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	03/21/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50750 Based on interview and record review, the facility failed to accurately assess one of 35 sampled residents (Resident 147), when the Minimum Data Set (MDS- a federally mandated resident assessment tool) did not accurately reflect Resident 147's use of tobacco. This failure decreased the facility's potential to identify Resident 147's care needs. Findings: A review of Resident 147's admission record indicated Resident 147 was admitted to the facility in August 2024 with diagnoses including high blood pressure and generalized muscle weakness. A review of Resident 147's MDS, dated [DATE], indicated Resident 147's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 12 out of 15 which indicated mild memory impairment. The MDS further indicated Resident 147 was not a smoker. A review of Resident 147's smoking observation/assessments, dated 11/21/24 and 2/19/25, indicated, . Resident denies smoking or use of all tobacco products . During an interview on 3/20/25 at 10:05 a.m., with Resident 147, Resident 147 stated that he smoked cigars, and that the facility was aware. He further stated that he was a smoker even prior to being admitted to the facility. During an interview on 3/20/25 at 2:29 p.m., with Licensed Nurse 6 (LN 6), LN 6 confirmed that Resident 147 was a smoker. During a concurrent interview and record review on 3/21/25 at 1:16 p.m., with MDS Coordinator (MDSC), MDS dated [DATE] and Resident 147's smoking observation/assessment, dated 2/19/25 were reviewed. The MDSC confirmed Resident 147's MDS and smoking observation/assessment showed resident was not a smoker which was not accurate. A review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care [LTC] Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, indicated, .Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate . assessments of each resident's functional capacity and health status .

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

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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 50750 Based on interview and record review, the facility failed to follow up with the Preadmission Screening and Resident Review (PASRR, a federal process that ensures people with serious mental illness, intellectual or developmental disabilities are not inappropriately placed in nursing facilities and received the most appropriate care and services) for one of 25 sampled residents (Resident 117). This failure had the potential to result in inappropriate placement and unidentified specialized services for Resident 117. Findings: A review of Resident 117's admission record indicated Resident 117 was initially admitted to the facility in February 2023 and was readmitted in November 2024 with diagnoses including unspecified psychosis (when someone experiences psychotic symptoms including but not limited to delusions or hallucinations but does not meet the criteria for a specific, named psychotic disorder) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 117's PASRR Level I Screening Result, dated 11/19/24, indicated that PASRR Level II evaluation was required. During a concurrent interview and record review on 3/21/25 at 9:08 a.m., with Director of Nursing (DON), PASRR Level I Screening Result dated 11/19/24 was reviewed. DON stated she was unaware Resident 117 needed a PASRR Level II evaluation. DON stated, There was not a follow up unfortunately on this one [PASRR Level II] . She further stated a missed PASRR Level II evaluation had a potential risk for Resident 117 to miss services that she needed. A review of the facility's policy titled, Pre-Admission Screening and Resident Review (PASARR), revised March 2023, the policy indicated, 1. All new admissions and readmissions are screened for mental disorder (MD) . a. If the Level I screen indicates that the individual may meet the criteria for a MD .he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for four of 35 sampled residents (Resident 165, Resident 226, Resident 578 and Resident 147) when: 1. Resident 165 had no care plan for smoking; 2. Resident 226 had no care plan for the rashes (an area of irritated or swollen skin that can be itchy); 3. Resident 578's care plan for smoking was not implemented by staff; and 4. Resident 147 had no care plan for smoking. These failures had the potential to not meet residents physical and psychosocial needs. Findings: 1. A review of the Admission Record indicated Resident 165 was admitted [DATE] with diagnoses including encounter for orthopedic aftercare following surgical amputation (removal of a limb) and gas gangrene (soft tissue infection caused by bacteria producing toxins and gas that damage tissues). A review of the Smoking Observation/assessment dated [DATE] indicated Resident 165 was a smoker and may smoke without supervision. In an interview on 3/20/25 at 12:28 p.m., Resident 165 stated he was a smoker and he goes to the designated smoking area 8 times a day. Resident 165 further stated he had his own cigarettes and lighter with him and there was a sitter in the smoking area. In an interview on 3/21/25 at 9:46 a.m., the Medical Records Director (MRD) confirmed she could not find Resident 165's care plan for smoking prior to 3/20/25. In a concurrent interview and record review on 3/21/25 at 11:41 a.m., the Minimum Data Set Coordinator (MDSC) confirmed Resident 165 smoked tobacco based on the MDS (a federally mandated resident assessment tool) dated 2/24/25. The MDSC stated ideally the moment a resident is identified as a smoker, a care plan should be created. The MDSC confirmed Resident 165 had no care plan for smoking. 2. A review of the Admission Record indicated Resident 226 was admitted [DATE] with diagnoses including acute on chronic congestive heart failure (a type of heart failure where fluid can build up in the lungs and other parts of the body causing congestion). A review of Resident 226's physician order indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-an order dated 3/5/25 indicated nystatin (used to treat fungal or yeast infections) external cream apply to upper arms topically two times a day for rashes; and, -an order dated 3/5/25 indicated hydroxyzine (used to relieve symptoms of allergic conditions such as chronic itchy hives) 50 mg (milligram, a unit of measurement) give 1 tablet every 6 hours as needed for itching. In a concurrent observation and interview on 3/18/25 at 4:40 p.m., Resident 226 was lying in bed with a gown on. Resident 226 stated she had itching on her back. Resident 226 then turned on her side and pulled back her gown and she showed the rashes on the left side of her back. In a concurrent interview and record review on 3/21/25 at 11:54 a.m., the MDSC stated nystatin and hydroxyzine were ordered on 3/5/25 and the the nystatin was discontinued on 3/7/25 for Resident 226 . The MDSC confirmed Resident 226 had no care plan for the rashes. On 3/21/25 at 2:20 p.m., the Medical Records Director (MRD) provided Resident 226's Skin Observation dated 3/5/25. The skin observation indicated Resident 226 had rashes on her upper arms, chest and back. A review of the policy and procedure revised August 2024 and titled, Care Plans, Comprehensive indicated, A comprehensive care plan that includes measurable objectives to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 48874 3. Review of Resident 578's admission record indicated he was admitted in November 2024 with multiple diagnoses including chronic pulmonary lung disease (COPD-a chronic lung disease causing difficulty in breathing). Review of Resident 578's MDS dated [DATE] indicated Resident 578 used tobacco. Review of Resident 578's, Smoking Observation/assessment dated [DATE], indicated Resident 578 was currently using tobacco. A review of Resident 578's care plan dated 11/26/25 indicated, Resident 578 has the potential for injury related to smoking and an intervention that indicated, Cigarettes and lighter will be stored at the nurse's station. During a concurrent observation and interview on 03/20/25 at 2:13 p.m. with Certified Nursing Assistant 6 (CNA 6) in the smoking area, CNA 6 stated she was supervising the smokers that day and stated she did not keep Resident 578's cigarettes or lighter with her. During a concurrent observation and interview on 03/20/25 at 2:53 p.m., observed Resident 578 sitting in the facility's designated smoking area with his walker close by. The walker had a black plastic bag hanged on it that contained cigarettes and two lighters. Resident 578 stated he smoked frequently, and he kept his cigarettes and lighters on him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/25 at 3:09 p.m. with Licensed Nurse 8 (LN 8), LN 8 confirmed Resident 578's cigarettes and lighters were not kept at the nurse's station and further stated no resident cigarettes and lighters are kept at the nurse's station. During an interview on 3/21/25 at 9:03 a.m. with LN 9, LN 9 stated she was a nursing supervisor. LN 9 stated that the nursing supervisors do the smoking assessment and that the staff should follow the care plan for smoking residents. During a review of the facility's policy titled, Smoking Policy-Residents, revised September 2024, the policy indicated, Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan and all the personnel caring for the resident shall be alerted to these issues. During a review of the facility's policy tilted, Care Plans, Comprehensive, revised August 2024, the policy indicated, Assessments of residents are ongoing, and care plans are revised as the information about the residents and the resident's conditions change. 50750 4. A review of Resident 147's admission record indicated Resident 147 was admitted to the facility in August 2024 with diagnoses including high blood pressure and generalized muscle weakness. A review of Resident 147's MDS, dated [DATE], indicated Resident 147's Brief Interview for Mental Status (BIMS,tests memory and recall) score was 12 out of 15 which indicated mild memory impairment. During an interview on 3/19/25 at 10:15 a.m., with Resident 147, Resident 147 stated that he smoked a cigar once daily. During an interview on 3/20/25 at 9:46 a.m., with CNA 3, CNA 3 confirmed Resident 147 was a smoker and CNA 3 had observed Resident 147 smoking. During a record review of Resident 147's care plan (CP), dated 3/3/25, there was no documented smoking CP for Resident 147. During a concurrent interview and record review on 3/21/25 at 2:23 p.m., with Director of Nursing (DON), Resident 147's CP was reviewed. DON confirmed Resident 147 did not have a CP for smoking. She stated it was her expectation that the care plan should have been initiated as soon as they found out that Resident 147 was smoking. A review of the facility's policy titled, Smoking Policy- Residents, revised September 2024, the policy indicated, 8. Any smoking-related privileges, restrictions, and concerns .shall be noted on the care plan .

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. 50351 Based on Observation, interview, and record review, the facility failed to ensure assistance with use of hearing aids was provided for 1 of 35 sample residents (Resident 94). This failure had the potential to result in Resident 94's care needs not being met. Findings: A review of Resident 94's admission record, indicated resident 94 was admitted in May 2021 with multiple diagnoses including Cognitive Communication deficit and Muscle weakness. During a review Resident 94's Ear Service Record dated 12/12/2024, the record indicated resident had hearing aids for the left and right ear. The record further indicated, .Res (sic. Resident) needs help with hearing . During a review of Resident 94's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 02/26/25, indicated Random Resident 2 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 6 out of 15 which indicated severe cognitive impairment; Section B which includes Hearing indicated resident had minimal difficulty- difficulty in some environments (e.g. when person speaks softly or setting is noisy). Review of Resident 94's weekly summary dated 2/21/25 indicated Resident was hard of hearing. During an observation and interview on 3/18/25 at 2:01 p.m., in Resident 94's room, Resident 94 was observed sitting in wheelchair. Resident 94 asked surveyor to come closer when speaking to him. Resident 94 stated he had hearing aids and would like education on how to charge them. During an observation and interview on 3/21/25 at 9 a.m., Resident 94 was observed in his room sitting in wheelchair. A Certified Nursing Assistant (CNA 9), was assisting with care. The Surveyor attempted to speak to resident and he asked to come closer and speak louder as he was hard of hearing. When the resident was asked about the hearing aids and if he had received assistance to use and charge them, he stated, . I have had these [hearing aids] for 2 months and no one has helped me figure out how to charge them. Resident 94 further stated the hearing aids were still in the box. During an interview on 3/21/25 at 9:01 a.m., with CNA 9 in Resident 94's room, CNA 9 confirmed Resident 9 had hearing aids that were labeled and should have been assisted to use them every day. Resident 94 requested for assistant to use the hearing aids from CNA 9. During an interview on 3/21/25 at 9:06 a.m. with Licensed Nurse 10 (LN 10), LN 10 stated residents with hearing aids, should have a hearing aids order. LN 10 confirmed there was no order for hearing aids for Resident 94. During an interview on 3/21/25 at 9:11 a.m., with Social Services (SS), the SS reviewed Resident 94 records and stated the resident had hearing aids. SS further stated the orders for hearing aids were not entered by social services department. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/25 at 10:11 a.m. with LN 8, the LN 8 stated CNAs would notify the licensed nurses if they found out a resident had hearing aids. LN 8 indicated that licensed nurses documented the orders (hearing aids) in the resident's record. During an interview on 3/21/25 at 1:57 p.m. with Director of Nursing (DON), the DON stated social services communicated with nursing staff if a patient had a new set of hearing aids. DON further stated any staff can put in care plans for hearing aids and there is no specific communication system with social services, primarily just verbal. DON further stated the only way to know if hearing aids were provided for a resident was if social services communicated verbally, directly, and followed up with the resident. During a review of policy and procedure (P&P) titled, Assistive Devices and Equipment, dated September 2024, the P&P indicated, . the facility provides the resident with assistance . hearing aids . Residents are trained, as indicated, on the safe use of equipment and devices . staff are required to demonstrate competency on the use of devices and equipment and are available to assist and supervise residents as needed . During a review of P&P titled, Activities of Daily Living (ADLs), Supporting dated October 2024, the P&P indicated, .Resident will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) are completed .the resident's response to interventions will be monitored, evaluated, and revised as appropriate .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50541 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 14) out of a census of 171, was assisted with nail care as part of their Activities of Daily Living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) when Resident 14 had long fingernails with brownish substance underneath the fingernails on her left hand. This failure had the potential to result in Resident 14 acquiring an infection through harboring residue and bacteria. Findings: Resident 14 was admitted to the facility in November 2015 following an anoxic brain injury (a condition where blood flow to the brain is interrupted, causing brain tissue to die). According to Resident 14's care plan, initiated 10/30/22, [Resident 14] requires extensive to total assistance of 1-2 persons with all personal care . and was left with a contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) to the right hand. Resident 14's care plan further indicated, [Resident 14] has severe cognitive deficits .inability to make decisions .dependent on others to make all daily decisions regarding personal care .and unable to participate with BIMS [Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident] interview. In addition, Resident 14's care plan indicated, [Resident 14] is non-verbal and unable to make needs known .she is dependent on others to observe. During a review of Resident 14's care plan, initiated 10/30/22, indicated, Staff will ensure that [Resident 14's] needs are met .as evidenced by [Resident 14] will be .groomed daily. Resident 14's care plan also indicated, [Resident 14] will be assisted by staff as needed to complete ADLs and [Staff will] assist [Resident 14] with personal hygiene and grooming as needed. During an observation on 3/19/25 at 8:58 a.m. in Resident 14's room, Resident 14 was observed with long fingernails with brownish substance underneath the fingernails on her left hand. During a concurrent observation and interview on 3/19/25 at 9:14 a.m. in Resident 14's room with Licensed Nurse 1 (LN1), LN 1 stated Resident 14's nails on her left hand were dirty and should have been cleaned. LN 1 stated the expectation was for the certified nursing assistants (CNAs) and licensed nurses (LNs) to perform nail care as needed and the CNAs should be checking the residents' nails when getting them out of bed for the day. LN 1 further verified it was especially important to clean Resident 14's left hand to prevent infection, as it was her only serviceable hand. When LN 1 was asked if the nails on Resident 14's left hand should be cleaned, LN 1 stated, One hundred percent. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/20/25 at 2:23 p.m. with Director of Nursing (DON), Resident 14's clinical record was reviewed. The DON verified Resident 14 never refused nail care and the resident was non-verbal. The DON stated she would expect staff to perform nail care as needed and the nails should always be clean. The DON further stated having dirty fingernails is a dignity and infection control issue. During a review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting, dated October 2024, indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including .grooming.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51484 Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained in a consistent manner for a census of 171 when: 1. A discontinued bottle of a controlled medication, a medication with high potential for abuse or addiction, was not stored with other controlled medications in the Director of Nursing's (DON) office and it did not have a count sheet; and, 2. Unused and discontinued controlled medications were not removed from the active medication storage areas for destruction. These failures had the potential for medication error and drug diversion. Findings: 1. During an inspection of medication storage room [ROOM NUMBER] station 2 on 3/18/25 at 2 p.m. with Licensed Nurse 3 (LN 3), a discontinued bottle of lacosamide, a controlled medication used to treat seizures, 10 mg/ml (milligram/milliliter, unit of measure) was found in the medication storage room's cabinet with non-controlled medications. The bottle did not have a count sheet. During an interview on 3/18/25 at 2:05 p.m. with LN 3, LN 3 stated lacosamide was a controlled medication and discontinued controlled medications should have not been stored in the medication room. LN 3 further stated the medication was supposed to be taken to the DON's office for proper storage with a count sheet. During an interview on 3/20/25 at 11:35 a.m. with the DON, DON stated the expectation of the Licensed Nurses staff was to bring all discontinued controlled medications to her office for proper storage until they can be destroyed with the facility's pharmacist. During a review of the facility's Policies and Procedures, P&P, titled, Discarding and Destroying Medications, dated October 2024, the P&P indicated, All unused controlled substances are retained in a securely locked area with restricted access until disposed of. The medication disposition record contains, as a minimum, the following information: The resident' s name, The name and strength of the medication, the prescription number (if any), date medication destroyed, and signature of witnesses. 2. During an inspection of medication cart 3, located in the front station on 3/19/25 at 10:38 a.m. with LN 4, seven blister packs of discontinued controlled medications were found stored along with residents active medications. During an interview on 3/19/25 at 10:59 a.m. with LN 4, LN 4 stated discontinued controlled medications should not be left in the medication cart and they should be given to the DON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/25 at 11:35 a.m. with the DON, the DON stated the expectation of the Licensed Nursing staff was to bring all discontinued controlled medications to her office for proper storage until they can be destroyed with the facility's pharmacist. During a review of the facility' s P&P titled, Storage of Medications, dated October 2024, the P&P indicated, Discontinued, outdated, or deteriorated drugs or biologicals are placed on designated appropriate bins for destruction.

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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. 51484 Based on observation, interview, and record review, the facility failed to implement the facility's medication storage policies and procedures, when: 1. Expired pharmaceutical products were found inside medication carts, 3 in the front station and 4 in the back station; 2. Loose pills were found in 2 medication carts; 3. Blister pack found behind drawer in the bottom of medication cart 3 front station; and, 4. Medications were found at the bedside in Random Resident 1's room and Resident 37's room. These failures had the potential for drug diversion as well as residents receiving ineffective concentrations of prescribed medications. Findings: 1. a. During an inspection of medication cart 4 back station on 3/19/25 at 10:10 a.m., an expired multi dose vial of Humulin R (regular) insulin, a medication used to treat high blood sugar, 100 unit/ml (unit/milliliter, unit of measure) was found with an expiration date of 3/16/25. During an interview on 3/19/25 at 10:10 a.m., with Licensed Nurse (LN 1), LN 1 confirmed that the vial of insulin was expired and expired insulin should have been discarded immediately. During an interview on 3/20/25 at 11:35 a.m. with the Director of Nursing (DON), the DON stated, the expectation of the Licensed Nursing staff was to not have expired medications in the medication cart. During a review of Humulin R's prescribing information revised November 2019, the manufacture stated to discard the vial 31 days after opening. During a review of the facility's policy titled, Administering Medication, revised October 2024, policy indicated, The expiration date on the medication label must be checked prior to administering. During a review of the facility's P&P titled, Storage of Medications, dated October 2024, the P&P indicated, Discontinued, outdated, or deteriorated drugs or biologicals are placed on designated appropriate bins for destruction. 1. b. During an inspection of medication cart 3 front station on 3/19/25 at 10:59 a.m., two expired multidose inhalers; fluticasone propionate and salmeterol inhalation powder, combination of two medications used to help with breathing issues, 500mcg/50mcg (micrograms, unit of measure) and 250mcg/50mcg were both found with an expiration date of 2/7/25. (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 3/19/25 at 10:59 a.m., with LN 4, LN 4 stated expired medications, controlled or noncontrolled, should be given to the DON for disposal. During an interview on 3/20/25 at 11:35 a.m. with the DON, the DON stated, the expectation of the Licensed Nursing staff was to not have expired medications in the cart. During a review of the product package and manufacturer's recommendations dated 1/5/25, indicated both inhalers needed to be discarded one month after removal from the foil pouch. During a review of the facility's policy titled, Administering Medications through a Metered Dose Inhaler, revised October 2010, the policy indicated Check the expiration date on the inhaler. Return any expired medications to the pharmacy. 2. During an inspection of medication cart 4 back station on 3/19/25 at 10:10 a.m., two loose pills were found inside the medication cart. During an interview on 3/19/25 at 10:10 a.m., with LN 1, LN 1 confirmed the quantity of loose pills in the medication cart and stated, loose pills should not be found in the drawer. During an inspection of medication cart 3 front station on 3/19/25 at 10:59 a.m., two loose pills in the bottom of the drawer and 1 loose pill were found in the bottom of the cart. During an interview on 3/19/25 at 10:59 a.m., with LN 4, LN 4 confirmed the quantity of loose pills in the medication cart and stated, loose pills should not be found in the drawer. During an interview on 3/20/25 at 11:35 a.m. with the DON, the DON stated the expectation was for carts to be free of loose medication, carts are to be cleaned and maintained properly. During a review of the facility's policy titled, Storage of Medication, revised October 2024, policy indicated, The staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. During an inspection of medication cart 3 front station on 3/19/25 at 10:59 a.m., a blister pack was found behind drawer in the bottom of medication cart. During an interview on 3/19/25 at 10:59 a.m., with LN 4, LN 4 confirmed blister pack in the bottom of medication cart and stated, the blister pack should not be found in the bottom of the cart. During an interview on 3/20/25 at 11:35 a.m. with the DON, the DON stated the expectation was for carts to be cleaned and maintained properly. During a review of the facility's policy titled, Storage of Medication, revised October 2024, policy indicated, The staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 50750 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. a. During an observation on 3/18/25 at 9:30 a.m., in Random Resident 1's (RR 1) room, an unlabeled medicine cup containing a white cream with a paste-like texture was found on top of the nightstand next to RR 1's bed. During an interview on 3/18/25 at 9:34 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that the cream in the medicine cup was RR 1's barrier cream (topical solution that form a physical shield between the skin and irritants). During a concurrent observation and interview on 3/18/25 at 9:37 a.m., with Licensed Nurse 5 (LN 5), in RR 1's room, LN 5 confirmed the medicine cup on top of the nightstand was RR 1's barrier cream. LN 5 stated the barrier cream should not be at the bedside and should have been discarded after it was used. 4. b. During a concurrent observation and interview on 3/18/25 at 10:01 a.m., in Resident 37's room, an unlabeled medicine cup containing a white cream was found on Resident 37's pull-out bedside table next to her bed. Resident 37 stated the cream was used for her knees. During a concurrent observation and interview on 3/18/25 at 10:15 a.m., with LN 5, in Resident 37's room, LN 5 confirmed it was Resident 37's lidocaine cream (topical cream used to relieve pain). LN 5 stated it should not be at the bedside and any leftover cream must be discarded. During an interview on 3/21/25 at 2:18 p.m., with Director of Nursing (DON), DON stated any medications should not be left or kept at bedside. A review of the facility's policy titled, Storage of Medications, dated September 2024, the policy indicated, 1. Drugs and biologicals used in the facility are stored in locked compartments/area.

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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** 36681 Based on observation, interview, and record review, the facility failed to maintain an effective infection control program, for a census of 171, when: 1. Resident 227's enteral feeding (providing nutrition) through a gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) bag used for water flush was not labeled; 2. Medication cart was not cleaned of white powder residue from a previously crushed medication; and, 3. Staff did not wear proper Personal Protective Equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while providing care to a resident on Enhanced Barrier Precaution (EBP- an infection control intervention designed to reduce the transmission of multidrug-resistant organisms [MDRO]). These failures increased the risk of spreading and or transmission of diseases to vulnerable residents in the facility. Findings: 1. A review of the Admission Record indicated Resident 227 was admitted end of February 2025 with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke, blood flow to the brain is interrupted causing brain tissues to die) and gastrostomy status. A review of Resident 227's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 3/7/25 indicated Resident 227 had severe cognitive impairment. A review of Resident 227's physician order dated 3/20/25 indicated Enteral Feed Order .Provide fluid flush via . tube 75 ml (milliliters, unit of measurement) /hr [ml per hour] x 8 hours to provide total 600 ml. In an observation on 3/20/25 at 9:15 a.m., Resident 227 was lying in bed with the head of bed elevated at least 30 degrees with one pillow. Resident 227 had ongoing tube feeding via pump. There was an unlabeled clear bag hanging with 150 ml of water. In a concurrent observation and interview on 3/20/25 at 9:24 p.m., Licensed Nurse 9 (LN 9) confirmed the clear bag hanging with 150 ml of water had no label. The LN 9 stated typically the flush bag should be labeled. The LN 9 further stated the label comes in the package and the label will indicate name and when it was started. In an interview on 3/20/25 at 5:05 p.m., the Director of Nursing (DON) stated her expectation was for the water flush bag for G-tube to be labeled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the policy and procedure revised September 2024 and titled, Enteral Feedings - Safety Precautions indicated, To ensure the safe administration of enteral nutrition .Check the enteral nutrition label against the order before administration. Check the following information: .Resident name .Date and time . prepared .method (pump, gravity, syringe) .Rate of administration (mL/hour). 51484 2. During a medication administration observation on 3/18/25 at 8:22 a.m., LN 2 was observed administering medication on a medication cart that was not cleaned of white powder residue from a previously crushed medication. During an interview with LN 2 on 3/18/25 at 8:25 a.m., she indicated that the white powder was a crushed Acetaminophen (medication used for pain) tablet and medication cart surfaces should be cleaned prior to administration of medications. During an interview with DON on 3/20/25 at 11:35 a.m., she stated the expectation was to keep surfaces clean, clean with appropriate cleaner, and don't wipe the medication on the floor. A review of the facility policy statement titled, Storage of Medication, revised September 2024, indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 50750 3. A review of Resident 100's admission record indicated he was admitted to the facility in February 2022 with diagnoses including chronic kidney disease (damaged kidneys and can't filter blood as well) and high blood pressure. A review of Resident 100's MDS dated [DATE], indicated that Resident 100 had an indwelling catheter (a small, flexible tube that is inserted into the bladder to drain urine). During an observation on 3/18/25 at 10:34 a.m., in Resident 100's room, Certified Nursing Assistant 2 (CNA 2) was wearing gloves and was removing the blankets covering Resident 100. CNA 2 stated she will be providing patient care. During an observation on 3/18/25 at 10:35 a.m., by Resident 100's door, a purple circle sticker was posted next to Resident 100's name. A PPE sign and an Enhanced Standard Precautions sign were posted by the door. During another observation on 3/18/25 at 10:38 a.m., in Resident 100's room, CNA 2 was wearing gloves while she helped Resident 100 get cleaned up. During an interview on 3/18/25 at 10:41 a.m., with CNA 2, CNA 2 stated she helped Resident 100 with teeth brushing, flossing, brief changing, and getting dressed. CNA 2 stated that the purple circle sticker next to the resident's name meant that the resident is on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview on 3/18/25 at 10:41 a.m., with CNA 2, CNA 2 confirmed she was not wearing a gown while helping Resident 100. She stated, I wasn't wearing a gown, but I know I was supposed to . During an interview on 3/20/25 at 3:43 p.m., with Infection Preventionist 2 (IP 2), IP 2 stated that the nursing staff were expected to wear proper PPE during high contact care activities with residents on EBP. Examples that were given by IP 2 regarding high contact care activities were brushing and flossing residents' teeth, wound care, getting dressed, brief change, and transferring residents. A review of the facility's policy titled, Multidrug- Resistant Organisms; Infection Precaution & Enhanced Standard Precautions, revised March 2024, indicated, .EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . For residents for whom EBP are indicated, EBP is employed when performing high-contact resident care activities: Dressing, Bathing/Showering, Transferring, Providing Hygiene, Changing Linens, Changing briefs or assisting with toileting .

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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. 48874 Based on observation, interview, and facility document review, the facility failed to provide 80 square feet of space per residence in rooms 302, 303, 304, 305, 306, 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 171. During review of the document addressed to the California Department of Public Health (Department), dated 3/19/2025, the following rooms are observed not to meet the minimum space requirement for each resident: Room Resident Sq. Ft Resident 302 (Resident 59) 65 303 (Resident 92) 65 304 (Residents 578, 153) 65 305 (Residents 126, 133) 65 306 (Resident 38) 65 307 (Resident 101, 579) 65 309 (Resident 580) 65 310 (Residents 66, 82) 78.12 312 (Residents 105, 138) 75.02 314 (Resident 130) 75.02 During concurrent observations and interviews beginning 3/18/24 at 8:40 am with residents in rooms 302, 303, 304, 305, 306, 307, 309, 310, 312 and 314, the rooms were observed as clutter free with room for personal belongings of the residents. There was space for residents with walkers and wheelchairs to move easily in and out of the bathrooms. There were no validated issues or safety concerns regarding lack of space for the delivery of care verbalized by the residents in any of these rooms. During an interview on 3/19/25 at 3:51 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she had no issues with moving around these rooms to provide care and had not heard any complaints about the size of the room from residents. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 3/19/25 at 3:57 p.m. with Licensed Nurse (LN) 8, LN 8 stated she can care for the residents and lack of space has not been a problem in these rooms. During an interview on 3/19 25 at 4:10 p.m. With the Director of Maintenance (DM), The DM stated there had been no room alterations done to these rooms since the last recertification survey. Review of a facility document addressed to the Department dated 3/19/25, indicated the administrator requested a continuance of the room size waiver for rooms 302, 303, 304, 305, 306, 307, 309, 310, 312, and 314. The letter additionally notes, in order to ensure there that no issues arise in terms of resident complaints about privacy and room size, our staff will conduct frequent rounds with residents in these rooms and ensure that they are not negatively affected. There have not been any comments in resident council regarding the room sizes. The Department recommends continuing the room size waiver for rooms 302, 303, 304, 305, 306, 307, 309, 310, 312 and 314.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 50541 Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for two residents (Resident 14 and Resident 227), for a census of 171. This failure had the potential to result in unmet care needs and placed the residents at risk for safety. Findings: 1. Resident 14 was admitted to the facility in November 2015 following an anoxic brain injury (a condition where blood flow to the brain is interrupted, causing brain tissue to die). Resident 14's care plan, initiated 10/30/22, indicated, [Resident 14] has severe cognitive deficits .unable to participate with BIMS [Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident] interview. In addition, Resident 14's care plan indicated, [Resident 14] is non-verbal and unable to make needs known .she is dependent on others. During an observation on 3/19/25 at 8:58 a.m. in Resident 14's room, Resident 14 was sitting in a wheelchair next to her bed. Resident 14's call light was left in the bed, out of reach of Resident 14. During a concurrent observation and interview on 3/19/25 at 9:14 a.m. in Resident 14's room with Licensed Nurse 1 (LN 1), LN 1 verified Resident 14's soft touch call light was out of reach of Resident 14 and was usually placed under Resident 14's neck. LN 1 stated Resident 14 is non-verbal and would be unable to call out for help. LN 1 stated the expectation was that call lights should always be in reach of the residents. During an interview on 3/20/25 at 2:21 p.m. with Director of Nursing (DON), the DON stated it was her expectation that call lights would be within reach of residents, .so they [Residents] don't have to reach and possibly fall or call for help. The DON further stated if the call light was out of reach, a non-verbal resident would not be able to voice their needs. When asked if the call light should be within reach when a resident is resting in bed or sitting in a chair, the DON stated, Of course, for sure. During a review of Resident 14's care plan, initiated 10/30/22, the care plan indicated, [Resident 14] requires extensive to total assistance of 1-2 persons with all .mobility needs .poor mobility with right hand and bilateral lower extremities contractures and decreased range of motion, inability to verbalize needs. She is non-ambulatory. Resident 14's care plan further indicated, Be sure call light is within reach. 36681 (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the Admission Record indicated Resident 227 was admitted end of February 2025 with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke, blood flow to the brain is interrupted causing brain tissues to die) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status. A review of Resident 227's Minimum Data Set (MDS- a tool used for assessment) dated 3/7/25 indicated Resident 227 had severe cognitive impairment and required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) to roll left and right (ability to roll from lying on back to left and right side, and return to lying on back on the bed). A review of Resident 227's care plan dated 3/4/25 indicated an actual ADL (Activities of Daily Living) self care and mobility decline and the interventions included encourage to use call light for assistance. A concurrent observation and interview was conducted on 3/19/25 at 9:56 a.m., inside Resident 227's room. Resident 227 was lying in bed with the head of bed elevated. Resident 227 was able to state her first name. Resident 227's call light was located on the left side of her bed and it was out of reach. In a follow up observation on 3/19/25 at 10:33 a.m., Resident 227's call light was located on the left side of her bed and it was out of reach. A concurrent observation and interview was conducted on 3/19/25 at 10:37 a.m., inside Resident 227's room with Certified Nursing Assistant 7 (CNA 7). The CNA 7 confirmed Resident 227 was using the touch light [call light] located on the left side of her bed and it was not within reach. The CNA 7 stated the call light should not be there, it (call light) should be close to resident and within reach. A concurrent observation and interview was conducted on 3/20/25 at 9:27 a.m., inside Resident 227's room with LN 9. The LN 9 confirmed Resident 227's call light was underneath resident's pillow by her shoulder. The LN 9 stated there was a better spot for the call light. The LN 9 further stated it could be positioned anywhere within resident's arm reach. During a review of the facility's policy and procedure titled, Answering the Call Light, dated December 2024, indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.