STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055776	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Healthcare Center	12225 Shale Ridge Lane Auburn, CA 95602

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48874 Based on observation, interview, and record review the facility failed to ensure resident rights were maintained for one (Resident 31) out of a census of 164 when the RP (responsible party) was not given the opportunity to consent for a placement of PPD skin test (a test to help diagnose tuberculosis (TB), a lung illness) and an addition of D-Mannose (a supplement to help prevent urinary tract infections) to Resident 31's medication profile. This failure resulted in Resident 31's RP not being able to participate in the plan of care and Resident 31 receiving medical treatment without proper consent. Findings: A review of Resident 31's admission record-indicated that Resident 31 was first admitted to the facility in the fall of 2016 with several diagnoses including hemiparesis (weakness) and hemiplegia (unable to move) following cerebral infarction (decreased blood flow to the brain affecting dominant side, dysphagia (trouble swallowing) following cerebral infarction, and functional quadriplegia (paralysis of all limbs). A review of Physician orders dated 9/8/22, indicated, Resident Is (Incapable) Of Understanding Rights, Responsibilities, And Informed . A review of the Physician orders dated 5/26/24, indicated, Tubersol Solution, [PPD skin test] 5 unit/0.1 ml [a unit of measurement] inject 0.1 cc intradermally [just beneath the skin] every evening shift 365 days for TB screening. A review of Nurse's Progress notes dated 5/19/24 at 7:19 p.m. indicated, Contacted Resident's RP to discuss chest x-ray to rule out TB. RP declined chest x-ray, stating resident is a known reactor to tuberculin skin tests, he has a history of positive results and was on INH [treatment for positive PPD but person does not have symptoms of TB] for one year, in the 1990's. RP seemed upset that the resident was given a tuberculin test. Informed RP that I would note provided information. POC [Plan of Care] continuing. In an interview on 5/23/24 at 11:04 a.m. with LN 1, LN 1 stated that when a PPD is placed for a resident she does not need to get consent from the resident or RP because they have already given consent when the resident was admitted . (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/22/24 at 8:55 am with the IP (Infection Prevention Nurse), IP stated that Resident 31 was readmitted on [DATE], and that the RP would have been made aware that Resident 31 was going to be screened for TB with a PPD skin test. She further stated that residents and RPs are made aware and give consent for this when they sign the consent to treatment section of the admission paperwork. In an interview on 5/24/24 at 8:32 a.m. with ADON (Assistant Director of Nursing), ADON stated that when a resident is admitted the resident or RP agrees to TB screening as part of the consent to treat. She confirmed that on the Care Profile for Resident 31, it states, Notify RP of any changes to Resident 31's plan of care. During an interview on 5/24/24 at 11:09 a.m. with the IP, the IP confirmed that other than the consent to treatment paperwork that Resident 31's RP signed, she could not produce another document with RP's signature consenting to PPD testing. A review of admission paperwork dated 5/16/23, In the section titled, Consent to Treatment it indicated, We will keep you informed about the routine nursing and emergency care we provide to you, and we will answer your questions about the care and services we provide you. A review of Physician orders dated 4/3/24, indicated, Mannose D 500 mg capsules-Give 2 capsules by mouth one time a day for frequent UTIs (Urinary Tract Infection- An illness in any part of the urinary tract, the system of organs that makes urine). In an interview on 5/23/24 at 11:26 a.m. with LN 2 stated that when an LN takes an order for medication or treatment, it is the LN's responsibility to call the RP. If the RP is not contacted there is risk that the resident has loss of control in the resident's care. During an interview on 05/22/24 at 09:15 a.m. with the DON (Director of Nursing), the DON stated that the RP should be notified with changes in treatment or medication. She stated that when the nurse takes a medication order, the nurse calls RP and notifies the RP. She further stated that the documentation that this was done would be found in the progress notes. In an interview on 5/23/24 at 9:24 a.m. with the DON, the DON stated that the RP for Resident 31 was not contacted regarding the addition of the D-Mannose. She stated her expectation would be that the LNs notify the RP with any changes in treatment for the residents. She further stated that the RP would be upset because she was not included in planning of the resident's care. During a review of the facility policy titled, Resident Rights, dated 2001, it indicated that, Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be informed of, and participate in, his or her plan of care and treatment.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 45718 Based on observation, interview and record review, the facility failed to ensure the Resident's personal and medical information was protected when the dietary tray tickets were discarded in the general trash. This failure had the potential to compromise the privacy and confidentiality of the 164 residents receiving facility prepared meals. Findings: During a Kitchen Tour on 5/21/24 at 8:21 a.m., in the dishwashing area, tray tickets with resident's name, ID number, room number, diet order and texture, food likes/dislikes, and food allergies were observed in the general trash bin. The Dietary Manager (DM) confirmed the resident's tray tickets were in the general trash. He stated, he was aware of the issue of throwing the tray tickets in the general garbage trash and he believed it was a HIPAA (Health Insurance Portability and Accountability Act, group of law designed to protect medical records and other health records) violation if the tray tickets were thrown in the general trash bin. During an interview on 5/23/24 at 8:44 a.m., the Registered Dietitian (RD) stated, dietary tray tickets should not be thrown in the general trash. She stated, the tray tickets should be kept in the shred box for resident's confidentiality. A review of the facility policy titled, Confidentiality of Information and Personal Privacy revised October 2021, indicated, .4. Access to resident personal and medical records will be limited to authorized staff and business associates . A review of facility policy titled, Resident's Rights, reviewed October 2023, indicated, 1. Federal and state laws guarantee certain basic rights to all residents .These rights include the resident's right to: .t. privacy and confidentiality .3. The unauthorized release, access, or disclosure of resident information is prohibited .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48445 Based on observation, interview, and record review, the facility failed to protect one of 33 sampled residents' (Resident 106) property from loss when Resident 106's inventory sheet was not signed and not verified for accuracy. This failure resulted in Resident 106 losing her phone and feeling sad, and decreased the facility's capabilities on protecting residents' properties from loss. Findings: During a review of Resident 106's admission records, Resident 106 was admitted in November of 2021 with diagnoses which included hemiplegia and hemiparesis (weakness of one side of the body) following cerebral infarction (damage to tissues in the brain due to loss of oxygen to the area). Resident 106's minimum data set (MDS, an assessment tool), dated 2/8/24, indicated Resident 106 had moderate cognitive impairment. During an interview on 5/21/24 at 8:54 a.m. with Resident 106, Resident 106 stated, My phone was lost here when I moved to this room several months ago, I told my son, reported to staff, everybody looked, no one found it, that made me feel terrible, my [family members] call me .but now I don't talk to them anymore .made me feel sad because there's no one to talk to. During a review of a facility document titled, Inventory Sheet dated 11/2/21, the document indicated, Galaxy A51 [a smartphone manufactured by Samsung Electronics] listed under the section of items removed after admission but there was no signature of the staff who removed the item. There was also no signature of resident representative or staff indicated on the document verifying the accuracy of the list. During a concurrent interview and record review on 5/23/24 at 8:27 a.m. with Licensed Nurse (LN) 6, LN 6 stated, We just moved in this hallway a couple of months ago. Everyone got an inventory, and inventory sheets were checked. LN 6 reviewed Resident 106's chart but LN 6 was not able to locate the new inventory sheet done during the room transfer. During a concurrent observation and interview on 5/23/24 at 8:47 a.m. with LN 6, LN 6 was observed asking Resident 106 about the missing phone and Resident 106 confirmed the phone was lost during the room transfer. LN 6 searched Resident 106's belongings with resident's consent. LN 6 confirmed the phone was not in the room and stated, I had no idea. I was part of the move, we moved residents around and had inventory sheets. The goal is to get the phone back. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/23/24 at 9:48 a.m. with the Social Services Director (SSD), the SSD stated, We don't do inventories for change of rooms typically, but it should be done to make sure nothing is missing. The SSD confirmed there was no inventory during the transfer and the last inventory was done 11/2021 upon admission. The SSD confirmed there were no signatures on the inventory sheet and stated, No one signed her form, it should be signed by the RP [Responsible Party] or resident upon admission and by staff completing the list. No one confirmed that the list was accurate . During a concurrent interview and record review on 5/23/24 at 11:45 a.m. with the Director of Nursing (DON), the DON stated, Expectation is for staff to inventory things when they come in to the facility .when they move, verify the belonging are listed accurately and should match, resident or RP should be able to verify their belongings and staff who did the inventory should also sign .we can't confirm if the belonging got there. The DON confirmed the phone was on the inventory list and stated, I don't see any signatures on it. We don't know if belongings were complete or if it was removed. During a review of the facility provided document titled, RESIDENT RESPONSIBILITIES AND RULES OF CONDUCT, undated, 7. Residents are encouraged to leave all valuables at home. All valuables .retained by the resident will be inventoried, and a copy of such inventory will be provided to the resident or representative. The original copy shall be filed in the resident's medical record. During a review of the facility's policy and procedure (P&P) titled, Personal Property, dated 8/2023, the P&P indicated, The resident's personal belongings and clothing shall be inventoried and documented upon admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45770 Based on interview and record review the facility failed to develop a comprehensive person-centered care plan for one of 33 sampled residents (Resident 126) when Resident 126's care plan did not address the order for nectar thick fluid consistency when it was initiated. This failure had the potential for the order to be missed and not implemented. Findings: A review of Resident 126's clinical record indicated she was admitted in 7/2022 with diagnoses including cerebral infarction (stroke, blood flow to the brain is disrupted) with residual effects and seizures. A review of Resident 126's Minimum Data Set (MDS, an assessment tool used to guide care), dated 4/18/24, indicated that Resident 126 had severe cognitive impairment, unable to make own healthcare decisions. A review of Resident 126's Order Summary Report, dated 10/17/23, and the quarterly Nutritional Risk Review, dated 4/18/2024, both documents indicated a diet order of finger food regular chopped meat texture with thickened liquids nectar consistency. In a concurrent interview and record review on 5/24/24 at 10:28 a.m. with the Director of Nursing (DON) the DON confirmed there was no care plan developed to address Resident 126's order for nectar thick liquids when it was ordered in 10/2023. DON stated staff should have developed and completed the care plan within 7 days and revised as resident's condition change. A review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive reviewed 10/2023 the P&P stipulated The comprehensive, person-centered care plan is developed within seven (7) days . Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44780 Based on interview and record review, the facility failed to meet professional standards of quality for Resident 59 in a census of 167 when Licensed Nurse (LN) 12 and LN 13 failed to report to the facility's physician about Resident 59's verbalization to commit suicide. This failure had the potential to adversely affect Resident 59's safety. Findings: A review of Resident 59's 'Admission Record' indicated Resident 59 was admitted to the facility under Hospice services in early April 2024 with terminal diagnosis of cognitive social or emotional deficits following Cerebral Vascular Accident (damage to the brain from interruption of its blood) with underlying Dementia (group of thinking and social symptoms that interferes with daily functioning), Bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and depression. In a review of Resident 59's Minimum Data Set (MDS, a standardized assessment tool), dated 4/9/2024, the section about the resident's mood showed symptoms of little interest or pleasure in doing things, feeling down and depressed or hopeless. A review of Resident 59's 'Progress Notes,' dated 5/16/2024, written by LN 12 at 1:05 p.m., indicated, . resident feeling overwhelmed today. Resident voiced to CNA [Certified Nursing Assistant] Staff that she has thoughts of hurting herself. I went to speak with the resident and she stated, I want to commit suicide. All sharp items including silverware have been removed from resident reach and room .Resident asked if she has any plans as to how she will harm herself and she has no plan. Will continue to monitor resident for any changes . A review of Resident 59's 'Progress Notes,' dated 5/16/24, written by LN 13 at 10:55 p.m., indicated, .Notified during report of resident's suicidal thoughts .Notified NOC [night] CNA re. suicidal thoughts . In an interview on 5/21/24 at 4:02 p.m. with LN 13, LN 13 stated, .Resident is depressed, she verbalized wanted to commit suicide, we removed anything sharp, frequent checks . In a concurrent interview and record review for Resident 59 on 5/22/24 at 11:10 a.m. with Assistant Director of Nursing (ADON), ADON stated, .records showed documentation about the suicide ideation, we notified hospice but also, we need to carry on with the interventions. Attempt to notify the family, difficult to get hold of her sister, who is the RP [responsible party], hospice physician notified, hospice was notified, no care plan made, typically we do have a care plan. If you are asking for suicidal ideation, there should be a care plan. There should a change of condition in the chart, not that I see one. Our process is the situation like this warrants the Change of condition . ADON confirmed that the Director of Nursing (DON) and facility physician were not informed about the resident's suicidal ideations. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview on 5/24/24 at 11:10 a.m., the DON stated that it was her expectation that this incident would be reported to her, hospice, Social Services Director, notify facility's physician or Nurse Practitioner (NP), open a change of condition, remove items that might be dangerous to the patient. They would be doing monitoring for every 15 minutes for 72 hours. The DON confirmed she and the ADON did not see the follow up to the facility physician. In a concurrent interview on 5/24/24 at 9:26 a.m., with Social Services Director (SSD), SSD stated that it is her expectation for staff to inform her immediately of a residents' verbalization of suicidal thoughts. A review of the facility's policy and procedure titled, Suicide Threat Management, dated 2001, indicated, Staff shall report any resident threats of suicide immediately to the Charge Nurse .After assessing the resident in more detail, the Charge Nurse shall notify the resident's Attending Physician and responsible party, and shall seek further direction from the physician .Staff shall document details of the situation objectively in the resident's medical record . A review of the California Business and Professions Code, Division 2, Chapter 6, Article 2, Section 2725(b)(1), indicated the nurses' functions included direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45770 Based on observation, interview, and record review, the facility failed to ensure one of 33 sampled residents (Resident 43) received care in accordance with professional standards when Resident 43 was not turned and repositioned every two hours as ordered. This failure increased Resident 43's risk to develop skin breakdown. Findings: A review of an Admission Record indicated Resident 43 was admitted in late 2/2015 with diagnoses including contractures (fixed stiffening of the muscle fibers) of the upper extremities, hips, and ankles and a history of left ankle pressure ulcer (localized damage to skin and soft tissue because of prolonged pressure and shear). During observations on 5/22/24 at 7:50 a.m., 9:50 a.m. and 10:36 a.m., Resident 43 was lying flat on his back with both legs bent to the side. A review of Resident 43's Minimum Data Set (MDS, an assessment tool used to guide care) dated 3/17/24, showed he was dependent with bed mobility which required two-person assistance to complete the activity. A review of Resident 43's Order Summary Report dated 1/6/2022 and 11/14/2023 indicated two orders for turning and repositioning every two hours. In a concurrent observation and interview on 5/22/24 at 10:36 a.m. with Licensed Nurse 3 (LN 3), LN 3 acknowledged after doing a skin check that the left posterior (back) of Resident 43's ankle (the site of his old pressure ulcer) was noted to have developed redness again. During a concurrent interview and record review on 5/22/24 at 10:45 a.m. with LN 3, a documentation for Resident 43's turning and repositioning task, dated 5/21/24 and 5/22/24, were reviewed. LN 3 confirmed that the task was not signed every two hours as ordered and stated that the task should have been documented as completed to prove that it's being done by staff. During an interview on 5/24/24 at 10:28 a.m. with the Director of Nursing (DON) the DON verified that Resident 43 had an order for turning and repositioning every two hours, she also confirmed that the documentation for the task was not done as ordered every 2 hours. A review of the facility's Policy and Procedure (P&P) titled Repositioning revised 8/2023 the P&P stipulated The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort, to prevent skin breakdown .Residents who are in bed should be repositioned frequently . A review of the facility's P&P titled Physician Orders revised 10/2023 indicated Prescribed medications and treatment orders will be carried out in accordance with the physician/nurse practitioner order.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45770 Based on observation, interview, and record review the facility failed to provide necessary care and services for two of 33 sampled residents (Resident 126 and Resident 153) when: 1. Resident 126's order for thickened fluid consistency was not implemented; and 2. The fluid restriction order was not maintained and accurately monitored for Resident 153. These failures had the potential to increase the risk of aspiration for Resident 126 and to delay the improvement of Resident 153's bilateral lower extremity edema (swelling caused by trapped fluid in the body tissue). Findings: 1. A review of Resident 126's clinical record indicated she was admitted in 7/22 with diagnoses including cerebral infarction (stroke, blood flow to the brain is disrupted) with residual effects and seizures. A review of Resident 126's Minimum Data Set (MDS, an assessment tool used to guide care), dated 4/18/24, indicated that Resident 126 had severe cognitive impairment, unable to make own healthcare decisions. A review of Resident 126's Order Summary Report, dated 10/17/23, indicated a diet order of finger food regular chopped meat texture with thickened liquid nectar consistency. During a concurrent observation ad interview on 5/21/24 at 1:19 p.m. inside Resident 126's room, Certified Nurse Assistant 6 (CNA 6) gave Resident 126 a cup of coffee with her lunch tray, CNA 6 confirmed that she served Resident 126 a cup of regular thin coffee as requested. During a concurrent observation, interview, and record review on 5/22/24 at 1:22 p.m. with Licensed Nurse 4 (LN 4) verified the coffee that was served to Resident 126 was not thickened and should have been prepared nectar thick consistency as written and ordered by the physician. In a concurrent interview and record review on 5/24/24 at 10:28 a.m., with the Director of Nursing (DON) the DON confirmed Resident 126's diet included nectar thickened liquids. DON stated she expects the nursing staff to follow the doctor's order and implement it accurately to be able to provide proper care to residents and prevent accidents. 2. A review of an Admission Record indicated Resident 153 was admitted in 4/24 with diagnoses including bilateral lower extremity edema and fluid retention. During a concurrent observation and interview on 5/21/24 at 9 a.m. with Resident 153 inside her room, Resident 153 was sitting in her wheelchair and her legs, feet and ankles were noted to have edema. Resident 153 stated she's not in pain but her legs feel so tight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 153's Order Summary Report dated 5/8/24 it indicated an order for fluid restriction of 1. 5 liters a day with a breakdown of 720 milliliters (ml, unit of measurement) from dietary, and 780 ml from nursing - 300 ml for the morning shift, 300 ml for afternoon shift and 180 ml for the night shift. In a concurrent observation and interview on 5/23/2024 at 8:10 a.m. with Certified Nurse Assistant 3 (CNA 3) CNA 3 gave Resident 153 two full cups of hot water and coffee before the breakfast tray was served. CNA 3 stated he gives the same amount of fluid to Resident 153 whenever he's assigned to her. CNA 3 also confirmed he was not aware of Resident 153's order for fluid restriction. In a concurrent interview and record review on 5/23/24 at 11 a.m. with Licensed Nurse 15 (LN 15). A Progress Note for Resident 153 dated 5/20/24 was reviewed. LN 15 verified Resident 153's order for 1.5 liters of fluid restriction daily but added Resident 153 was non-compliant with the order which he reported to the Nurse Practitioner (NP). A review of a NP's progress note, dated 5/22/24, indicated the NP spoke with Resident 153 regarding her compliance with the fluid restriction order. Resident 153 replied to the NP that she's committed to her health and will follow the order for fluid restriction. In a concurrent interview and record review on 5/24/24 at 10:28 a.m., with the DON, Resident 153's Medication Administration Record (MAR) was reviewed, and the DON confirmed the amount of fluid offered and given daily by staff to Resident 153 exceeded the amount of fluid restriction ordered by the physician. The DON stated the nursing staff should have monitored Resident 153's fluid intake, and documented it accurately to help improve her condition. The DON further added, a care plan for non-compliance should have been developed if the resident refused to follow the doctor's order. A review of the facility's Policy and Procedure (P&P) titled Encouraging and Restricting Fluids reviewed 10/2023 the P&P stipulated The purpose of this procedure is to provide the resident with the amount of fluids that meet his/her needs. This may include encouraging or restricting fluids .Encourage the resident to follow any specific instruction or restriction. A review of the facility's P&P titled Therapeutic Diets revised 10/2023 it stipulated Therapeutic diets are prescribed by the MD/NP to support the resident's treatment and plan of care . A review of the facility's P&P titled Physician Orders revised 10/2023 it indicated Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 36681 Based on observation, interview, and record review, the facility failed to ensure the physician's order to change the oxygen cannula (a small, flexible tube with two open prongs used to deliver supplemental oxygen to the nose) was followed for two of 33 sampled residents (Resident 27 and Resident 99). This failure increased the potential for residents to have infections (growth of germs) caused by oxygen tubing not being changed as ordered. Findings: 1. A review of the 'ADMISSION RECORD' indicated Resident 27 was admitted with diagnoses including acute respiratory failure with hypoxia (a condition wherein there was not enough oxygen in the blood). A review of Resident 27's physician order, dated 4/23/24, indicated, Change Nasal Cannula, as needed AND every night shift every Sun [Sunday]. In an observation on 5/21/24 at 11:02 a.m., Resident 27's oxygen tubing was dated 5/12/24. A concurrent observation and interview was conducted on 5/21/24 at 3:25 p.m. with the Licensed Nurse 5 (LN 5). Resident 27's oxygen tubing was dated 5/12/24. The LN 5 stated she would check Resident 27's clinical records. In a follow-up interview on 5/21/24 at 4:15 p.m., the LN 5 stated the date written on Resident 27's oxygen tubing was the date the tubing was changed. The LN 5 further stated the oxygen tubing should be changed every Sunday. In an interview on 5/24/24 at 10:49 a.m., the Infection Prevention Nurse (IP) stated if the oxygen tubing was not changed as scheduled it could cause contamination. The IP further stated the oxygen tubing needs to be changed as scheduled to minimize the growth of bacteria [type of germ]. 45770 2. A review of Resident 99's clinical record indicated he was admitted the early part of 3/24 with diagnoses including acute respiratory failure with hypoxia. In a concurrent observation and interview on 5/21/24 at 9:28 a.m., with Certified Nurse Assistant 3 (CNA 3) Resident 99 was sitting upright in bed using some oxygen via nasal cannula. The tubing had yellowish discoloration and water inside. CNA 3 confirmed the tubing was labeled 5/12/24. During a concurrent interview and record review on 5/21/24 at 9:57 a.m., LN 4 stated Resident 99 had an order for the continuous use of oxygen via nasal cannula, 3 liters per minute. LN 4 acknowledged that the cannula tubing was last changed on 5/12/24 as indicated on the label attached to it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an Order Summary Report dated 3/7/24 it indicated Resident 99 had an order for the use of oxygen 3 liters/minute via nasal cannula continuously for shortness of breath. The order also included changing the nasal cannula every Sunday night and as needed. In an interview on 5/24/24 at 10:28 a.m. with the Director of Nursing (DON), the DON stated she expected her staff to carry out and follow the physician's order accurately and be able to implement it on time. A review of the facility's policy and procedure (P&P) revised October 2023 and titled, Oxygen Administration indicated, .Oxygen therapy is administered by way of . nasal cannula .The nasal cannula is a tube that is placed into the resident's nose .The Oxygen tubing is changed at least weekly, labeled with the date it was changed . A review of the facility's P&P titled Physician Orders revised 10/2023 indicated Prescribed medications and treatment orders will be carried out in accordance with the physician/nurse practitioner order.

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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** 36681 Based on observation, interview, and record review, the facility failed to ensure the fluid intake for one of 33 sampled residents (Resident 27) was accurately monitored and communicated to the physician. This failure increased the potential for Resident 27 to experience fluid overload (too much fluid in the body). Findings: A review of the 'ADMISSION RECORD' indicated, Resident 27 was admitted with diagnoses including end stage renal disease (the kidneys [remove waste products from the blood] can no longer function on their own) and dependence on renal dialysis (the blood goes through a dialyzer [special machine removing waste and extra fluid from the blood] before it is pumped back to the body). A review of Resident 27's physician order dated 4/23/24 indicated, Fluid Restrictions- Trial 1 L [liter - approximately 34 fluid ounces]/day. every shift for Trial period recommended by Dialysis RD [Registered Dietitian] Please notify NP [Nurse Practitioner] if [Resident 27] noncompliant. 1.0 L [liter] FR [Fluid Restriction] Breakdown: Dietary: 360ml [sic, milliliter- unit of measurement] [360 ml is approximately 12 fluid ounces] daily. Nursing: 640ml daily. @AM shift 240ml [approximately 8 ounces] @PM shift 240ml @NOC (night) shift 160ml [approximately 5 ounces] . Further review of Resident 27's clinical record indicated a 'Readmission H&P [sic, History & Physical]' dated 5/17/24, indicated, [Resident 27] . readmitted . after a 3-day admission at [acute care hospital] for acute respiratory failure secondary to bilateral pleural effusions [fluid builds up in the space between the lung and chest wall] and fluid overload. In a concurrent observation and interview on 5/21/24 at 11:20 a.m., Resident 27 had a dry dressing on the left upper arm. Resident 27 stated he will go for dialysis tomorrow. In an interview on 5/22/24 at 8 a.m., the Certified Nursing Assistant 4 (CNA 4) stated Resident 27 was on fluid restrictions per physician's order. In a concurrent observation and interview on 5/23/24 at 8:15 a.m., Resident 27 was lying in bed and there were two thirds full of an 8 ounce [approximately 5 ounces] water bottle at his bedside. Resident 27 confirmed he drank from the water bottle, and he stated nobody controls the amount of water he drinks. Resident 27 did not respond when he was asked who provided the water bottle at bedside. In an interview on 5/23/24 at 2:45 p.m., the CNA 5 stated she was assigned to Resident 27 today. The CNA 5 further stated Resident 27 on dialysis every Monday, Wednesday, and Friday and the resident was on fluid restriction of 1 liter per day, broken down in 3 shifts. The CNA 5 added the fluids from the kitchen was sent with the meal tray. The CNA 5 stated Resident 27 cannot have a water bottle at bedside. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent observation and interview on 5/23/24 at 2:51 p.m., the CNA 5 confirmed there was an 8 ounces water bottle, half full in Resident 27's bedside. The CNA 5 stated she did not see the water bottle this morning and CNA 5 had no idea who provided the water bottle to Resident 27. The CNA 5 took the water bottle and discarded the contents in the sink and stated the water bottle should not be there. In a concurrent interview and record review on 5/23/24 starting at 4:18 p.m., the Nurse Supervisor (NS) stated Resident 27's one liter of fluid restriction was recommended by the dialysis Registered Dietitian. The NS confirmed there were 3 days wherein Resident 27's fluid intake was over 1 liter per day on 5/5, 5/11, and 5/18 (non dialysis days) and this was an indication of Resident 27's noncompliance. A follow-up interview was conducted with the CNA 4 on 5/24/24 at 9:27 a.m. The CNA 4 stated her documentation for Resident 27's fluid intake consisted of the fluids taken by the resident from the kitchen, by her [CNA 4], and the fluids given by the nurse. The CNA 4 further stated staff cannot leave a water pitcher at Resident 27's bedside. An interview was conducted with Resident 27's Attending Physician (AP) on 5/24/24 at 9:42 a.m. The AP stated Resident 27 was confused and staff should be monitoring his fluid intake. The AP further stated if Resident 27 was non-compliant with the fluid restriction, her expectation was for the nurses to communicate the noncompliance with her or to the NP. A follow-up interview and record review was conducted with the NS on 5/24/24 at 9:51 a.m. The NS confirmed Resident 27's fluid intake documented by the CNAs and the fluid intake documented by the licensed nurses (LNs) were different. The NS further confirmed the fluid intake for Resident 27 as follows: - on 5/5/24, the CNAs documented a total fluid intake of 1060 ml (100, 720, and 240) and the LNs documented a total of 600 ml (240, 240, and 120); - on 5/11/24, the CNAs documented a total fluid intake of 1100 ml (440, 360, and 300) and the LNs documented a total of 840 ml (480, 240, and 120); and - on 5/18/24, the CNAs documented a total fluid intake of 1320 ml (240, 480, and 600) and the LNs documented a total of 480 ml (120, 240, and 120). The NS stated her expectation was for the CNAs to communicate with the LNs on how much fluid was given every shift for a resident on fluid restriction. The NS further stated there was no notification made to the MD or NP of Resident 27's noncompliance with the fluid restriction. There was no documented evidence in the clinical records of the AP or NP notified of Resident 27's noncompliance with the fluid restriction. A review of the facility's policy reviewed [DATE], and titled, Encouraging and Restricting Fluids, indicated, The purpose of this procedure is to provide the resident with the amount of fluids that meet his/her needs. This may include . restricting fluids . Verify that there is a physician's order for any fluid restriction . Record fluid intake . If the resident refuses to follow restriction, inform the MD [Medical Doctor]/NP .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48445 Based on interview and record review, the facility failed to ensure accurate accountability of controlled medications (medications with high potential for abuse or addiction) when random controlled medication audits of the Medication Administration Record (MAR) and Controlled Drug Record (CDR) for three out of three residents (Residents 30, 119 and 120) did not reconcile to indicate the medications were given to the residents. This failure resulted in the facility not having accurate accountability of controlled medications and the potential for abuse, misuse, and diversion of these medications. Findings: Resident 30 had a physician's order dated 12/2/23 for Morphine (medication used to treat moderate to severe pain) 15 milligrams (mg, a unit of measurement), one tablet every 12 hours for pain management. The MAR indicated one tablet was administered to Resident 30 on 5/12/24 at 8 a.m. The CDR did not indicate Morphine was signed out for Resident 30 on this date and time. The CDR also indicated the tablet count was 21 on 5/11/24 at 8 p.m. but the count was 20 on the succeeding entry on 5/11/24 at 7:15 a.m. Resident 119 had a physician's order, dated 8/15/23, for Norco (medication used to treat moderate to severe pain) 5-325 mg, one tablet every six hours as needed for pain. The MAR indicated one tablet was administered to Resident 119 on 5/18/24 at 11:57 p.m. The CDR did not indicate Norco was signed out to Resident 119 on this date and time. The CDR also indicated one tablet of Norco was signed out on 5/2/24 at 1:20 a.m., 5/7/24 at 1 p.m., 5/19/24 at 11:30 p.m., and 5/21/24 at 2:45 a.m., but the MAR did not indicate that Norco was administered on these dates. Resident 120 had a physician's order, dated 9/10/22, for Norco 5-325 mg, one tablet every six hours for pain management. The MAR indicated one tablet was administered to Resident 120 on 5/14/24 at 12 p.m. The CDR did not indicate Norco was signed out for Resident 120 on this date and time. During a concurrent interview and record review on 5/23/24 at 11:45 a.m. with the Director of Nursing (DON), the DON confirmed the discrepancies with the count on the MAR and CDR on the three residents. The DON stated the expectation for staff is when they give a narcotic or any medication, they should document in the MAR and the CDR should match. The DON further stated, It looks like the medications are not given as ordered. We don't know if they were given. During a review of the facility's Policy and Procedure (P&P) titled, Controlled Medications, revised 4/2023, the P&P indicated, 4. When a controlled medication is administered, the licensed nurse administering the medication enters the following information on the accountability record and the medication administration record (MAR): a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose, completed after the medication is actually administered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48445 Based on interview, and record review, the facility failed to ensure one of 33 sampled residents (Resident 10) was free from unnecessary medication when Resident 10's antibiotic (medication used to treat infections caused by bacteria) was renewed without documented clinical rationale. This failure resulted in unnecessary medication for Resident 10, which had the potential for increased risk of antibiotic resistance and exposure to side effects associated with prolonged antibiotic use. Findings: During a review of Resident 10's admission record, the record indicated Resident 10 was admitted to the facility in February of 2024 with multiple diagnoses which included overactive bladder (a problem with the organ that stores urine that causes the sudden need to urinate), chronic kidney disease (gradual loss of kidney function), and urinary tract infection (UTI, an infection in any part of the system of organs that makes urine). Resident 10's Minimum Data Set (MDS, an assessment tool) indicated Resident 10 had intact cognition. During an interview on 5/22/24 at 9:09 a.m., within the medication pass observation, with Licensed Nurse (LN) 12, LN 12 stated Resident 10's Macrobid (antibiotic used to treat UTI) 100 milligrams (mg, a unit of measurement) was not in the cart, and she would confirm if the order was still active. During a review of the facility provided document titled, Physician's Orders, dated 5/14/24, the document indicated, + [positive] UTI Macrobid i [one] PO [by mouth] BID [twice daily] x [for] 7 days new onset urinary incontinence urinary urgency bladder discomfort, malaise [a feeling of overall weakness]. Urine C&S [culture and sensitivity, a test to find germs that cause an infection and what kind of medicine will work best to treat the infection] .which by itself doesn't meet criteria except pt [patient] is highly symptomatic. During a review of Resident 10's physician order dated 5/14/24, the order indicated an order for Macrobid 100 mg by mouth two times a day for UTI. The order indicated the end date of the medication as Indefinite. During a review of Resident 10's nursing progress notes dated 5/22/24, the notes indicated, Verbal order received from NP [Nurse Practitioner] to extend Macrobid order. New stop date of 5/24. Orders carried out. During a review of Resident 10's physician order dated 5/22/24, the order indicated the renewal of Macrobid 100 mg by mouth two times a day for UTI to be given until 5/24/24. A review of Lexi-comp, a nationally recognized drug information resource, indicated, Dosing: Adult .Cystitis [bladder infection], acute uncomplicated or acute simple cystitis (infection limited to the bladder without signs/symptoms of upper tract, prostate, or systemic infection), treatment: Macrobid: Oral: 100 mg twice daily; treat females for 5 days and males for 7 days. (www.lexicomp.com; accessed 5/24/24) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent phone interview and record review on 5/24/24 at 8:58 a.m. with the Pharmacy Consultant Supervisor (PCS), the PCS confirmed Macrobid was started on 5/14/24 and verified that the order didn't have an end date and stated, In the direction there wasn't an end date. I don't know why it was discontinued. The PCS confirmed the antibiotic was extended for another two days on 5/22/24 and stated, I don't see anything documented about the reason on extending Macrobid. I don't know if they just missed a dose. That's just the reason that I can see .I didn't see any necessary documentation that she's having symptoms . Technically, if you could be giving an antibiotic, that can contribute to antibiotic resistance. An extended period of time, when it's not needed, could contribute to resistance. It may not have been necessary. During an interview on 5/24/24 at 10:38 a.m. with the Attending Physician (AP), the AP stated, I'm not sure why [NP] extended it unless [Resident 10] is having symptoms. Sometimes I will extend an antibiotic if resident is symptomatic, with this case, I don't see any reason listed to extend it. CBC [complete blood count] is about the same. It wasn't documented. If they are symptomatic, I will continue the antibiotic. It should have been documented why it was extended .every medication has side effects, the main thing is resistance. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship - Orders for Antibiotics, revised 12/2016, the P&P indicated, 3. Appropriate indications for use of antibiotics include: a. Criteria met for clinical definition of active infection or suspected sepsis .4. Empirical use of a antibiotic based on clinical criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record. During a review of the facility's P&P titled, POLICIES, PRACTICES AND INTERVENTIONS TO IMPROVE ANTIBIOTIC USE, revised 10/2017, the P&P indicated, 1. Policies that support optimal antibiotic use . Documentation of dose, duration and indication, which includes both rationale (i.e. prophylaxis vs therapeutic) .4. Infection and syndrome specific interventions to improve antibiotic use .Reduce antibiotic prophylaxis for prevention of UTI, as antibiotic exposure may increase the risk of side effects and resistant organisms.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45718 Based on observation, interview, and record review, the facility failed to consistently monitor, and document side effects and behaviors associated with psychotropic medications (medications that affect the mind, emotions, and behavior) use for one of 33 sampled residents (Resident 91). This failure had the potential for unnecessary use of psychotropic medications for Resident 91. Findings: A review of Resident 91's clinical record indicated he was originally admitted to the facility winter of 2021 with multiple diagnoses that included depression (mood disorder that causes a persistent feeling of sadness and loss of interest) and other psychotic disorder (mental disorders characterized by disconnection from reality which results in strange behavior often accompanied by disturbances of thought) not due to a substance or known physiological condition. A review of Resident 91's physician's order indicated the following psychotropic medications: OLANZapine Oral Tablet 7.5 MG (MG, milligram, unit of measurement) (Olanzapine) Give 1 tablet by mouth at bedtime for Psychosis M/B [manifested by] visual hallucinations. Lexapro Oral Tablet 20 MG (Escitalopram Oxalate) Give 40 mg by mouth one time a day for Depression M/B verbalization of sadness. bupropion HCl ER (SR) Oral Tablet Extended Release 12 Hour 150 MG (Bupropion HCl) Give 1 tablet by mouth every 12 hours for Depression m/b expressions of sadness. A review for Resident 91's Medication Administration Record (MAR) indicated the following: Monitor Episodes Anti-Depression m/b expressions of sadness every shift for Bupropion. Monitor Episodes of depression as evidenced by Verbalizations of sadness Drug Lexapro every shift for Lexapro use Day. Monitor Episodes Of PSYCHOSIS AEB [as evidenced by]: Visual hallucination Drug: Olanzapine every shift for Olanzapine use. Monitor S/E Antidepressant Drug: Bupropion SE Dry Mouth, Blurred Vision, Tachycardia [fast heart rate], Urinary Retention, Constipation, Confusion, Delirium Hallucinations, Flushing, Increased Blood Pressure, Postural Hypotension, Sedation, Fatigue, Dizziness, Ataxia [lack of coordination], Insomnia, Headache, Dry Eyes, Increased or Decreased Appetite Weight Loss or Gain, Nausea, Diarrhea, Anxiety Nervousness, Seizures, Sexual Dysfunction, Mania, Possible Liver Enzyme or Blood Abnormalities, Possible Falls, Suicidal Ideation, every shift for Bupropion. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor S/E Antidepressant Drug: Lexapro Dry Mouth, Blurred Vision, Tachycardia, Urinary Retention, Constipation, Confusion, Delirium, Hallucinations, Flushing, Increased Blood Pressure, Postural Hypotension, Sedation, Fatigue, Dizziness, Ataxia, Insomnia, Headache, Dry Eyes, Increased or Decreased Appetite, Weight Loss or Gain, Nausea, Diarrhea, Anxiety, Nervousness, Seizures, Sexual Dysfunction, Mania, Possible Liver Enzyme or Blood Abnormalities, Possible Falls, Suicidal Ideation, every shift. Monitor S/E Anti-Psychotic Drug: Dry Mouth, Blurred vision, Tachycardia, Urinary Retention, Constipation, Confusion, Delirium, Hallucinations, Flushing, Increased Blood Pressure, Sedation, Loss Of Appetite, Photosensitivity, Possible Blood Abnormalities, Day Fainting, Falls, Cardiac Arrhythmias, Orthostatic Hypotension, Increase In Cholesterol & Triglycerides, Unstable Or Poorly Controlled Blood Sugar, Weight Gain, Akathisia [inability to remain still], Parkinsonism [brain condition that causes slowed movement and stiffness], Dystonia [lack of muscle tone], Tardive Dyskinesia [repetitive, involuntary movements], every shift for Drug: Olanzapine .Neuroleptic Malignant Syndrome, Cerebrovascular Event, Subdued Behavior, Withdrawal Compared To Baseline, Or Limitation In Functional Capacity. Drug: Olanzapine. The MAR indicated Resident 91 was not monitored for the listed behavior and side effects monitoring for a total of 50 shifts from February 2024 to May 2024 (9 shifts for the month of February 2024, 14 shifts for March 2024, 15 shifts for April 2024 and 12 shifts for May 2024). During a concurrent observation and interview on 5/21/24 at 10:19 a.m., in Resident 91's room, Resident 91 was lying in bed, his call light was within reach. Resident 91 was calm and conversant. During a concurrent interview and record review on 5/23/24 at 4:23 p.m., the Director of Nursing (DON) verified several shifts for Resident 91's behavior and side effects monitoring were not signed from February to May 2024. She stated if it was not signed then it was not done. She further stated residents with psychotropic medications should be monitored for behaviors and side effects of the medications. She further stated monitoring is important because it helps them decide whether to continue or to adjust the dose. A review of facility policy titled, Psychotropic Medication Use, revised October 2023, indicated, .7. The staff will observe, document, and report to the Physician/Nurse Practitioner information regarding the effectiveness of any interventions, including psychotropic medications .8. Nursing staff shall monitor for and report any side effects and adverse consequences of psychotropic medications to the Attending Physician/Nurse Practitioner . A review of facility policy titled, Psychotropic Medication Use, revised October 2023, indicated, .7. The staff will observe, document, and report to the Physician/Nurse Practitioner information regarding the effectiveness of any interventions, including psychotropic medications .8. Nursing staff shall monitor for and report any side effects and adverse consequences of psychotropic medications to the Attending Physician/Nurse Practitioner .

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Westview Healthcare Center	12225 Shale Ridge Lane Auburn, CA 95602

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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 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. 48445 Based on observation, interview, and record review, the facility failed to ensure opened biological's (medicine derived from living organisms), eye drops, and ear drops were dated once opened, appropriately labeled to correctly identify which resident they were for, and were not available for resident use past their expiration date for a census of 164. These failures had the potential for residents to receive medications with unsafe or reduced potency from improper storage or being used past their expiration date. Findings: During a concurrent observation and interview on 05/21/24 at 3:11 p.m. with Licensed Nurse (LN) 6, an inspection of the Station 4 Back Hall Medication Cart identified the following medications past the recommended use-by-date: - One bottle of Artificial Tears eye drops (used to relieve dry eyes) 15 mL (milliliters, a unit of measurement) - labeled opened on 4/23 - One bottle of LubriFresh P.M. Nighttime eye ointment (used to relieve irritation and dryness of the eye) 3.5 g (grams, a unit of measurement) - open date 11/2/23 LN 6 confirmed the observations and stated she confirmed with pharmacist that both medications were only good for 60 days after opening and past their recommended use-by-dates. During a concurrent observation and interview on 5/21/24 at 3:45 p.m. with LN 9, an inspection of the Station 2 Back Hall Medication Cart identified the following medications past the recommended use-by-date, and without appropriate labeling: - One bottle of GoodSense Eye Drops (used to relieve eye redness and irritation) 15 mL - opened 9/25 - One bottle of Mucus-ER (used to thin and loosen secretions in the airway) 600 mg (milligrams, a unit of measurement) tablets - no label or date - One bottle of Iron Supplement liquid (used to prevent and treat low levels of iron [a mineral] in the body) 473 mL - no label or date LN 9 confirmed the identified medications and biological's were not labeled appropriately and stated, I won't give the medication if there's no label, no open dates .we don't know if the medication is still good. (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 concurrent observation and interview on 5/21/24 at 4:23 p.m. with LN 10, an inspection of the Station 2 Front Hall Medication Cart identified the following medications without appropriate labeling: - One Ayr Nasal gel (used to moisturize and soothe dry noses) - no label or date - One bottle of sunscreen lotion (provides sun protection) - no label or date - One Visine eye drops (used to relieve dry, itchy, and irritated eyes) - no label or date - One Visine box with resident identifiers containing an unlabeled bottle of Tetrahydrozoline HCL (eye redness reliever) 0.05% (percent, a unit of measurement) 15 mL eye drops LN 10 confirmed the identified medications and biologicals were not labeled appropriately and stated, Medications should be labeled properly .each resident should have their own sunscreen and the bottle should be labeled for each resident. During a concurrent observation and interview on 5/22/24 at 2:03 p.m. with LN 11, an inspection of the Station 3 Back Hall Medication Cart identified the following medications past the expiration date and without appropriate labeling: - One bottle of Zinc (a supplement to help the immune system and metabolism function) 50 mg tablets - no label or date - One bottle of Senna (stool softener) 50 mg tablets - no label or date - One bottle of Loratadine (used to relieve allergies) 10 mg tablets - no label or date - One bottle of Micro-Guard antifungal powder with Miconazole Nitrate 2% (used to treat fungal infections in the skin) 85 g - no label - One bottle of Tetrahydrozoline HCL 0.05% 15 mL eye drops - no resident label, dated 2/14/24 - One bottle of Systane lubricant (used to hydrate the eyes) 10 mL eye drops - no label or date - One bottle of Carbamide Peroxide 6.5% ear drops (used to treat earwax buildup) 15 mL - no open date - 12 vials of expired refresh eye drops (used to lubricate and moisturize the eyes) - expiration: March 2024 LN 11 confirmed the identified medications and biologicals were not labeled appropriately and the eye drops were past the expiration date. During an interview on 5/23/24 at 11:15 a.m. with the Infection Prevention Nurse (IP), the IP stated, There should never be expired medications, we remove it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 11:45 a.m. with the Director of Nursing (DON), the DON stated, Expectation for expired meds [medication] is to put it out of the cart and destroy it before it expires .They [staff] have sheets on the station as their guide for them to know the expiration dates and how long medications are good for . They [medications] are not going to have the full effect if its past the date. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 8/2023, the P&P indicated, 5. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .7. The expiration/beyond use date on the medication label is checked prior to administering. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2001, the P&P indicated, Medication Storage .3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .Medication Labeling .2. The medication label includes, at a minimum: .d. expiration date, when applicable; e. resident's name .4. For over the counter (OTC) medications in bulk containers (if permitted by state law) the label contains: .f. expiration date (if applicable). g. Open date .8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.

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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. 45718 Based on observation, interview, and record review, the facility failed to store foods according to professional standards for food safety when: 1. There were opened and unlabeled food items in the freezer and the cooking area; 2. A yellow cutting board was stained with black markings; and, 3. [NAME] puffy substances were observed at the bottom of the steel storage racks in the dry storage room. These failures had the potential to increase the risk of foodborne illnesses for a total of 164 residents who received food from the kitchen. Findings: 1. During the initial kitchen tour on 5/21/24 starting at 8:21 a.m., the Dietary Manager (DM) acknowledged the following food items were found opened and without labels (stickers on the packages to indicate the opened date and expiration date): - one gallon of milk in the refrigerator; - one opened box of cookie dough in the freezer; and, - 3 cans of vegetable oil spray in the cooking area. The DM stated, it was important to label the opened food items so you know when they were opened and when they should be discarded. A review of facility policy titled, LABELING AND DATING OF FOODS, reviewed September 2023, indicated, All food items in the storeroom, refrigerator and freezer need to be labeled and dated .Newly opened food items will need to be .labeled with an opened date and used by date . A review of facility policy titled, Storage of Food and Supplies, revised May 2023, indicated, Liquid food such . oil .which have been opened will be closed, labeled and dated . 2. During the initial kitchen tour on 5/21/24 starting at 8:21 a.m., the DM acknowledged a yellow cutting board was stained with black markings on both sides. The DM stated the black markings were from the rubber stand. A review of the FDA document titled Food Code, dated 2017, section 4-501.12 Equipment Cutting Surfaces, indicated, .Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED, or discarded if they are not capable of being resurfaced . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During the initial kitchen tour on 5/21/24 starting at 8:21 a.m., the DM acknowledged there were brownish puffy substances at the bottom of the 4 metal storage racks in the dry storage room. The DM stated the brown substances were dust and it should have been cleaned. A review of facility policy titled, Storage of Food and Supplies, revised May 2023, indicated, 5. Routine cleaning should be developed and followed . A review of the FDA (Food and Drug Administration) document titled Food Code, dated 2022, section 3-304. 11 Food Contact with Equipment and Utensils indicated, .Pathogens can be transferred to food .that have been stored on surfaces which have not been cleaned and sanitized .Food that comes into contact directly or indirectly with surfaces that are not clean and sanitized is liable to such contamination . A review of the FDA document titled Food Code, dated 2022, section 4-601.11 Equipment, Food-Contact Surfaces, Non-food contact Surfaces, and Utensils, indicated, .(A) EQUIPMENT FOOD-CONTACT SURFACES .shall be clean to sight and touch .

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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** 44780 Based on observation, interview, and record review, the facility failed follow and maintain an effective infection prevention and control program for a census of 164 when : 1. There were unsanitary conditions in the laundry room; 2. Unlabeled urinals were found in shared bathrooms of two rooms and in Resident 15's shared bathroom; 3. An unlabeled jug of distilled water was found on the floor inside Resident 119's room; and 4. Staff personal belongings and a cigarette lighter were found on medication carts. These failures had the potential to spread germs and cause infection among residents, staff, and visitors. Findings: 1. In a concurrent observation and interview on 5/23/24 starting at 11:53 a.m. with the Maintenance Director (MD) in the laundry room, the vent on the ceiling right above the table that had clean laundry, appeared to be dusty. The MD confirmed that the vent was dirty and stated we clean this every day, they must have missed one spot . When asked what can happen to the clean clothes on the table below, MD stated having a dusty vent on top of the clean clothes could cause cross contamination. Further observation with the MD, a collection of water was observed on the floor behind the washers. MD confirmed that there was water on the floor and stated, .this is the first time I am seeing this, this is from a leak. The MD further stated that .this can contaminate the laundry .It can get other things dirty. On further observation of the other side of the wall, where residents' clean personal clothing was kept, the lower part of the wall appeared to have peeled paint and stains of an old water leakage at the base of the wall and stains of water were observed on the floor. The MD stated .it is damaged dry wall, there are wet spots on the floor . MD further confirmed that there were clean resident personal clothes in that area and .the floor needs to be retiled, base board is missing, we have to remodel this area . In an observation and concurrent interview on 5/23/24 at 12:01 p.m. with Infection Prevention Nurse (IP), Infection Preventionist Consultant (IPC), MD, the IP looked at the water collection behind the washers and stated, . I have not seen this before, it just occurred, the laundry room should not be like this . IP further looked at the vent on the ceiling in the clean clothing room, and confirmed that there was dust on the ceiling vent and that appeared to be dirty. When the IP was asked about the appearance of the wall in the clean clothing room, IP stated, .this is an old building, looks like paint needs to be done, I am not sure if there is mold in the wall . In a follow-up interview with the IP on 5/23/24 at 2:11 p.m. with IPC present in the room. IP stated, .my expectation is that the vent will be clean. It appeared to have dust in the vent at that time . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/24/24 at 8:50 a.m., the Administrator (ADM) stated that with regards to the collection of water behind the washers in the laundry room, his expectation was that there wouldn't be water there. A review of the facility's policy and procedure titled, Infection prevention and Control, revised October 2023, indicated, An infection prevention and control program (IPCP) are established and maintained to help prevent the development and transmission of communicable diseases and infections .the infection prevention and control program is developed to address the facility-specific infection control needs and requirements. The program is based on accepted national infection prevention and control standards. The infection prevention and control program are a facility-wide effort involving all disciplines and individuals. 48445 2. During a concurrent observation and interview on 5/21/24 at 9:10 a.m. with Licensed Nurse (LN) 8, inside the shared bathroom of Resident 15's room, two unlabeled urinals were observed on top the toilet bowl tank. LN 8 confirmed the observation and stated they were probably used for the suprapubic catheter of Resident 15. LN 8 further stated, It's not supposed to be there, and it should be labeled. [It] can cause cross contamination and the filthy factor. We change urinals every 30 days and because it has no label, we don't know when it was used first and when to change it. During an observation on 5/21/24 at 10:32 a.m. in the shared bathroom of room [ROOM NUMBER] and room [ROOM NUMBER], used urinal with dried brownish substance without label was observed hanging inside the bathroom. During a concurrent observation and interview on 5/21/24 at 10:40 a.m. with LN 6, in the shared bathroom, LN 6 confirmed the observation and verified the urinal was used. LN 6 stated, They should be labeled and dated and should be in the bedside, for infection control issues. During an interview on 5/23/24 at 9:02 a.m. with LN 7, LN 7 stated, All four residents didn't need any urinals, no catheters, using briefs. If using urinal, it should be labeled and dated, I would say it's good for 30 days. I don't know how it got there. During an interview on 5/23/24 at 11:02 a.m. with the IP, the IP stated, Residents have a holder, labeled by their name. We change urinals when it is visibly dirty or damaged, no specific amount of time. [For] Resident who has catheter, urinals are used to drain the bag, discard the contents in the toilet and discard if visibly dirty or keep it on the urinal holder by the bed. There can be a lot of different effect, you don't know who it belongs to, possible cross contamination or infection. During an interview on 5/23/24 at 11:45 a.m. with the Director of Nursing (DON), the DON stated, [The] expectation is urinals should be labeled and placed on the holders appropriately. If it's not labeled, we don't know who it belongs to, that might cause cross contamination and infection. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, revised 10/2018, the P&P indicated, 11. Prevention of Infection .a. Important facets of infection prevention include: .(3) educating staff and ensuring that they adhere to proper techniques and procedures . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 119's admission records, the records indicated Resident 119 was admitted in October of 2022 with multiple diagnoses which included obstructive sleep apnea. Resident 10's minimum data set (MDS, an assessment tool) indicated Resident 119 had intact cognition. During a review of Resident 119's care plan titled, CPAP [a machine that uses mild air pressure to keep breathing airways open while asleep] CARE PLAN, revised on 2/9/24, the care plan indicated, [Resident 119] has order CPAP Therapy r/t [related to] Dx [diagnosis] of Obstructive Sleep Apnea [intermittent airflow blockage during sleep] .Resident refuses to use CPAP because he does not like to shave his thick beard, which causes air leak . During a concurrent observation and interview on 5/21/24 at 10:54 a.m. with Resident 119 in his room, an unlabeled and undated jug containing 3/4 full distilled water was observed on the floor beside the nightstand. Resident 119 stated the jug was used for his CPAP. During a concurrent observation and interview on 5/21/24 at 11:25 a.m. with LN 8, inside Resident 119's room, LN 8 confirmed the jug of distilled water on the floor was opened and was unlabeled and undated, and stated Infection control issue. During an interview on 5/23/24 at 9:12am with LN 7, when asked about Resident 119's CPAP, LN 7 stated, [Resident 119] once had it. [Resident 119] hasn't had it in more than 6 months .Distilled water is used for humidification. We either use it all or throw it after use since it's opened. We are not supposed to keep it at bedside, opened, because technically that's a medication. During an interview on 5/23/24 at 11:08 a.m. with the IP, the IP stated, Jug should be labeled and dated, should not be on the floor .it is risk for contamination. During an interview on 5/23/24 at 11:45 a.m. with the DON, the DON stated, If it's not labeled, we don't know who it belongs to that might cause cross contamination and infection. During a review of the facility's policy and procedure (P&P) titled, CPAP/BiPAP Support, revised 8/2023, the P&P indicated, Humidifier (if used): a. use clean, distilled water only in the humidification chamber. 4. During a concurrent observation and interview on 5/21/24 at 4:23 p.m. with LN 10, during an inspection of Station 2 Front Hall medication cart, a pouch was observed on the bottom drawer of the cart. LN 10 confirmed the observation, removed the pouch from the drawer and stated, It belongs to [name of LN], the AM [morning] shift nurse, it should not be there. During a concurrent observation and interview on 5/22/24 at 2:03 p.m. with LN 11, during an inspection of Station 3 Back Hall medication cart, a cigarette lighter was found in the medication cart's narcotic drawer. LN 11 confirmed the observation and stated, Someone might have put it in there. During an interview on 5/23/24 at 11:45 a.m. with the DON, when asked if staff were supposed to put personal belongings inside the medication cart, the DON stated, No, they are not supposed put personal stuff in the med carts, only medication. The DON further stated, Lighter is not supposed to be there, there's contamination, it doesn't belong there. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Labeling and Storage, dated 2001, the P&P indicated, 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49933 Based on observation, interview, and facility document review, the facility failed to provide 80 square feet of space per resident in rooms 302, 303, 304, 305, 306, 307, 309, 310, 312, and 314. This failure decreased the facility's potential to provide adequate personal space for the residents in these rooms for a census of 164. Findings: During an observation and concurrent review of a facility document Sq. Feet details -Patient Rooms. dated 1/12/2016, on 5/23/24, at 10:50 a.m., the following rooms were observed to not meet the minimum space requirement for each resident: Room Occupancy Sq. Ft/ Res 302 2 Residents 65 303 2 Residents 65 304 2 Residents 65 305 2 Residents 65 306 2 Residents 65 307 2 Residents 65 309 2 Residents 65 310 2 Residents 78.12 312 2 Residents 75.02 314 2 Residents 75.02 During an observation and concurrent interviews conducted on 5/23/24 beginning at 10:50 a.m., room numbers 302, 303, 304, 305, 306, 307, 309, 310, 312, and 314 were observed to be uncluttered with sufficient space for the personal effects of residents. There was enough room for entrance, egress (going out), and maneuvering of equipment in and out of the rooms and access to the bathrooms. There were no validated issues or safety concerns regarding lack of space for the delivery of care verbalized by any of the residents in these rooms. During an interview on 5/23/24 at 11a.m., Certified Nursing Assistant (CNA 2) stated he had no issues with moving around the room to provide care for the residents. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/23/24 at 11:04 a.m., Licensed Nurse (LN 14) stated the residents had no issues in the rooms. During an interview on 5/23/24 at 11:06 a.m., LN 1 stated she had no issues with the room size. The LN 1 stated they do not have to rearrange furniture in the room. There were no complaints received from the residents. During an observation and concurrent interview on 5/24/23 at 11:10 a.m. in room [ROOM NUMBER], the Maintenance Director (MD) stated there have been no alterations in rooms 300 through 315. The MD took measurements of 309 and the room measured 11.5 feet by 12 feet 3.5 inches. Resident 97 states I like my room size. Resident 70 had no issues with the room size and had no safety issues. Review of a facility document addressed to the Department dated 5/24/24, indicated the Administrator (ADM) requested a continuance of the room size waiver for rooms 302, 303, 304, 305, 306, 307, 309, 310, 312 and 314. These rooms provided 130-156 square feet for each 2-person occupancy room: 65-78 square feet per resident. The ADM additionally noted, There have not been any comments in Resident Council regarding the rooms size. The Department recommends continuing the room size waiver for rooms 302, 303, 304, 305, 306, 307, 309, 310, 312, and 314.