at 10:34 a.m. with Medical Records (MR), MR stated there was no Physician Orders for Life-Sustaining Treatment (POLST, medical order that provide clear instructions to healthcare providers about the medical treatments a patient wants or does not want to receive in the event of a serious illness or medical emergency) or advance directive in Resident 11 and Resident 18's Electronic Health Records (EHR) and record chart. MR further added, she was responsible for ensuring POLST form and Advance Directive was in resident chart. During a concurrent interview and record review on 1/23/25 at 3:25 p.m. with Social Service Director (SSD), in SSD's office, SSD stated, Resident 11 and 18 did not have POLST in their chart. SSD further stated, POLST was important for staff to know if there was advance directive in place so that treatment preference can be carried out in case anything happens, or in emergency situation. 49091 3) During a record review of the Admission Record, the record indicated Resident 38 was admitted to the facility 10/11/2024. During a record review of the Admission Record, the record indicated Resident 249 was admitted to the facility 1/2/2025. During a record review on 1/21/2025 at 5:37 p.m., Resident 38 and Resident 249's Electronic Health Record (EHR) were reviewed, and no Advanced Directives (AD) was found. During an interview on 1/22/2025 at 11:09 a.m. with Social Service Director (SSD), when asked for Advance Directives for Resident 38 and Resident 249, SSD stated she needed time to look for that information. During a concurrent interview and record review on 1/24/2025 at 10:02 a.m. with Director of Nursing (DON), DON stated facility did not have or had reached out to Resident 249 and Resident 38 and/or their family representatives to offer them resources to have Advance Directives on their files until 1/22/2025. (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 the facility's policy and procedure (P&P) titled Advance Directives, dated 12/16, the Advance Directive indicated, 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family member and/or his or her legal representative, about the existence of any written advance directives. 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. During a review of facility's Policy and Procedure (P&P) titled Requesting, Refusing and/or Discontinuing Care or Treatment dated 2/2021, the P&P indicated, Residents/representatives are informed of his or her rights to formulate an advance directive. 51636

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52135 Based on interview and record review, the facility failed to complete quarterly Minimum Data Set (MDS, a resident assessment used to guide resident's care, Quarterly MDS assessment is used to track a resident's status between comprehensive assessment to ensure resident's gradual change in status are monitored) assessment in a timely manner for one of two sampled residents (Resident 28) for over four months. This deficient practice resulted in Resident 28 not receiving the assessment and placed her at risk for not receiving appropriate care and services based on her health status. Findings: During a review of Resident 28's Admission Record printed on 6/22/25 indicated Resident 28 was admitted to the facility on [DATE]. During an interview and record review on 1/23/25 at 10:50 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 28's MDS assessment history was reviewed. MDSC stated he missed to complete Resident 28's Quarterly assessment in 10/2024.The MDSC stated he did not assess Resident 28 after 7/28/24, when quarterly MDS should be completed at least within 92 days. The MDSC stated not completing quarterly MDS assessment for Resident 28 placed Resident 28 at risk for unidentified significant change in health status and hence risk for not receiving care based on her current health condition.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52135 Based on observation, interview and record review, the facility failed to accurately assess two of three sampled residents (Resident 13 and Resident 23) for tobacco use status on comprehensive Minimum Data Set (MDS, an assessment used to guide care). Facility inaccurately coded NO to Current Tobacco Use for Resident 13 and Resident 23 who were smoking daily. The failure resulted in inaccurate reflection of Resident 13 and Resident 23's clinical status and placed them at risk for not receiving person-centered care. Findings: During a record review of Resident 13's Admission Record, printed on 1/24/25, the record indicated Resident 13 was admitted to the facility on [DATE]. During a record review of Resident 23's Admission Record, printed on 1/24/25, the record indicated Resident 23 was admitted to the facility on [DATE]. During an observation on 1/22/25, 1/23/25, 1/24/25 at 10:10 a.m., 1:19 a.m., and 10:16 a.m. respectively, Resident 13 and Resident 23 were observed smoking at facility's patio. During an interview on 1/23/25 at 11:42 a.m., Resident 13 stated he started smoking when he was teenager, and never quit smoking since then. During an interview on 1/24/25 at 10:00 a.m., Resident 23 stated she has been smoking since her 20's without a quitting period. During an interview on 1/24/25 at 10:15 a.m., Restorative Nursing Aid(RNA), who was supervising Resident 13 and Resident 23 during smoking time at the facility's patio, stated Resident 13 and Resident 23 had been smoking since their admission to the facility. During an interview and record review with facility's MDS Coordinator (MDSC) on 1/24/25 at 11:27 a.m., Resident 13's Significant change in status MDS assessment dated [DATE]; and Resident 23's Admission MDS assessment dated [DATE] were reviewed. The MDS assessments for Resident 13 and Resident 23 indicated both residents were cognitively intact and were not using tobacco at the time of assessments were completed. The MDSC stated he inaccurately coded the MDS on Current Tobacco Use section for both resident s, because both resident s were smokers.

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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** 49091 Based on interview and record review, the facility failed to ensure one resident's (Resident 14) Pre-Admission Screening Resident Review (PASARR-Preadmission Screening and Resident Review is 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) for serious mental illness was accurately completed and sent to the appropriate state mental authority for Level II evaluation and determination. This failure had the potential to prevent Resident 14 from receiving appropriate required mental health services. Findings: During a record review of Resident 14's Admission Record, printed 1/23/25, it indicated Resident 14 was admitted to the facility on [DATE] with diagnoses including epilepsy (a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior such as bodily movements), major depressive disorder (a mental illness that causes a persistent low mood and loss of interest in activities. It can also affect how a person thinks and functions in their daily life), delusional disorders (a mental health condition that involves having fixed false beliefs that are not based in reality. People with delusional disorder can have delusions about their relationships, their bodies, or the world around them), dementia (a progressive disease that destroys memory and other important mental functions), and congestive heart failure (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs). During a record review of Resident 14's Minimum Data Set (MDS - an assessment screening tool used to guide care), dated 10/4/24, active diagnoses included depression and psychotic disorder (a severe mental illness that causes a person to lose touch with reality). During a record review of correspondence from the Department of Health Care Services (DHS), dated 4/13/23, regarding Negative Level 1 Screening Indicates Level II Mental Health Evaluation Not Required, it indicated, Federal law requires all individuals seeking admission to a Medicaid Certified Nursing Facility (NF) receive a Level I Screening. The Level I Screening identifies if an individual has a suspected Mental Illness (MI) .if MI is suspected, then a Level II Mental Health Evaluation may be conducted to determine if the individual can benefit from specialized mental health services. The process is known as the Preadmission Screening and Resident Review (PASRR). Level 1 Screening for: Resident 14 Submitted on: 4/13/2023 Result: Negative Reason: No MI (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Level II Mental Health Evaluation Referral: Not Required During an interview on 1/24/25 at 11:16 a.m. with the Admission Director (AD), the AD stated it is the facility's responsibility to ensure the Level I PASARR's are done correctly. The AD stated the facility did not notice the error in Resident 14's Level 1 PASARR, and this might have resulted in Resident 14 failing to receive available services from the Department of Developmental Services Regional Center (DDS-Under the [NAME] Developmental Disabilities Services Act, DDS is responsible for overseeing the coordination and delivery of services and supports to more than 400,000 Californians with developmental disabilities including cerebral palsy, intellectual disability, autism, epilepsy and related conditions appropriate treatment and services) . Review of the facility's policy and procedure titled, Preadmission Screening & Resident Review (PASARR), revised 12/11/17, it indicated, the facility will obtain/complete a Preadmission Screening and Resident Review (PASARR) timely, and all errors or if pre-screening is done and resident was not admitted ; DHS suggests responding by email (subject error) or contacting DHS via phone (PASARR Support Number).

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Orinda Care Center, LLC	11 Altarinda Road Orinda, CA 94563

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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** 49091 Based on interview and record review, the facility failed to ensure/perform a Pre-Admission Screening and Resident Review (PASARR-a screening tool to determine if individuals with serious mental illness or intellectual/developmental disability or related condition require nursing facility services or specialized services) for one (Resident 2) of four sampled residents. This failure had the potential to result in Resident 2 not being provided specialized care and services to address a mental illness. Findings: During a record review of the Resident 2's Admission Record, printed 1/23/25, it indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), paranoid schizophrenia (a mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior), epilepsy (a brain disorder in which a person has repeated seizures over time. Seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior such as bodily movements), amnestic disorder (a condition that causes memory loss, making it difficult to learn new information or recall past events, and cognitive communication deficit (a difficulty with communication caused by an impairment in cognitive processes). During a record review of Resident 2's Minimum Data Set, (MDS - an assessment screening tool used to guide care), dated 12/31/24, active diagnoses included depression (a mental disorder that involves a long-lasting low mood and loss of interest in activities) and schizophrenia. Review of clinical records showed Resident 2 did not have a (PASARR) Level I completed. During an interview on 1/24/25 at 11:16 a.m. with the Admission Director (AD), the AD stated it is the facility's responsibility to ensure that the Level I PASARR is done correctly. The AD stated if the Level I PASARR is not completed, residents might not receive the appropriate care and treatment services from the Department of Developmental Services Regional Center (DDS-Under the [NAME] Developmental Disabilities Services Act, DDS is responsible for overseeing the coordination and delivery of services and supports to more than 400,000 Californians with developmental disabilities including cerebral palsy, intellectual disability, autism, epilepsy and related conditions appropriate treatment and services) . During a record review of the facility's policy and procedure titled, Preadmission Screening & Resident Review (PASARR), revised 12/11/17, it indicated the facility will obtain/complete a Preadmission Screening and Resident Review (PASARR) timely, and PASARR must be printed and be within chart upon 5th day (after admission).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 51636 Based on observation, interview, and record review, the facility failed to provide an alternative for use of splint (a medical device used to support and immobilize a part of the body, to promote healing and reduce pain) for over a month, for one of 14 sampled residents (Resident 38) to manage left hand deformity, when Resident 38 refused to wear a splint. Resident 38 stated he had a history of plate implant surgery on his left hand. This failure resulted in Resident 38 to experience pain when he used his left hand to wheel the wheelchair and potential risk for skin breakdown of his left hand while pushing the wheelchair. Findings: During a record review of Resident 38's Admission Record (Admission Record is a document used to communicate basic information about a resident) printed on 1/21/25, the record indicated Resident 38 was admitted to the facility 10/11/24. During a review of Resident 38's Minimum Data Set (MDS is a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 10/17/24, the assessment indicated Resident 38 was able to understand others and make himself understood. The Brief Interview for Mental Status (BIMS) Score for Resident 38 was 14 out of 15 (BIMS is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status). During an observation and interview with Resident 38 on 1/21/25 at 11:21 a.m., Resident 38 was sitting in a wheelchair, stated he had plate implant surgery on his left hand near his wrist years ago. Resident 38's left hand was contracted with all the fingers and palm were cramped together. Resident 38 stated he had pain in his left hand every time he pushed his wheelchair in the facility. Resident 38 did not have any splint and or assistive device on his hand. During an interview with Certified Nursing Assistant (CNA) 3 on 1/24/25 at 2:13 p.m., CNA 3 stated she did not know Resident 38 had left hand deformity. During an interview with Licensed Vocational Nurse (LVN) 2 on 1/22/25 at 2:37 p.m., LVN 2 stated she was not aware of Resident 38's left hand deformity and/or pain. During a record review of Resident 38's therapy progress notes, the notes indicated on 10/14/24, Resident 38 had history of left hand tenodesis (tenodesis is a surgical procedure used to treat tendon injuries by anchoring the tendon to a bone, typically to relieve pain and restore function), was on contracture (a condition where muscles, tendons, or other soft tissues shorten and become stiff, limiting the range of motion and causing deformities) precautions and staff was to conduct an evaluation for splint/orthotic device. The notes dated 12/11/24 and 12/31/24 indicated, Resident 38 declined to have splint placed on hands. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Occupational Therapy Assistant & Physical Therapy Assistant (COTA) and Director of Rehabilitation (DRE) on 1/22/25 at 2:45 p.m., COTA stated Resident 38 had refused to apply the splint on his left hand, however Resident 38's doctor was not notified of above. COTA also stated that facility did not come up with another alternative to manage Resident 38's left hand after his refusals to wear a splint since 12/2024.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40968 Based on observation, interview, and record review, the facility failed to ensure range of motion (ROM) exercises were provided for two of five sampled residents (Resident 6 and 18) reviewed for limited ROM. This failure had the potential to result in decline in the Resident 6 and Resident 18's ROM. Findings: a. During a review of Resident 6's admission record, dated 1/23/25, the admission record indicated Resident 6 was admitted to the facility on [DATE]. During a review of Resident 6's MDS, dated , 1/7/25, the MDS revealed, Resident 6 had a Brief Interview for Mental Status (BIMS, an assessment tool used by the facilities to screen and identify memory, orientation, and judgment status of the resident) Score of 5/15, meaning, Resident 6's cognition was severely impaired. The MDS indicated, Resident 6 had multiple diagnoses that included progressive neurological conditions Cerebrovascular Accident (CVA, stroke) and muscle weakness. The MDS also indicated, Resident 6 had functional limited range of motion on both sides of the lower extremities. The MDS further indicated, Resident 6 required maximal assist with mobility. During a review of Resident 6's Occupational Therapy (OT) D/C Summary, dated 11/12/24, under discharge recommendation indicated, Restorative Program Established. During a review of Resident 6's PT D/C Summary, dated 11/12/24, under discharge recommendation indicated, Restorative Program Established. b. During a review of Resident 18's admission record, dated, 1/23/25, the admission record indicated Resident 18 was admitted to the facility on [DATE] and was readmitted on [DATE]. During a review of Resident 18's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/17/24, indicated Resident 18 had multiple diagnoses which included progressive neurological conditions (type of illness that affects the nervous system like brain, spinal cord, or nerves and gets worse over time) that included cerebral palsy (condition that affects posture and movement) quadriplegia [(condition characterized by the loss of impairment of movement and sensation in all four limbs (arms and legs)] seizure or epilepsy (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, loss of consciousness), muscle wasting and atrophy (loss of muscle mass and strength). The MDS, revealed, Resident 18 had functional limited in range of motion in the upper and lower extremities on both sides. The MDS also revealed, Resident 18 was dependent on two or more helpers with mobility. During a review of Resident 18's Physical Therapy (PT) Discharge (D/C) Summary, dated 11/1/23, the discharge summary indicated Resident 18, did not reach maximum potential with skilled services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/23/25, at 1:11 a.m. with Restorative Nurse Assistant (RNA), RNA stated, Resident 18 and Resident 6 did not receive ROM exercises because they were not in the system to receive RNA services. RNA further added, there was no Therapy Referral to Restorative Nursing Program completed for Residents 18 and 6 from the rehabilitation department. During a concurrent interview and record review on 1/23/25 at 1:34 a.m. with Director of Rehabilitation (DRE), Resident 18's PT discharge summary dated 11/1/23 was reviewed. DRE stated, Resident 18 required increase ROM exercises to prevent contractures and minimize further decline in functional mobility and ROM ability. During a concurrent interview and record review on 1/23/25 at 1:37 p.m. with DRE, Resident 6 was discharged from physical therapy and an RNA program was established on 11/12/24. DRE added, once RNA program was established, the expectation from the nursing team was to follow what was on Resident 6's Therapy Referral to Restorative Nursing Program form. DRE also added, there as potential for Resident 6 to decline in functioning and mobility for not receiving RNA services. During a concurrent interview and record review on 1/24/25 at 1:32 p.m. with the Director Of Nursing (DON), DON stated, both Resident 18 and Resident 6 did not receive ROM exercises because there was no communication between the rehabilitation department and nursing department to carry out RNA services. DON further added, nursing department was expected to perform ROM exercises to prevent contractures and prevent worsening of conditions. During a review of facility's policy and procedures (P&P) titled, Restorative Nursing Services, dated 7/2017, it indicated under policy statement, Residents will receive restorative nursing care as needed to help promote optimal safety and independence.1. Restorative nursing care consist of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g. physical, occupational or speech therapies) 2. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51636 Based on observation, interview, and record review, the facility failed to follow up on one of 14 sampled residents (Resident 249)'s request to change routine pain medication (Oxycodone) from every six hours to every four hours. This failure resulted in Resident 249 to experience unrelieved pain and made him feel frustrated and unhappy. Findings: During a record review of Resident 249's Admission Record (Admission Record is a document used to communicate basic information about a resident) printed on 1/21/25, the record indicated Resident 249 was admitted to the facility on [DATE] and Resident 249 had a Diagnosis of Acquired absence of left leg above knee. During a review of Resident 249's Minimum Data Set (MDS is a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 1/15/25, the assessment indicated Resident 249 was able to speak clearly, understand others and make himself understood. The Brief Interview for Mental Status (BIMS) Score for Resident 249 was 14 out of 15 (BIMS is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status). During a review of Resident 249's Physician order summary report dated 1/02/25, indicated to administer Oxycodone 20 mg one tablet every 6 hours as needed for moderate to severe pain. During an observation and interview with Resident 249 on 1/21/25 at 10:23 a.m., Resident 249 was sitting in a wheelchair. Resident 249 stated he recently had left above knee amputation few months ago and had been experiencing back pain after the fall on 1/14/25. Resident 249 stated he had asked the nurse to have his pain medication, Oxycodone every 4 hours instead of every 6 hours, however his concern was not addressed yet. Resident 249 stated it made him feel unhappy and frustrated. During a record review of Resident 249's nursing progress notes, the record indicated Licensed Vocational Nurse (LVN 1), on 1/15/25 at 2:57 p.m. documented, she had administered all the scheduled and PRN pain medications to Resident 249 and he requested a pain medication for breakthrough pain. LVN 1 followed up with the doctor. On 1/17/25 at 2:34 p.m. Licensed Vocational Nurse (LVN 3) documented, Resident 249 complained of back pain from the fall and pain scale was seven out of 10 (pain scale is a tool used by residents to describe the intensity of their pain. 0 indicated no pain and 10 is highest pain level). Resident 249 told LVN 3 the pain medication was effective for only 4 hours. During an interview with LVN 1 on 1/24/25 at 12:20 p.m., LVN 1 stated she notified Resident 249's complaint of pain and need of increased frequency of pain medication to his doctor, but she did not get a response. LVN 1 was unable to show if she followed up on Resident 249's request even after she did not get a response from the doctor. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview with LVN 3 on 1/24/25 at 1:02 p.m., LVN 3 stated she did not follow up with Resident 249's doctor on 1/17/25, since she was rushing to finish her work before the end of her shift and/or did not endorse the need of Resident 249's increased frequency for pain medication administration to other nurses. During a review of facility's P&P titled, Pain Assessment and Management dated 10/2022, the P&P indicated The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49091 Based on interview and record review the facility failed to have Registered Nurse (RN) coverage for at least eight (8) consecutive hours a day for a total of 11 days. This deficient practice had the potential to cause delayed delivery of necessary assessment and treatment services for resident's day-to-day care. Findings: During a record review of the facilities Payroll Based Journal (1/2024 - 12/2024) was reviewed, which indicated the facility did not use the services of an RN for at least eight consecutive hours a day on the following dates: 1/13/24, 1/27/24, 2/11/24, 2/17/24, 2/25/24, 3/2/24, 3/3/24, 3/30/24, 7/21/24, 7/28/24, and 8/31/24. During a concurrent interview and record review on 1/23/25 at 1:53 p.m. with the Administrator (ADM), the facility payroll document titled NHPPD SNF CNA/RNA HOURS, dated 1/13/24 - 8/31/24 was reviewed. The ADM acknowledged there was not an RN in the facility for eight consecutive hours a day on the following days: 1/13/24, 1/27/24, 2/11/24, 2/17/24, 2/25/24, 3/2/24, 3/3/24, 3/30/24, 7/21/24, 7/28/24, and 8/31/24. The ADM stated this practice put resident health at risk since Licensed Vocational Nurses do not have as the same knowledge level and skills as RN's. During an interview on 1/23/25 at 2:55 p.m., Licensed Vocational Nurse 1 (LVN1) stated RN's are needed in the facility to perform formal nursing assessments, and to provide experienced oversight in emergencies. During a record review of the facility document titled Fall Incidents 2024, (undated), it indicated there were two resident falls when an RN was not onsite to perform a post-fall assessment (7/28/24 and 8/31/24). During a record review of the Facility Assessment Tool, dated 6/2024-1/2025, it indicated Staffing: 1 DON (Director of Nursing) RN full-time days; if has other responsibilities, add RN as assistant DON to equal one FTE (full-time position), and the facility provides sufficient staff with appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52135 Based on interview and record review, the facility failed to plan and implement parameters for Glargine insulin (a type of insulin helps maintain blood glucose levels throughout the day and night) administration for one of six sampled residents (Resident 7) for over five months period. Resident 7 received insulin for certain blood glucose levels on some days and did not on other days. The failure placed Resident 7 at risk for not receiving insulin as needed and posed risk for hyperglycemia (high blood glucose) or hypoglycemia (a condition which blood glucose is too low). Findings: During a review of Admission Record printed on 1/24/25, Resident 7 was admitted to the facility on [DATE]with diagnosis of Type 2 diabetes mellitus (a form of diabetes) with hyperglycemia. During a record review, Resident 7's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) assessment was reviewed. MDS assessment indicated that Resident 7 was cognitively intact. During an interview with Resident 7, he stated he know that he was a diabetic and supposed to get insulin every day. During a review of Resident 7's Physician Orders dated 6/3/24, indicated to inject 10 Glaring insulin subcutaneously at bedtime every day for diabetes. During a concurrent interview and record review on 1/23/25 at 12:10 p.m., with DON (Director of Nursing), Resident 7's MAR (Medication administration Record) dated 01/2025 and nurse notes from 1/1/25 thru 1/23/25 were reviewed. The MAR indicated Resident 7 received 10 units of Glargine insulin on 1/2, 1/5, 1/17, 1/21 and 1/22/25, when Resident 7's blood sugar levels were 130, 128, 109, 102 and 108 mg/dl respectively. The MAR, however indicated, Resident 7 did not receive 10 units of Glargine insulin on 1/11, 1/14, 1/16/25, when his blood sugar levels were 133, 108, and 109 mg/dl respectively. When asked how the nurses decided if Resident 7 required Insulin administration or not, the DON stated he was unable to find the parameters for use of insulin for Resident 7. The DON stated there should be a parameter for insulin administration to minimize the risks for hyperglycemia or hypoglycemia. During a phone interview with facility Pharmacy consultant (PC) 1 on 1/24/25 at 11:47 a.m., the PC 1 stated she might have missed recognizing that there were no parameters set up for insulin administration for Resident 7, however insulin holding parameter was important to give clear instruction to nurses when to hold/administer insulin.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091 Based on observation, interview and record review, the facility failed to ensure one of two sampled residents was free from significant medication errors when the facility incorrectly reconciled and transcribed the dosage of a prescribed anti-seizure (seizures are episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior such as bodily movements) medication to Resident 99. Licensed nursing staff then administered the incorrect dosage of the medication to Resident 99 for a period of 22 days. This failure resulted in Resident 99 experiencing multiple seizures, hospitalization , and death. Findings: During a record review of Resident 99's Administration Record, printed on August 21, 2024, it indicated Resident 99 was admitted to the facility on [DATE], with diagnoses including non-traumatic intracranial hemorrhage (a life-threatening condition that occurs when there's bleeding in or around the brain), malignant neoplasm of the brain (a cancerous brain tumor), post-traumatic seizures (seizures that occur after a traumatic brain injury (TBI). They can be a symptom or risk factor for post-traumatic epilepsy (PTE), which is when seizures occur repeatedly and without warning), hemiplegia (the loss of muscle function on one side of the body) and hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body). During a record review of Resident 99's Admission History and Physical, dated 8/21/24, the Physician (PHY) indicated that Resident 99 was not mentally competent. During a record review of Resident 99's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), it indicated Resident 99's active diagnoses included cancer, and seizure disorder/epilepsy (a brain disorder in which a person has repeated seizures over time). During an interview and record review on 1/23/25 at 1:36 p.m. with the Director of Staff Development (DSD), Resident 99's Discharge Summary from the acute care hospital (ACH 1) dated 8/20/24 and Physician Order Summary dated 8/20/24 were reviewed. The DSD stated she assisted with entering physician orders onto the physician summary sheet on 8/20/24, when Resident 99 was admitted to the facility. Discharge Summary from ACH 1 dated 8/20/24 indicated Resident 99 was prescribed levetiracetam 10 ml (milliliters-a unit of measure) of 100 mg (milligrams-a unit of measure)/ml solution (total of 1000 mg) every 12 hours for seizure disorder. The DSD stated, however, she transcribed the order as levetiracetam oral solution 100 mg/ml, give 10 ml by mouth every 12 hours as needed for seizure disorder on 8/20/24, with a discontinuation date of 9/10/24. The DSD stated she did not find out about this error until on 1/23/25. During a record review of Resident 99's progress notes dated 8/27/24, the record indicated Resident 99 was witnessed having a seizure in the facility at 7:40 p.m., lasting approximately seven minutes. Resident 99 was sent out to the hospital for evaluation and returned to facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 99's Order Summary Report dated 9/1/24, it indicated the following: levetiracetam oral solution 100/mg/ml (levetiracetam), give 10 ml by mouth every 12 hours as needed for seizure disorder-started 8/20/24, no end date. During a review of Resident 99's Medication Administration Records (MAR) for August 2024, MAR indicated facility nursing staff did not give Resident 99 levetiracetam on any day during the month of August 2024. During a concurrent record interview and interview on 1/23/25 at 3:50 with Clinical Consultant (CC), Resident 99's progress notes from 8/20/24 to 9/13/24 were reviewed. The CC was unable to find any documentation to indicate what prompted nursing staff to change the levetiracetam dosage from PRN (as-needed) to BID (twice a day) on 9/10/24. The CC also stated levetiracetam was meant to be therapeutic, and must be given routinely, not on as-needed basis. During a review of Resident 99's Medication Administration Records (MAR) for September 2024, it indicated the following: levetiracetam oral solution 100 mg/ml (levetiracetam) Give 10 ml by mouth every 12 hours as needed for seizure disorder, start date 8/20/24-DC date 9/10/2024. The MAR indicates that Resident 99 was administered this drug on 9/4/24. After the discontinuance of this order on 9/10/24, September MAR read as follows: levetiracetam oral solution 100 mg/ml (levetiracetam) Give 10 ml by mouth two times a day for seizure, start date 9/10/24 2100. The MAR indicated Resident 99 received as ordered from 9/10/24 until Resident 99 was hospitalized on [DATE]. During a record review of Resident 99's progress notes, effective date 9/10/24, Resident 99 had two seizures, one lasting one minute three seconds, and one lasting 30 seconds. During a record review of Resident 99's progress notes, effective date 9/12/24, Resident 99 had two seizures, one lasting 30 minutes, and one lasting 45 seconds. During a phone interview on 1/24/25 at 10:13 a.m. with Licensed Vocational Nurse 6 (LVN6), LVN6 stated she did not recall why Resident 99's levetiracetam dosage was changed, and did not write a progress note about it. LVN6 stated she usually receives the medication orders and carries them out. LVN6 also stated we don't usually give (the medication) on an as-need basis, because it is given to stabilize the condition, and the doctor should be called. During a phone interview on 1/24/25 and 11:31 a.m. with the Pharmacy Consultant (PC), the PC stated she visits the facility once a month to do a variety of tasks including reviewing resident medications. The PC stated that she would alert the facility if levetiracetam is given as-needed, as it is given for maintenance, and that she probably just missed to capture it. During a phone interview on 1/24/25 at 11:32 a.m. with the Physician (PHY), the PHY stated he remembered the facility transcribed the medication (levetiracetam) incorrectly, and several days had passed before he was notified of the error. At that time the PHY changed the order from as-needed to twice a day. During a phone interview on 1/27/25 at 12:16 p.m. with Resident 99's family representative (RP), the RP stated the facility had never notified her that a medication error had been made while Resident 99 was at the facility. (continued on next page)

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	055775	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orinda Care Center, LLC	11 Altarinda Road Orinda, CA 94563

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 99's Progress Notes, dated 9/1/24, Resident 99 had a seizure during a video conference, lasting approximately seven minutes. The neurologist (a medical doctor who specializes in diagnosing and treating disorders of the brain and nervous system) recommended the resident be sent out to acute care hospital for continuous EEG (electroencephalogram- a medical test that records the electrical activity of the brain monitoring). Resident 99 was transferred to an acute care facility (ACH 2). During record review of Resident 99's Transfer/Discharge Summary from ACH 2, dated 9/16/24, it indicated Resident 99 was transferred (from facility) to an acute care hospital on 9/13/24 for repeated seizure activity. The levetiracetam dosage was then increased, as Resident 99 continued to experience seizures during EEG monitoring. Since neurology recommended continuous EEG monitoring, Resident 99 was transferred to another hospital (ACH 3) to that could provide this evaluation. During a record review of Resident 99's Death Summary from ACH 3 dated 9/29/24, it indicated transferred to (ACH 3) for continuous EEG monitoring on September 15. He was found to be in focal nonconvulsive status epilepticus (a medical emergency that involves a series of seizures or a single seizure that lasts at least 30 minutes). Status post (after) intubation (a medical procedure that involves inserting a tube (called an endotracheal tube) into the trachea (windpipe) to maintain an open airway) and transfer to neurocritical care unit on September 17 .continued to have intermittent right focal seizures despite five anti-seizure medication regimen. The patient was transitioned to comfort-focused care (type of medical treatment that focuses on providing comfort and support to patients who are near the end of their lives) on September 29. The patient passed away on September 29. During review of facility policy and procedure titled Reconciliation of Medications on Admission, revised 7/1017, it indicated, the purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility .Preparation-1. Gather the information needed to reconcile the medication list: a. approved medication reconciliation form . General Guidelines- .2. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taken continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process.

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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. 40968 Based on observation, interview, and record review, the facility failed to ensure pharmacy services policies and procedures were followed when: 1. Licensed Vocational Nurse (LVN) 1 left the medication cart unlocked and unattended in the hallway. 2. The refrigerator for medication was not maintained within the required temperature range of 36 F to 46 F as outlined in the facility policy and procedure. These failures had the potential for loss or misuse of medications and the potential to jeopardize the residents' health and safety due to improper storage conditions. Findings: 1. During an observation on 1/21/25, at 2:55 p.m., medication cart II was unlocked, unsupervised and unattended with drawers facing the hallway directly outside the dining and activity room. During a concurrent observation and interview with LVN 1 on 1/21/25 at 2:57 p.m., LVN 1 returned to the medication cart II then proceeded to lock the cart. LVN 1 stated, she did not ensure it fully locked prior to leaving medication cart II unattended. LVN 1 further added, it was important to keep medication cart locked because anyone unauthorized can take medications from the cart. 2. During a concurrent observation and interview on 1/23/25, at 12:45 p.m. inside the medication room, with the Director Of Nursing (DON), there were multiple medications including vaccines, insulin, Tuberculosis skin test, and a refrigerated emergency kit containing various medications, were stored at a temperature of 30 F, as indicated by the thermometer. DON stated, refrigerated medications should be stored at 40 F. DON further added, medications stored outside the parameters may be compromised and become ineffective. During a concurrent interview and a second observation on 1/24/25, at 1:37 p.m. a second observation of storage of refrigerated medications was conducted with the DON. The temperature of the refrigerator storing refrigerated medications was noted to be 35 F. DON stated, the temperature was not acceptable and that refrigerated medications are compromised. DON acknowledged, he did not take corrective actions concerning proper storage of refrigerated medications. During a review of the facility's policy and procedure (P&P), titled Security of Medication Cart, dated, April 2007, the P&P indicated, 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should be parked in the doorway of the resident's room during the medication pass. The cart doors and drawers should be facing the resident's room. 3.the cart should be parked in the hallway against the wall with doors and drawers facing the wall . 4. The medication carts must be securely locked at all times when out of the nurse's view. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, MEDICATION STORAGE IN THE FACILITY, dated, 4/2008, indicated, Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is only accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized.B. Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. During a review of the facility's P&P titled, MEDICATION STORAGE IN THE FACILITY, dated, 4/2008, indicated, Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .K. Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring.O. Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51636 Based on observation, interview, and record review, the facility failed to follow food safety standards: 1. Cook1 did not wear beard net while preparing desert, when he had about an inch long beard. 2. Five bowls with dry cereal and one bowl with white granulated powder were left unlabeled and undated in the kitchen cabinet. These failures posed a potential risk for food safety and placed facility's residents at risk for food borne illnesses. Findings: During a concurrent observation and interview with [NAME] 1 and Dietary Services Supervisor (DSS) on 1/21/25 at 9:42 a.m., in the kitchen, [NAME] 1 was preparing desert that needed to be served during lunch on that day. [NAME] 1 had a surgical mask on his face, with about one-inch-long uncovered beard visible on both sides of the face, and did not have a beard net on. When asked if facility provided beard nets, Cook1 asked if he needed to wear beard net even with face mask on. During a review of facility's Policy and Procedure (P&P) titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices dated 11/2022, the P&P indicated, Hair net or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. During a concurrent observation and interview with DSS and [NAME] 1 on 1/21/25 at 9:53 a.m., in the kitchen, there were five bowls with dry cereal covered with a clear plastic wrap; and one small bowl with white granulated powder covered with plastic lid in a closed cabinet, with other clean utensils. Both cereal bowls and bowl with white powder were not labeled and dated. [NAME] 1 stated the cereal in the bowls were poured that morning and Evening [NAME] was responsible for adding the label onto the cereal bowls. DSS then stated any food should be labeled and always dated. DSS stated the white granulated powder was food thickener and needed to be labeled as well. During a review of facility's P&P titled Food Receiving and Storage dated 11/2022, the P&P indicated, Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 51636 Based on interview, and record review, the facility failed to comply with Health Insurance Portability and Accountability Act (HIPAA) to protect Resident-identifiable information, including but not limited to full name, date of birth (DOB), and clinical status. Clinical staff including attending physician, nurses, nursing managers; and non-clinical staff including Administration, medical records personnel used their personal cell phones to exchange residents' Protected Health Information (PHI) and confidential biographical details and received text messages for above details even when they were off duty. This failure posed a potential significant risk to protect the privacy and security of facility's residents' information. Findings: During an interview and record review with Licensed Vocational Nurse (LVN) 1 on 1/24/25 at 12:17 p.m., Resident 249's clinical chart for pain management was reviewed. LVN 1 stated she was aware of Resident 249's complaints of pain as she had notified the doctor about it. When asked to show the communication between LVN 1 and Resident 249's doctor, LVN 1 stated she used her personal cell phone to send a text message Resident 249's doctor. During an interview and record review with LVN 1 on 1/24/25 at 12:20 p.m., LVN 1's personal phone was reviewed. LVN 1 stated she used an app called Signal to send a group text thread to clinical team which included doctor, nurses working at the facility, and management team including Director of Nursing (DON), Director of Staff Development (DSD), Administrator (ADM). LVN 1 then showed the group text message dated 1/15/25, which included Resident 249's full name, DOB, and included details for his complaints of pain, episode of fall, request to change his pain medication, details of current narcotic pain medication including name and dosage of the medication. LVN 1 then stated all staff had access to Signal messaging app. LVN 1 stated she was not sure if it was an encrypted app. LVN 1 stated she had been using this messaging app to exchange resident's PHI since she started working at the facility, 09/2024. LVN 1 also stated she took her personal cell phone with her, at her home, at the restaurants, in public areas, when she was off the clock and not working, posing a higher risk of lost/stolen residents' PHI. During an interview with DON on 1/24/25 at 12:43 p.m., DON stated he did not have a facility designated device assigned to him and had Signal app downloaded on his personal cell phone. DON stated he did not know how to ensure if Signal app was an encrypted application. DON stated he needed to enter a passcode to open the Signal app only once a while but not all the time. DON stated he was able to access all text messages and residents' PHI exchanged among staff on the Signal app, even when he was off the clock. The DON stated he carried his personal cell phone around wherever he needed to go, when he was off the clock. The DON stated his staff also continued to get the messages even when they were off. The DON stated it was risky because anyone could break into their personal cell phones, posing an extreme risk for breech to residents' PHI, however they had not discussed this being an issue as an Interdisciplinary Team (IDT) so far. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with ADM on 1/24/25 at 12:56 p.m., ADM stated she did not think exchanging residents' PHI, using Signal app on staff's personal cell phones was concerning as she had verbally reminded the staff not to view and respond to the messages when they were off duty. ADM stated she considered reminding staff. During an interview and record with facility's Clinical Consultant (CC) and ADM on 1/24/25 at 1:43 p.m., facility's California Employee Handbook 2023 was reviewed. ADM stated facility followed the handbook to maintain confidentiality of residents' records. The handbook indicated, ADM and certain staff members were permitted to use their personal mobile devices during work hours to communicate facility related business .If you use devices on which information may be received and/or stored, including but not limited to cell phones . you are required to use these methods in strict compliance with the trade secrets and confidential communication policy established by the facility . CC stated providing access to facility residents' PHI to the staff on their personal cell phone and being able to access this info even when the staff was not on the clock/working, posed risk for medical breach. The CC also stated it was likely not enough to just remind the staff not to use personal device/apps when they are off the clock. During a review of facility's Policy and Procedure (P&P) titled Confidentiality of Information and Personal Privacy dated 10/2017, the P&P indicated, The facility will safeguard the personal privacy and confidentiality of all residents personal and medical records.

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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** 40968 Based on observation, interview, and record review, the facility failed to follow infection control prevention practices when: 1. Resident 11's nasal cannula (nc, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing was undated and unlabeled. 2. LVN (Licensed Vocational Nurse) 3 did not properly disinfect stethoscope (a device used to amplify internal body sounds) between residents. 3. Housekeeping Manager (HKM) held Resident 14's clean blankets against her clothing during transport to Resident 14's room. These failures had the potential for cross contamination and spread of infections among residents at the facility. Findings: 1. During a review of Resident 11's admission record, dated 1/23/25, indicated Resident 11 was admitted to the facility on [DATE]. During a review of Resident 11's Minimum Data Set (MDS, a federally mandated assessment tool) dated, 12/27/24, indicated Resident had multiple diagnoses that included, Asthma (lung condition that causes inflammation and narrowing of airways), Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that cause long-term breathing problem). During a review of Resident 11's order summary report, dated 12/22/24, indicated, oxygen: Change oxygen tubing to include NC and/or mask & storage bag every week. Date tubing and bag . During an observation on 1/21/25, at 10:33 a.m., Resident 11 was observed receiving oxygen via nc. The nc tubing was not labeled with date. During a concurrent observation and interview on 1/21/25 at 10:44 a.m. with LVN 3, LVN 3 acknowledged nc tubing was not labeled or dated. LVN 3 stated, there was no way for nursing team to know when the nc tubing was due to be changed when not labeled. LVN 3 added, the importance of labeling the nc tubing was to prevent Resident 11 who received oxygen from developing infection. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, dated 12/2011, the P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The P&P further indicated, .7. Change the oxygen cannula and tubing every seven (7) days, or as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 1/22/25 at 7:48 a.m. LVN 3 was observed using a stethoscope on Resident 22 and 14 without cleaning and disinfecting the stethoscope in between residents. LVN 3 was then observed using same stethoscope on Resident 31 and 1 also without cleaning and disinfecting between residents. LVN 3 stated, there was risk of spread of infection when she did not clean and disinfect stethoscope between residents. During an interview on 1/22/25, at 9:15 a.m., with the Infection Preventionist (IP), IP stated, stethoscope was a shared equipment and must be disinfected between each resident. IP added, there was risk of cross contamination when shared equipment was not disinfected after each use. IP also stated, it was important for nc tubing to be labeled with date, so that nursing team will know when the tubing is due to be changed. IP further stated, there was risk for infection especially for residents with low immune system. During a review of facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 9/2022, indicated, .5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment. 3. During a concurrent observation and interview on 1/24/25, at 11:35 a.m. in the presence of facility's IP, at the stairwell, HKM was seen carrying four clean blankets with her arms wrapped around holding the blankets against her personal clothing. HKM stated, she was transporting the blankets from laundry to Resident 14's room. IP acknowledged, HKM did not follow infection control practices and stated, HKM should have kept the beddings covered during transport to residents' room. During a follow up interview on 1/24/25, at 11:50 a.m., HKM acknowledged she did not follow policy when she carried residents bedding without cover, and held the beddings against her clothing. HKM also added, she was supposed to keep newly washed bedding clean during transport by securing the items in clean bag. During a review of facility's P&P, titled Departmental (Environmental Services)- Laundry and Linen, dated, 1/2014, indicated, The purpose of this procedure is to provide a process for the safe and septic handling, washing, and storage of linen. P&P also indicated, .7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. During a review of facility's P&P, titled Laundry and Bedding, Soiled, dated 9/2022, indicated under Transport .6. Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness.