STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055826	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Oaks Post Acute	830 E Chapel St Santa Maria, CA 93454

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 52066 Based on interviews, record review, and facility policy review, the facility failed to provide residents with access to their personal funds on weekends for 1 (Resident #20) of 5 residents sampled for personal funds . Findings included: A facility policy titled, Deposit of Resident Funds, revised 03/2021, revealed 1. Should the resident permit the facility to hold, safeguard, and manage his or her personal funds, the facility will: c. provide the resident access to funds of fifty (50) dollars or less within twenty-four (24) hours, and access to funds in excess of fifty (50) dollars within three banking days. 2. Funds not on deposit in the resident's account are deposited into the resident petty cash fund managed by the facility on behalf of the residents. The State Operations Manual (SOM) Appendix PP - Guidance to Surveyors for Long Term Care Facilities guidance at tag F567 indicated, Resident requests for access to their funds should be honored by facility staff as soon as possible but no later than: - The same day for amounts less than $100.00 ($50.00 for Medicaid residents); - Three banking days for amounts of $100.00 ($50.00 for Medicaid residents) or more. An Admission Record revealed the facility admitted Resident #20 on 10/12/2022. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus with hyperglycemia, hypothyroidism, and mixed hyperlipidemia. A quarterly MDS, with an ARD of 11/01/2024, revealed Resident #20 scored 15 on a BIMS, which indicated the resident had intact cognition. During an interview on 12/18/2024 at 12:41 PM, Resident #20 stated they had asked for funds on the weekend and were told they could not get any because, I have to ask the lady [Business Office employee] for it. The resident stated the Administrator could not give the money to them because, we have to ask on the weekdays. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2024 at 3:02 PM, the Director of Nursing (DON) stated the Business Office employee was available five days a week. The facility would manage the residents' money for them, and whenever they asked for their money after hours and on weekends, they expected that the residents would have access to it. The DON indicated both the Administrator and the DON had access to the residents' funds. During an interview on 12/18/2024 at 3:59 PM, the Administrator stated that upon admission, the residents were encouraged to have their valuables and funds stored for them. The Administrator indicated that on the weekends, they wanted to limit who had access to the residents' funds. The Administrator stated he was available on weekends for an emergency but, if it can wait until Monday, then we encourage that. He indicated the facility tried to accommodate the residents before the weekend if they were aware.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on observations, interviews, records reviews, and facility policy review, the facility failed to ensure an evaluation for causative factors was conducted and documented after each fall to facilitate the ability to develop effective fall prevention interventions and failed to ensure accurate information about residents' falls was maintained for 2 (Resident #36 and Resident #25) of 2 sampled residents reviewed for accidents. Findings included: A facility policy titled, Fall Risk Assessment, revised 03/2018, indicated, 9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. A facility policy titled, Falls and Fall Risk, Managing, revised 03/2018, indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent resident from falling and to try to minimize complication from falling. The policy also specified, According to the Minimum Data Set (MDS), a fall is defined as: unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g. [for example], a resident pushes another resident). According to the policy, A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. The policy also indicated, 5) If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why current approaches remain relevant. 6) If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled, Assessing Falls and Their Causes, revised 03/2018, indicated, The purposes of the procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying the causes of a fall. The policy specified, Defining Details of Falls: 1. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. 2. For each individual, distinguish falls in the following categories: a. Rolling, sliding, or dropping from an object (e.g., from bed or chair to floor); b. Falling while attempting to stand up from a sitting or lying position. c. Falling while already standing and trying to ambulate. The policy indicated, Identifying Causes of a Fall or Fall Risk: 1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. [et cetera]. 2. Evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall; b. Time of last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e. Whether the resident was among other persons or alone; f. Whether the resident was trying to get to the toilet; g. Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or h. Whether there is a pattern of falls for this resident. 3. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. The policy also indicated, Documentation: When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found. 2. Assessment data, including vitals and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family, as indicated. 5. Completion of a falls risk assessment. 6. Appropriate interventions taken to prevent future falls. 1. An Admission Record indicated the facility readmitted Resident #36 on 01/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of hepatic encephalopathy, alcoholic cirrhosis, and chronic hypoxic respiratory failure. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/10/2024, revealed Resident #36 scored 7 on a Brief Interview for Mental Status (BIMS), which indicated the resident had severe cognitive impairment. According to the MDS, the resident used a walker for mobility, required substantial/maximal assistance with rolling to the left and right and with chair/bed transfer, and required partial/moderate assistance with moving from a lying to a sitting position and moving from a sitting to a standing position. The MDS indicated the resident did not have a fall at any time in the last two to six months prior to admission. A review of the care plan for Resident #36 revealed a focus area dated as initiated 01/04/2024 that indicated the resident was at high risk for falls related to gait/balance problems secondary to morbid obesity, generalized pain/weakness, incontinence, chronic anemia, and an unawareness of safety needs. Interventions dated as initiated on 01/04/2024 directed staff to anticipate and meet the resident's needs; be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed; ensure the resident was wearing appropriate footwear when ambulating or mobilizing in the wheelchair; follow the facility's fall protocol; and review information on past falls and attempt to determine the cause of falls, record possible root causes, alter or remove any potential causes if possible, and educate the resident / family / caregivers / interdisciplinary team (IDT) as to the causes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A document titled SBAR [Situation, Background, Appearance, Review] Communication Form and Progress Note for RNs [Registered Nurses]/LPNs [Licensed Practical Nurses]/LVNs [Licensed Vocational Nurses], dated 03/01/2024 and completed by Licensed Vocational Nurse (LVN) #6, indicated the LVN was notified at 9:35 PM that Resident #36 had fallen. According to the evaluation, a certified nurse aide (CNA) was providing incontinence care to the resident when the resident rolled to the right and rolled off the bed. The evaluation indicated the resident was seen on the side of the bed on their knees. According to the evaluation, the resident was assisted back to bed and complained of pain to their knees. The evaluation revealed that an abrasion was identified to the resident's right knee. The evaluation indicated acetaminophen was provided and that staff would continue to monitor. The evaluation indicated the physician was notified on 03/02/2024 at 10:00 PM. The resident's care plan did not contain evidence of any new interventions that were added after the resident's fall out of bed on 03/01/2024. As of 12/18/2024, all the interventions on the resident's fall prevention care plan were dated as initiated 01/04/2024. Review of Resident #36's medical record on 12/17/2024 revealed no evidence that the resident had experienced any further falls after 03/01/2024. An Incidents by Incident Type log, printed by the facility on 12/17/2024, revealed a list of the names of residents who had fallen between 01/01/2024 and 12/17/2024, as well as the dates of their individual falls; Resident #36's fall on 03/01/2024 was not included on the list. A Nursing Staffing Assignment and Sign-in Sheet, dated 03/01/2024 for the evening shift (the shift that began at 3:00 PM), indicated LVN #6 and Certified Nurse Aides (CNAs) #7, #8, #9, #10, #11, #12, and #13 were on duty on the date/shift of Resident #2's fall. During an interview on 12/18/2024 at 1:40 PM, LVN #6 stated he had worked a few shifts at the facility through a local staffing agency. LVN #6 stated he had not received any fall-specific training at the facility; however, he knew that when a resident fell while he was on duty, a change of condition form and a progress note must be completed after the resident was assessed. LVN #6 indicated he could not recall Resident #36 falling while he was on duty or any details related to any fall sustained by Resident #36. During an interview on 12/18/2024 at 2:05 PM, CNA #13 revealed that she had received fall training in the facility; however, she could not recall a fall sustained by Resident #36 while she was on duty. Attempts were made to contact CNAs #7, #8, #9, #10, #11, and #12 without success on the following dates/times: - CNA #7: 12/18/2024 at 2:46 PM (the surveyor left a message requesting a return call, but no return call was received). - CNA #8: 12/18/2024 at 2:48 PM (there was no option to leave a message). - CNA #9: 12/18/2024 at 2:49 PM (the surveyor left a message requesting a return call, but no return call was received). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- CNA #10: 12/18/2024 at 2:56 PM (the surveyor left a message requesting a return call, but no return call was received). - CNA #11: 12/18/2024 at 2:52 PM (the surveyor left a message requesting a return call, but no return call was received). - CNA #12: 12/18/2024 at 3:04 PM (the surveyor left a message requesting a return call, but no return call was received). During an interview on 12/18/2024 at 10:03 AM, the Director of Nursing (DON) indicated that once a nurse completed an eInteract (SBAR) form, the fall was to be reviewed the next working day during the clinical stand-up meeting, which was attended by the Administrator, DON, Social Worker, Activity Director, and a nurse (either the Infection Preventionist or the Director of Staff Development). The DON stated that during a fall investigation, the facility attempted to interview the resident and/or their family, as well as any possible staff witnesses. The DON indicated that due to Resident #36's size, the facility would usually provide education to staff about the proper way to turn the resident to prevent falls from the bed. During an interview on 12/18/2024 at 1:57 PM, the DON revealed she was unable to locate any documentation that an investigation was completed related to Resident #36's 03/01/2024 fall, nor was she able to locate any documentation that the IDT had met to discuss the fall or that specific interventions were implemented to prevent further potential falls for Resident #36. During an interview on 12/19/2024 at 11:50 AM, the Director of Medical Records indicated she was responsible for conducting audits on all falls in the facility to ensure the nursing staff had conducted the proper assessments and completed all the required documentation in the resident's electronic medical record. She stated she had been responsible for these audits for approximately three years. She stated that the nurse must complete a communication note in the electronic medical record to alert her that a fall had occurred and was ready for review. She stated if the nurse did not initiate the communication note and someone started a change of condition form, that person could add a note in the change of condition book at the nurses' station. She indicated staff had to manually make the notation in this area; otherwise, she was not notified of the fall or change in condition. She stated she conducted audits twice weekly for missing documentation and provided notices to the nursing staff when documents were incomplete or missing, and then the nurse must initial the notice and return it to her when the documents were completed. During an interview on 12/19/2024 at 11:53 AM, the DON stated the nurse on duty at the time of a fall/incident should follow the guidance when recording an incident. She stated the SBAR notes did not notify management in any way and that the only way for management to know about an incident was for the nurse to fill out the communication note. During an interview on 12/19/2024 at 12:22 PM, the DON revealed that she utilized a screen called the dashboard on the electronic medical record system to notify her when a fall had occurred. She stated the nurse at the time of the fall was to enter a communication note in the electronic medical record and handwrite a note in the change of condition binder at the nurses' station. The DON explained if there was a communication note written after a fall, then the fall was discussed during the daily clinical meeting in order to determine the root cause of the fall and determine a plan for appropriate interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an additional interview on 12/19/2024 at 2:56 PM, the DON stated she had no knowledge of Resident #36's 03/01/2024 fall prior to this week. She indicated the Medical Records Director would not be aware of a fall either, if the nurse did not complete a communication note. She stated her expectation was that nurses complete all required documents during the shift when the incident occurred. During an interview on 12/19/2024 at 3:12 PM, the Administrator indicated he expected the nurses to complete all required documentation on the shift when the incident occurred. During an interview on 12/19/2024 at 3:43 PM, the DON stated the last training the facility had provided on falls was in March of this year. 2. An Admission Record indicated the facility admitted Resident #25 on 10/06/2022. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, subsequent encounter for an unspecified fall, and age-related osteoporosis. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/2024, revealed Resident #25 had short- and long-term memory impairment. The assessment indicated the resident was independent with ambulation and had sustained one fall with no injury since entry or since the prior assessment. Resident #25's care plan included a focus area (not dated) that indicated the resident was at risk for falls related to confusion, dementia, hypertension, psychoactive drug use, an unawareness of safety needs, wandering, and the use/side effects of medication. Interventions (not dated) directed staff to anticipate and meet the resident's needs; be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed; ensure the resident was wearing appropriate footwear when ambulating or mobilizing in the wheelchair; follow the facility's fall protocol; and review information on past falls and attempt to determine the cause of falls, record possible root causes, alter or remove any potential causes if possible, and educate the resident / family / caregivers / interdisciplinary team (IDT) as to the causes. A document titled SBAR [Situation, Background, Appearance, Review] Communication Form and Progress Note for RNs [Registered Nurses]/LPNs [Licensed Practical Nurses]/LVNs [Licensed Vocational Nurses], dated 06/19/2024 and completed by Registered Nurse (RN) #14, indicated Resident #25 sustained an unwitnessed fall and was found on the floor between room [ROOM NUMBER] and the [NAME] nurse's station. Resident #25 was sitting on their buttocks with their arms extended for support. The report indicated that Resident #25 sustained no apparent injury . During an interview on 12/19/2024 at 8:40 AM, RN #14 indicated he worked in the facility periodically since May of 2024. RN #14 stated he recalled Resident #25 but was not present at the time of Resident #25's fall on 06/19/2024; however, he had been asked by the facility's Infection Preventionist (IP) nurse to initiate the documentation when he came on duty on the morning of 06/19/2024. RN #14 explained he was told the fall had occurred on the shift prior to his, but the documentation was not done, so he was asked to initiate it. RN #14 stated he did not have all the details of the fall and, therefore, could not complete all required documentation, but the initiation of the documentation would allow the facility to complete the remainder when they knew more details. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An SBAR Communication Form and Progress Note for RNs/LPNs/LVNs, dated 10/04/2024 and completed by Licensed Vocational Nurse (LVN) #15, indicated Resident #25 sustained a fall on 10/04/2024 after being seen kicking a barrel in anger and losing their balance. During an interview on 12/19/2024 at 9:18 AM, LVN #15 indicated she was familiar with Resident #25; however, she was not present at the time of the resident's fall on 10/04/2024 but had come in as the charge nurse on day shift. LVN #15 stated she recalled the nurse present at the time of the fall had to leave the facility, and she was asked to initiate the eInteract form on the nurse's behalf. An SBAR Communication Form and Progress Note for RNs/LPNs/LVNs, dated 10/17/2024 and completed by Licensed Vocational Nurse (LVN) #18, indicated Resident #25 sustained a fall on 10/17/2024; however, the document did not provide details related to how the fall occurred. Attempts were made to contact LVN #18 for a telephone interview on 12/18/2024 at 8:16 PM and 12/19/2024 at 10:22 AM (the surveyor left two messages requesting a return call, but no return call was received). An SBAR Communication Form and Progress Note for RNs/LPNs/LVNs, dated 11/27/2024 and completed by Registered Nurse (RN) #17, indicated Resident #25 sustained a fall on 11/27/2024 due to weakness, low blood pressure, and seizure-like activity for a few seconds. An interview with RN #17 was not possible, as the Administrator informed the survey team that RN #17 was out of the country at the time of the survey. During an interview on 12/18/2024 at 10:03 AM, the Director of Nursing (DON) indicated that once a nurse completed an eInteract form, the fall was to be reviewed the next working day during the clinical stand-up meeting, which was attended by the Administrator, DON, Social Worker, Activity Director, and a nurse (either the Infection Preventionist or the Director of Staff Development). The DON stated that during the investigation, the facility attempted to interview the resident and/or their family as well as any possible staff witnesses. During an interview on 12/18/2024 at 1:57 PM, the DON indicated she was unable to locate any documentation that an investigation was completed and that the IDT had met to discuss the resident's falls, nor was she able to provide documentation of interventions that were initiated to prevent further potential falls for Resident #25. During an interview on 12/19/2024 at 11:50 AM, the Director of Medical Records indicated she was responsible for conducting an audit on all the falls in the facility to ensure the nursing staff had completed all required documentation in the resident's electronic medical record. She indicated that the nurse must complete communication documentation to alert her a fall had occurred and was ready for review. She stated she conducted these audits twice weekly for missing documentation and provided notices to the nursing staff when documents were incomplete or missing, and the nurse must initial the notice and return it to her when the documents were completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 12/19/2024 at 12:22 PM, the DON revealed that she utilized a screen called the dashboard on the electronic medical record system to notify her when a fall had occurred as well as complete a handwritten note in a binder located at the nurses' station. The DON explained if there was a communication note written after a fall, then the fall was discussed during the daily clinical meeting in order to determine the root cause of the fall and determine a plan for appropriate interventions. During an additional interview on 12/19/2024 at 2:56 PM, the DON stated she had no knowledge of Resident #25's falls prior to this week and that the Medical Records Director would not be aware of falls and start her audits either if no communication notes were done. She stated her expectation was that the nurses complete all required documents during the shift when the incident occurred. During an interview on 12/19/2024 at 3:12 PM, the Administrator indicated he expected the nurses to complete all required documentation on the shift when the incident occurred.

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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. 37935 Based on observations, interviews, facility policy review, and review of the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code, the facility failed to ensure dishware was allowed to air dry before being stacked in 1 of 1 facility kitchen. Stacking the dishes while still wet/damp had the potential to create an environment conducive to microbial growth, which could result in foodborne illness. The failed practice had the potential to affect all 51 residents who resided in the facility and received meals from the kitchen. Findings included: An undated facility policy titled Dishwashing indicated, Dishes are to be air dried in racks before stacking and storing. The U.S. FDA 2022 Food Code requirement for drying equipment and utensils indicated, Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. On 12/17/2024 at 10:10 AM, Dietary Aide #2 was observed to stack three visibly wet dessert bowls on a tray on top of each other without allowing them to air-dry. There were also several visibly wet plate holders and plate covers that were observed stacked on top of each other. During an interview on 12/17/2024 at 10:10 AM, Dietary Aide #2 stated she normally processed the dirty dishes, and the cook would then put away the clean dishes. She stated that sometimes, she did help the cook put away plate holders and covers along with the dessert cups, and always stacked them on top of each other. She stated it was important not to stack dishes wet because it could lead to bacterial growth. During an interview on 12/17/2024 at 10:15 AM, [NAME] #1 stated she put plate holders and plate covers away after flipping them over to remove the excess water. She picked up a plate holder she had stacked, and it was still visibly wet. She stated she would let the plate covers sit for a couple of minutes after they came out of the dishwasher. She confirmed the plate holders and plate covers were not dry and stated if they did not dry properly before they were stacked, bacteria could grow. She confirmed the stacked dessert bowls were still wet as well. During an interview on 12/17/2024 at 10:25 AM, the Food Service Supervisor (FSS) stated the staff were to let everything that came out of the dishwasher air-dry and not wipe anything dry. She stated dishes should be dry before stacking. She stated the stacked plate holders, plate covers, and dessert bowls were still wet. She stated it was important for the dishes to be dry before stacking because bacteria could grow. She stated the facility had approximately 60 plate holders and 60 plate covers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/17/2024 at 2:12 PM, the Director of Nursing (DON) stated she did not know the process for drying and storing dishes in the kitchen. She indicated she would expect kitchen staff to know the process behind properly drying and storing dishware. She stated all 52 residents in the facility received meals from the kitchen, and they had no residents on enteral (tube) feedings. (On 12/18/2024 at 8:51 AM, the facility corrected the previously provided census to 51 plus one bed hold). During an interview on 12/17/2024 at 2:41 PM, the Administrator stated the dishwasher had to reach a certain temperature, and then the dishes were supposed to be allowed to air-dry thoroughly before being stored. He stated if dishes were not dried and stored properly, it created an environment that could potentially grow bacteria. He expected the dishes to be dried and stored properly.

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Valley Oaks Post Acute	830 E Chapel St Santa Maria, CA 93454

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29673 Based on interview, record review, and facility document review, the facility failed to ensure the quality assessment and assurance (QAA) committee developed and implemented appropriate plans of action to correct and identify quality deficiencies related to evaluation, tracking, and documentation of falls to facilitate the ability to identify any patterns, determine causal factors, and enable the facility to ascertain whether appropriate and effective interventions were implemented for 2 (Resident #25 and Resident #36) of 2 residents reviewed for falls. Findings included: The facility's Quality Assurance Performance Improvement (QAPI) Plan 2024, dated 01/2024, indicated, Feedback, Data Systems, and Monitoring a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources. The plan also specified several sources of data that would be monitored through QAPI, one of which was, Adverse events (incident reports, 24 hour report) and indicated that the interdisciplinary team (IDT) would review adverse events daily. The plan specified the processes by which the information would be communicated included a dashboard, monthly reports/graphs, logs, and minutes of all meetings. During the survey conducted from 12/16/2024 to 12/19/2024, review of Resident #36's and Resident #25's medical records revealed the following occasions when residents experienced falls and there was insufficient documentation to indicate the facility followed up on the falls in accordance with their established processes by discussing the falls in morning meetings, conducting root-cause analyses, developing and implementing interventions to address any identified root causes, and/or evaluating interventions for their effectiveness: a. A document titled SBAR [Situation, Background, Appearance, Review] Communication Form and Progress Note for RNs [Registered Nurses]/LPNs [Licensed Practical Nurses]/LVNs [Licensed Vocational Nurses], dated 03/01/2024 and completed by Licensed Vocational Nurse (LVN) #6, indicated the LVN was notified at 9:35 PM that Resident #36 had fallen. According to the evaluation, a certified nurse aide (CNA) was providing incontinence care to the resident when the resident rolled to the right and rolled off the bed. The evaluation indicated the resident was seen on the side of the bed on their knees. According to the evaluation, the resident was assisted back to bed and complained of pain to their knees. The evaluation revealed that an abrasion was identified to the resident's right knee. The resident's care plan did not contain evidence of any new interventions that were added after the resident's fall out of bed on 03/01/2024. An Incidents by Incident Type log, printed by the facility on 12/17/2024, revealed a list of the names of residents who had fallen between 01/01/2024 and 12/17/2024, as well as the dates of their individual falls; Resident #36's fall on 03/01/2024 was not included on the list. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/2024 at 1:57 PM, the DON revealed she was unable to locate any documentation that an investigation was completed related to Resident #36's 03/01/2024 fall, nor was she able to locate any documentation that the IDT had met to discuss the fall or that specific interventions were implemented to prevent further potential falls for Resident #36. b. An SBAR Communication Form and Progress Note for RNs/LPNs/LVNs, dated 06/19/2024 and completed by Registered Nurse (RN) #14, indicated Resident #25 sustained an unwitnessed fall and was found on the floor between room [ROOM NUMBER] and the [NAME] nurse's station. Resident #25 was sitting on their buttocks with their arms extended for support. The report indicated that Resident #25 sustained no apparent injury. During an interview on 12/19/2024 at 8:40 AM, RN #14 indicated he was not present at the time of Resident #25's fall on 06/19/2024; however, he had been asked by the facility's Infection Preventionist (IP) nurse to initiate the documentation when he came on duty on the morning of 06/19/2024. RN #14 explained he was told the fall had occurred on the shift prior to his, but the documentation was not done, so he was asked to initiate it. RN #14 stated he did not have all the details of the fall and, therefore, could not complete all the required documentation. An SBAR Communication Form and Progress Note for RNs/LPNs/LVNs, dated 10/04/2024 and completed by Licensed Vocational Nurse (LVN) #15, indicated Resident #25 sustained a fall on 10/04/2024 after being seen kicking a barrel in anger and losing their balance. During an interview on 12/19/2024 at 9:18 AM, LVN #15 indicated she was familiar with Resident #25 but was not present at the time of the resident's fall on 10/04/2024; however, she had come on duty as the charge nurse on the day shift following the incident. LVN #15 stated she recalled the nurse present at the time of the fall had to leave the facility, and she was asked to initiate the eInteract (SBAR) form on the nurse's behalf. An SBAR Communication Form and Progress Note for RNs/LPNs/LVNs, dated 10/17/2024 and completed by Licensed Vocational Nurse (LVN) #18, indicated Resident #25 sustained a fall on 10/17/2024; however, the document did not provide details related to how the fall occurred. Attempts were made to contact LVN #18 for a telephone interview on 12/18/2024 at 8:16 PM and 12/19/2024 at 10:22 AM (the surveyor left two messages requesting a return call, but no return call was received). An SBAR Communication Form and Progress Note for RNs/LPNs/LVNs, dated 11/27/2024 and completed by Registered Nurse (RN) #17, indicated Resident #25 sustained a fall on 11/27/2024 due to weakness, low blood pressure, and seizure-like activity for a few seconds. An interview with RN #17 was not possible, as the Administrator informed the survey team that RN #17 was out of the country at the time of the survey. A completed Matrix for Providers (CMS-802) provided by the facility on 12/16/2024 indicated there were no residents who had experienced falls, with or without injury, in the past 120 days. Resident #25's falls in the past 120 days (as listed above) were not captured on the CMS-802. An Incidents by Incident Type log, printed by the facility on 12/17/2024, revealed a list of the names of residents who had fallen between 01/01/2024 and 12/17/2024, as well as the dates of their individual falls; Resident #25's falls on 06/19/2024, 10/04/2024, 10/17/2024, and 11/27/2024 were not included on the list. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/2024 at 1:57 PM, the DON indicated she was unable to locate any documentation that investigations were completed or that the IDT had met to discuss the resident's falls, nor was she able to provide documentation of interventions that were initiated to prevent further potential falls for Resident #25. The following interviews were conducted regarding the facility's processes for follow-up and audits related to falls: During an interview on 12/19/2024 at 11:53 AM, the Director of Nursing (DON) stated a communication note should be completed by the nurse at the time of an incident, and then the communication notes were reviewed during the daily morning meetings. The DON revealed that completion of an incident report did not trigger a notification to administration/management, and the only way the electronic health record (EHR) system would alert management of an incident was if the staff completed a communication note. During an interview on 12/19/2024 at 12:22 PM, the DON stated the dashboard of the electronic health record (EHR) system alerted her to review when there was a communication note. The DON stated the nurse had to choose Communication Note and New to initiate a communication note. She stated when an incident occurred, the nurse was also supposed add a handwritten note to the Change of Condition (COD) binder for the resident to be monitored. The DON stated the Medical Records staff audited the EHR communications and the COD binder. The DON indicated the nurse was required to initiate and complete a risk management report and that this would also populate a progress note. The DON stated that when there was a communication note regarding a fall, the IDT would discuss the incident during the clinical part of the morning meetings. She revealed the staff who attended that meeting were the DON, the Infection Preventionist (IP), the Activity Director, the dietitian, and the Administrator. The DON stated that during the meeting, they discussed incidents, including who was involved, how the incident happened, and what they could do about the issue. She stated the purpose of the meeting was to do a root-cause analysis and then decide on a plan of intervention. The DON stated they had identified an ongoing issue with the communication notes. The DON indicated registry (staffing agency) nurses were given a written process/checklist to follow for recording an incident and that filling out a communication form was on the list. According to the DON, when a registry nurse came to work in the building for the first time, the nurse who was going off duty showed the new or agency staff where to find the listed items in the EHR. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/2024 at 3:23 PM, the Administrator stated he was the QAA contact person. He explained that during QAA meetings, the IDT discussed issues that affected the entire facility. He indicated root-cause analyses were completed for all concerns that were discussed. The Administrator stated the QAA committee had discussed the audit processes but had not discussed the missing falls documentation. According to the Administrator, the facility had previously identified that registry staff had not completed all the required falls documentation. The Administrator revealed if documents were noted to be missing, the management staff reached out to registry staff to have them completed. The Administrator revealed the resolution of the issue was for the facility to no longer use registry staff. The Administrator stated they had put several things in place to attempt to recruit and hire permanent staff, including referral bonuses at each quarter for the new staff and the staff person who referred them, sponsoring the CNAs through training, advertising positions on job search websites, and hiring registry staff who performed well. The actions, as described the Administrator, did not specify how the QAA committee would identify and address when staff failed to initiate documentation to alert the IDT, management, or the QAA committee of falls and the lack of follow-up that occurred as a result of the missing documentation (evaluation for causative factors, development of interventions, follow-up monitoring) after a fall occurred.

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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. 29673 Based on observation, interview, record review, facility document review, facility policy review, and review of the Centers for Disease Prevention and Control (CDC) guidelines, the facility failed to ensure staff adhered to contact isolation precautions and donned the appropriate personal protective equipment while performing care or services in the room of a resident (Resident #26) with a known communicable disease (Clostridium difficile [C. diff]), to prevent the potential spread of C. diff infection to other residents. The failed practice was identified for 1 (Resident #26) of 1 resident reviewed for transmission-based precautions (TBP) and had the potential to affect 14 other residents who resided on the East Hall and were likely to receive care from staff assigned to Resident #26. Findings included: An undated facility policy titled, Standard and Other Precautions, indicated, Contact Precautions The following is adapted from CDC publication 2007 Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings, which can be obtained at www.cdc.gov. The policy specified, Contact Precautions are followed by all personnel when instructed to do so by the health department, state licensing agency, resident's physician, or other infection control professionals. Procedure The following procedures are followed when a resident must be on Contact Precautions: 2. Personal Protective Equipment a. Personnel caring for a resident on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment b. Gloves i. Wear gloves whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident (e.g. [such as], personal care equipment, bed rails). ii. [NAME] gloves upon entry into the room. c. Gowns i. [NAME] gown upon entry into the room. ii. Remove gown and observe hand hygiene before leaving the resident-care environment. iii. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other residents or environmental surfaces. d. Donning personal protective equipment upon room entry and discarding before exiting the resident room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE [Vancomycin-resistant Enterococcus], C. difficile, noroviruses and other intestinal tract pathogens. The CDC guidance titled, C. diff: Facts for Clinicians dated 03/05/2024 and obtained from https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html, indicated, C. diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item. The guidance also indicated, Wear gloves and gown when treating patients with potential infectious diarrhea, including C. diff, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff. In addition, handwashing alone may not be sufficient to eliminate all C. diff spores. The guidance indicated, If CDI [C. diff infection] is confirmed: Continue isolation and contact precautions. An Admission Record revealed the facility admitted Resident #26 on 11/20/2024. According to the Admission Record, the resident had diagnoses that included recurrent enterocolitis due to Clostridium difficile, end stage renal disease (ESRD), and need for assistance with personal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/16/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS also revealed resident #26 had an active diagnosis of a multidrug-resistant organism (MDRO), had a urinary tract infection in the last 30 days, and was taking antibiotics and/or had taken them in the past seven days. Resident #26's care plan included a focus area, dated 11/21/2024, that indicated the resident had C. difficile. Interventions directed staff to administer antibiotics/medications as ordered; disinfect all equipment used before leaving the room; implement enhanced contact isolation, including wearing gowns and masks when changing contaminated linens and bagging linens tightly before taking them to laundry; and use as much disposable equipment as possible or use dedicated equipment such as a thermometer and blood pressure cuff. The resident's care plan also had a focus area, revised on 11/29/2024, that indicated the resident was on oral antibiotic therapy (Vancomycin) until 01/08/2025 related to C. diff. Interventions directed staff to administer antibiotic medications as ordered by the physician and monitor and document side effects and effectiveness every shift. An observation on 12/16/2024 at 9:07 AM revealed a sign was posted outside the door to Resident #26's room that indicated the resident was on contact precautions. The sign indicated everyone was to clean their hands before entering and when leaving the room and that providers and staff were to put on gloves and a gown before entering the room and discard the gloves and gown before exiting the room. During an observation on 12/16/2024 at 9:50 AM, Housekeeper #3 went into Resident #26's room wearing gloves and a mask but no gown. During an interview on 12/16/2024 at 10:54 AM, Housekeeper #3 revealed she knew she was supposed to wear a gown to go in Resident #26's room, where the resident was on contact precautions, but she had forgotten to put on a gown when she went in to clean the room. During an observation on 12/16/2024 at 11:11 AM, Certified Nurse Aide (CNA) #4 went into Resident #26's room without donning PPE. CNA #4 folded up Resident #26's wheelchair and moved it across the room. CNA #4 used hand sanitizer upon exiting the resident's room but did not wash her hands. CNA #4 then went into another resident's room. During an interview on 12/19/2024 at 10:40 AM, CNA #4 revealed she had been trained in the previous 30 days on infection control. CNA #4 stated that when she went into the room of a resident who was on contact precautions, she should put on a gown and gloves before going in. CNA #4 stated she would take the gown and gloves off and put them in the trash in the resident's room and then wash her hands. CNA #4 stated that when she moved Resident #26's wheelchair on 12/16/2024, she was busy and forgot to put on PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/18/2024 at 4:19 PM, CNA #5 went into Resident #26's room and retrieved gloves from the box of gloves near the door on the inside the room. Without donning a gown, CNA #5 went to the resident's bedside and proceeded to rearrange and spread the bed linens, which touched her clothing at least twice. After rearranging the resident's top sheet and blankets, CNA #5 did not remove her gloves or wash or sanitize her hands before exiting the room with a wadded piece of material, which she placed in the linen hamper. After closing the linen hamper, she touched the lid of the hamper all over while still wearing the contaminated gloves, then proceeded to push the hamper down the hall. During an interview on 12/18/2024 at 4:19 PM, CNA #5 stated she was not required to wear a gown because she did not provide personal care to the resident. She asserted that a gown was only needed if she provided personal care to the resident. CNA #5 stated she did not remove her gloves because she was touching the linen hamper. During an interview on 12/19/2024 at 9:21 AM, the Infection Preventionist (IP) stated the types of infection control precautions used in the facility were standard, contact, droplet, and enhanced barrier. He stated if a resident was on contact precautions, any staff going into that cubicle (area around the resident's bed) needed to wear gown and gloves. The IP stated staff should use proper hand hygiene. He indicated Resident #26 was on contact precautions, and any staff who went into the resident's area of the room should wear a gown and gloves. He stated staff should remove the PPE before leaving the room and put it in the trash receptacle provided inside the resident's room. The IP stated that because Resident #26 had C. diff, all staff should have washed their hands with soap and water. He indicated staff should not have entered another resident's room or touched another resident without first washing their hands with soap and water. The IP stated staff should not wear gloves that they wore in Resident #26's room out into the hall. During an interview on 12/19/2024 at 11:45 AM, the Director of Nursing (DON) revealed that for a new admission, they used the hospital records to know what infection control precautions were needed. She stated if the resident had a change in their need for precautions, then they would verify the needs with the IP. She indicated the IP would post a sign for the appropriate precautions for staff. The DON revealed that for a resident on contact precautions, staff were required to wear gloves and a gown anytime they were touching the resident or areas with which the resident came into contact. She stated if they were touching the bedding or the resident's belongings, including the trash, the staff would be required to wear gloves and a gown. The DON stated the gloves and gown should be removed after providing for the resident's needs and before leaving the room. She stated the staff should go into the resident's bathroom and wash their hands with soap and water before leaving the resident's room. The Administrator sat in on the interview and agreed with the expectations expressed by the DON.