STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055833	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Gardens Post Acute, LLC	537 E. Fulton Street Stockton, CA 95204

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50598 Based on observation, interview, and record review, the facility failed to ensure 1 of 22 sampled residents (Resident 74) was treated with dignity and respect, when Certified Nursing Assistant (CNA) 3 and CNA 5 were speaking a foreign language over Resident 74 while providing care. This failure had the potential to impact Resident 74's self-esteem and quality of life. Findings: During an observation on 1/7/25, at 10:12 AM, CNA 3 and CNA 5, were observed on opposite sides of Resident 74's bed, providing Activities of Daily Living (ADL) care. While providing this care, CNA 3 and CNA 5 were observed speaking a foreign language over Resident 74 to each other. The conversation could be heard from outside of Resident 74's bedroom door. During a joint interview on 1/7/25, at 10:15 AM, with CNA 3 and CNA 5, CNA 3 stated CNA 5 was explaining something personal in their native language. CNA 5 stated the conversation had to do with something about her family and not Resident 74. CNA 5 stated they were only allowed to speak a foreign language in the break room. During an interview on 1/7/25, at 10:18 AM, with Resident 74, when asked about CNA 3 and CNA 5 speaking a foreign language over her while providing care, Resident 74 stated, They are not supposed to do that. They should know that. I hate it. During an interview on 1/9/25, at 3:43 PM, with the Director of Staff Development (DSD), the DSD stated the facility policy was to always speak English. The DSD stated staff speaking a foreign language made the resident feel emotionally uncomfortable and was a violation of their rights. The DSD stated this type of behavior was not acceptable and not the facility's practice. During an interview on 1/10/25, at 12:25 PM, with the Director of Nursing (DON), the DON stated Resident 74 had the right to feel a sense of belonging and to know what staff were talking about. The DON explained speaking a foreign language while providing care was a violation of a resident's right to dignity. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided document titled, DIGNITY AND RESPECT, dated March 2023, indicated, . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .To provide staff with guidelines to ensure residents are treated with kindness, respect, and dignity .Residents shall be treated with dignity and respect at all times .Resident's private space and property shall be respected at all times .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43943 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents who were permitted to self-administer medications (Resident 16 and Resident 60) had their medications stored in a safe manner, when expired and nonexpired medications were accessible to residents at their bedside and the facility failed to follow their self-medication administration Policy and Procedure (P&P). This failure had the potential for a medication overdose for Resident 16, Resident 60, and other residents in the facility, and low efficacy (decrease in effectiveness of medication) of Resident 16's expired medications. Findings: 1. Review of Resident 16's clinical record titled, ADMISSION RECORD, indicated Resident 16's diagnoses included diabetes mellitus (inability of the body to regulate blood sugar), hypertension (high blood pressure), and hypothyroidism (inability of the body to secrete enough thyroid hormone). During a concurrent observation and interview on 1/7/25, at 4:07 p.m., with Resident 16, prescribed (medications ordered by Medical Doctor -MD) and over the counter (OTC - purchased at a drug store) medications were found at Resident 16's bedside table and bedside drawer. The bedside table had Bengay (OTC pain reliever cream), Cepacol (OTC cough drops), Chloraseptic spray (OTC sore throat pain reliver spray), and Tylenol 500 milligrams (mg - unit of measurement - OTC pain reliever medication) that were unlocked and accessible to residents. Resident 16 stated she also had medications in her bedside drawer in a blue bag. Resident 16 stated she took Tylenol in-between her administered Norco (narcotic - prescribed pain medication that contained Tylenol) medication. During a concurrent observation and interview on 1/08/25, at 8:30 a.m., with the Licensed Nurse (LN) 8 and Resident 16, unlocked medications were found in a soft plastic lunch bag on Resident 16's bedside table. Resident 16 stated it was okay for LN 8 to open the bag to view the medications. The medications found in the lunch bag were: -Cepacol Extra Strength (OTC sore throat drops) - unable to visualize expiration date -Tylenol (OTC pain reliver) 500 mg - unable to see expiration date -Acetaminophen (OTC pain reliever) 500 mg - expiration date 6/26 -VICKS rub - (OTC pain ointment) - unable to visualize expiration date -Tiger Balm - (OTC pain ointment) - unable to visualize expiration date -Leg Cramps PM (nighttime - OTC pain medicine)- unable to visualize expiration date -Amlodipine (prescribed by MD - calcium channel blocker - used to treat chest pain) 10 mg - expired 4/11/22 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Atorvastatin (prescribed by MD - cholesterol reducer) 20 mg - expired 10/23 -Atorvastatin (prescribed by MD - 2nd bottle) 20 mg - expired 1/24 -Lisinopril (prescribed by MD - high blood pressure medication) 40 mg - expired 8/23 -Cephalexin (prescribed by MD - antibiotic used to treat bacterial infections) 500 mg - expired 12/23 - Ear Drops - (OTC - pain reliever) - unable to visualize expiration date - Aspirin (OTC medication used to relieve pain or thin the blood to prevent a stroke) 81 mg - expired 4/23 -Metformin (prescribed by MD - used to lower blood sugar) 1000 mg - expired 10/23 - Levothyroxine (prescribed by MD - used to treat low thyroid hormones) 175 mg - expired 7/24 - [NAME] Antibiotic ointment (OTC medication used to treat skin infections) - expired 2/21 - Gas X - (OTC medication used to treat excess gas) - unable to visualize expiration date - Tylenol cold and flu - (OTC medication - cold symptom reducer) - expired 6/20 - Mucinex (OTC medication used to treat congestion) - expired 2/24 - Phenylephrine (OTC medication used to treat nasal discomfort with a cold) - expired 7/24 - US med Glucometer pen (needle used to detect blood sugar) - unable to visualize expiration date During a concurrent interview on 1/8/25, at 8:45 a.m., with LN 8, Resident 16's medication orders were reviewed. LN 8 stated all the medications in the lunch bag at Resident 16's bedside were unlocked, and some medications were expired. LN 8 further stated blood pressure medication, cholesterol medication, blood glucose medication, and Tylenol, were all facility stored medications the facility administered to Resident 16 on a daily basis. LN 8 stated the facility did not have a way to track what medications Resident 16 self-administered. LN 8 further stated according to Resident 16's orders, she was only permitted to self-administer Centrum Silver (combination of vitamins and selected minerals used to prevent or treat vitamin deficiency), and Vitamin D3 (vitamin that helps the body absorb calcium and phosphorus). LN 8 stated Resident 16's self-administration of medications meant that Resident 16 took the specified medications independently without supervision, not that any medications could be stored at the bedside unsecured. LN 8 verified the lunch bag (at the bedside) with Resident 16's medications were not locked, and the medicine containers all had medication inside of them. LN 8 stated the facility had lock boxes and the medications at the bedside should have been locked. LN 8 further stated all of Resident 16's roommates (Resident 74, Resident 52, Resident 10) were confused and accessible medicaions at the bedside put them at risk for overdosing on medications. LN 8 stated Resident 16 was at risk for an overdose on Tylenol (could result in liver damage), Aspirin (bleeding), Levothyroxine (could result in seizures-uncontrolled body movements), and Metformin (hypoglycemia-low blood sugar that could result in death). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25, at 8:56 a.m., with Resident 16, Resident 16 stated she has had the medications at her bedside for about a year and a half. Resident 16 further stated staff had never checked the expiration dates on the medications. Resident 16 stated she had not kept a record of when she self-administered medications that were at her bedside. Resident 16 further stated she self-administered her bedside Tylenol and cold medicine when needed. Resident 16 stated all her roommates (Resident 74, Resident 52, Resident 10) were confused. During an interview on 1/8/25, at 11:07 a.m., with LN 9, LN 9 stated Resident 16 had a physician's order to self-administer Vitamin D and Centrum Silver. LN 9 further stated even when medications were self-administered, the medications should not be left unlocked at the bedside. LN 9 stated the facility had locked boxes that could be kept at the bedside, but the boxes were usually used to house the resident's cigarettes. LN 9 further stated the danger of Resident 16 having expired medications at the bedside was risk of overdose, other residents getting into the medications, and expired medications may have lost their efficacy. LN 9 stated the facility had residents with wandering behavior who could have gotten into the medications. LN 9 further stated the facility did not have a way to track which medications resident's self-administered and at what time. LN 9 stated Resident 16 should not have had unlocked medications at the bedside, and this placed Resident 16 and other residents at risk for injury (overdose). A review of Resident 16's clinical record titled, Self-Administration of Medication Assessment, dated 10/10/24, at 10:45 p.m., by LN 10, indicated Resident 16 was approved to self-administer Centrum Silver and Vitamin D3. A review of Resident 16's clinical record titled, Order Review History Report, dated 11/8/24, indicated Resident 16 was permitted to self-administer (unsupervised), Vitamin D3 (one time a day) and Centrum Silver (one time a day). A review of Resident 16's clinical record titled, Progress Notes, dated 1/7/25, at 6:14 p.m., by the Assistant Director of Nursing (ADON), indicated, .Noted resident has a Tylenol 500 mg ES [extra strength] at bedside with no MD [Medical Doctor] order, per resident she is taking as needed for her arthritis [inflammation of joints] pain . Resident also noted she was keeping expired medications at bedside .She takes Tylenol in-between her Norco . A review of Resident 16's clinical record titled, Medication Administration Record, (MAR) indicated Resident 16 received the following medications administered by the facility and that Resident 16 also had at her bedside: -Aspirin 81 mg (one time a day) -Atorvastatin 40 mg (one time a day) -Levothyroxine 75 Micrograms (mcg - unit of measurement) -Lisinopril 40 mg (one time a day) -Metformin 500 mg (two times a day) -Tylenol Extra Strength 500 mg (every six hours as needed for pian) (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 16's clinical record titled, Weekly Summary: Nursing Progress Notes, dated 1/7/25, at 3:06 p.m., by LN 8, indicated Resident 16 had some forgetfulness. A review of Resident 74's (Resident 16's roommate) clinical record titled, ADMISSION RECORD, indicated Resident 74's diagnoses included history of stroke (the brain was deprived of oxygen for a time and caused brain damage), depression (a mental health condition causing persistent low mood), and anxiety (feeling of worry, nervousness, and unease). A review of Resident 74's (Resident 16's roommate) clinical record titled Brief Interview Mental Status (BIMS- an evaluation of cognitive impairment - Severe impairment: 0-7 points; Moderate impairment: 8-12 points; Cognitively intact: 13-15 points), dated 12/13/24, indicated Resident 74's BIMS was 11 (moderately impaired). A review of Resident 52's (Resident 16's roommate) clinical record titled, ADMISSION RECORD, indicated Resident 52's diagnoses included alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform daily tasks). A review of Resident 52's (Resident 16's roommate) clinical record titled, BIMS, dated 10/9/24, indicated Resident 52's BIMS score was 01 (severe impairment). A review of Resident 10's (Resident 16's roommate) clinical record titled, ADMISSION RECORD, indicated Resident 10's diagnoses included dementia (general term for a number of neurological conditions that cause a decline in mental abilities, such as thinking, remembering, and reasoning). A review of Resident 10's (Resident 16's roommate) clinical record titled, BIMS, dated 10/9/24, indicated Resident 10's BIMS score was 04 (severe impairment). A review of the facility's document titled, Wander, indicated the facility had ten residents who wandered around the facility. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint concurrent interview and record review on 1/08/2, at 11:48 a.m., with the Administrator (ADM) and the Director of Nursing (DON), the facility's P&Ps titled, Labeling of Biologicals and Storage of Biologicals, dated 3/23; Resident Self Administer Medications, dated 3/23; and Resident 16's orders were reviewed. The ADM and the DON acknowledged Resident 16 had expired medications at her bedside. The ADM stated Resident 16's medications were not locked at the bedside and the medications should have been locked at the nurse's station. The DON reviewed Resident 16's medication orders and acknowledged that Resident 16 was only ordered to self-administer Vitamin D and Centrum Silver. The DON stated Resident 16 was at risk for an overdose of medications, especially Tylenol which could lead to liver failure. The ADM and the DON stated their expectations were for the staff to track which medications and at what time medications were self-administered. The DON stated medications that were expired could have a low efficacy rate. The P&P titled, Resident Self Administer Medications, indicated, .3. e. The resident's comprehension of instruction for the medications they are taking, including .when to report to staff . g. The resident's ability to ensure that medication is stored safely and securely .7. The licensed nurse will ask the resident if he or she has self-administered their medications and document results in the medical record. 8. Medications self-administered by the resident and which the resident has been determined safe to be maintained at bedside, shall be stored in a locked container to maintain safety . The P&P titled, Labeling of Biologicals and Storage of Biologicals, indicated, .The facility .provides accurate labeling to facilitate precautions and safe administration of medications, and safe and secure storage . 2. The medication label at a minimum includes the medication name .prescribed dose, strength, the expiration date .3. For medications designed for multiple administrations .the label identifies the specific resident for whom it was prescribed .6. If a multi-dose vial has been opened or accessed .the vial should be dated and discarded within 28 days . Storage of Drugs and Biologicals .4. The facility has procedures for the control and safe storage of medications for those residents who can self-administer medications . The ADM and the DON acknowledged the facility P&Ps were not followed. 49823 2. A review of Resident 60's ADMISSION RECORD, indicated Resident 60 was admitted to the facility in 2023 with diagnoses including chronic obstructive pulmonary disease (COPD, a long-term lung disease that causes shortness of breath and cough). During an observation on 1/8/25, at 1:30 p.m., Resident 60 pulled containers of medications out of a pink tote bag that she had on the shelf of her walker and showed them to the facility Regional Nurse Consultant (RNC) in the hallway near the conference room. During an interview on 1/9/25, at 11:35 a.m., with the RNC, the RNC confirmed Resident 60 had medications in her tote bag on the shelf of her walker in the hallway near the conference room on 1/8/25, and stated Resident 60 should not have been carrying medications in her tote bag on the shelf of her walker around the facility. The RNC stated that the risk was that other residents could access the medications. The RNC confirmed that the facility policy was not followed. During an interview on 1/9/25, at 12:20 p.m., with Resident 60, Resident 60 confirmed that she self-administered medications. Resident 60 stated that she started to self-administer medications on 1/8/25. Resident 60 further stated that she now had a locked box for her medications in her room and pointed to a black locked box on the table next to her bed. Resident 60 stated that her medications were in the locked box. Resident 60 did not state what medications were in the locked box when asked. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25, at 1:52 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 60 showed her two inhalers - Albuterol and Symbicort, OTC medication for toothache, and some OTC athletes foot cream that she wanted to self-administer. The ADON stated that as of yesterday there were two inhalers, the OTC foot cream, and OTC toothache medication in Resident 60's locked box. The ADON stated the risk of Resident 60 not keeping medications in the locked box was that other residents could access them. The ADON acknowledged that the facility policy was not followed. A review of Resident 60's Physician Order Summary, indicated the following orders: .May self-administer Albuterol Sulfate Inhalation Nebulization Solution [medication prescribed to improve breathing] 2.5mg/3ml [unit of measure] inhale orally via nebulizer every four hours as needed .order date 1/8/2025 . .May self-administer Anbesol Mouth/Throat Liquid 10% to affected area four times a day for mouth pain .If symptoms persist, irritation, severe pain or redness notify MD .order date 1/9/2025 . .May self-administer Athlete's Foot Cream 0.5 oz. Apply it between the toes twice a day or on the bottom or sides of the foot twice a day for two weeks. Notify MD if worsening .as needed for itching for 14 days to treat fungal skin infections, such as athlete's foot .order date 1/9/2025 . .May self-administer Budesonide-Formoterol Fumarate [Symbicort, medication prescribed to improve breathing] Inhalation Aerosol 160-4.5 mcg/act two puff inhale orally one time a day related to Chronic Obstructive Pulmonary Disease .rinse mouth with water and spit back to cup after each use .order date 1/9/2025 . A review of a facility policy and procedure (P&P) titled, Resident Self-Administer Medications, revised March 2023, indicated, .Procedure .8. Medications self-administered by the resident and which the resident has been determined safe to be maintained at bedside, shall be stored in a locked container to maintain safety . A review of a facility P&P titled, Labeling of Biologicals and Storage of Biologicals, revised March 2023, indicated, .Storage of Drugs and Biologicals .4. The facility has procedures for the control and safe storage of medications for those residents who can self-administer medications .

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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. 49823 Based on interview, and record review, the facility failed to implement an individualized care plan intervention for 1 of 22 sampled residents (Resident 44) when Resident 44 had recommendations from a PASRR level II screening (identifies additional resources needed for residents with mental illness, intellectual or development disabilities) which were not incorporated into Resident 44's plan of care. This failure had the potential for Resident 44 to not receive recommended services to support health and well-being. Findings: A review of Resident 44's ADMISSION RECORD, indicated Resident 44 was admitted to the facility in 2023. Resident 44's admission diagnoses included dementia (a general term for loss of memory, language, problem- solving and other thinking abilities that are severe enough to interfere with daily life), and schizophrenia (a serious mental disorder in which a person interprets reality abnormally). During a record review of Resident 44's facility Electronic Medical Record (EMR- a digital version of a resident's medical history including diagnoses, medications, tests, physician orders, care plans, and treatment records), the EMR indicated PASRR Level I positive screening results, but no PASRR Level II report. During a concurrent interview and record review on 1/9/25, at 7:57 a.m., with the facility Minimum Data Set Coordinator (MDS- a nurse that collects data related to residents in order to develop and evaluate a comprehensive care plan), Resident 44's EMR was reviewed. The MDS confirmed Resident 44's PASRR Level I screenings were completed on 2/2/23, & 2/23/23. The MDS stated Resident 44's PASRR Level II screening was completed on 2/13/23, but it was not attached to Resident 44's EMR. The MDS further stated the PASRR Level II screening should have been uploaded to Resident 44's EMR. The MDS logged into the PASRR website and found Resident 44's PASRR Level II screening letter dated 2/13/23. A review of Resident 44's PASRR Level II Screening/Evaluation, dated 2/13/23, indicated, .The results of this Level II Evaluation are provided in the PASRR Determination Report attached to this letter. Facility staff will receive a copy of this Determination Report, will discuss the results with you in a timely manner, and will incorporate the recommendations into your care plan . During a concurrent interview and record review on 1/9/25, at 8:33 a.m., with the MDS, Resident 44's Care Plan, was reviewed. The MDS stated the recommendations from Resident 44's PASRR II Screening/Evaluation should have been included in Resident 44's care plan. The MDS confirmed that the PASRR II recommendations were not included in Resident 44's care plan. The MDS stated that the risk was that the facility would not follow through on the PASRR Level II recommendations for Resident 44. (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 1/9/25 at 10:58 a.m., the Director of Nursing (DON), the DON stated the recommendations from the PASRR Level II Screening/Evaluation should have been added to the resident's care plans. The DON stated that the risk was that the recommendations would not be followed. The DON confirmed that the facility policy was not followed. During a review of a facility policy and procedure (P&P) titled, Develop-Implement Comprehensive Care Plans, revised March 2023, the P&P indicated, .The facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs . Guidelines .1. The comprehensive care plan describes .c. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASRR recommendations .Specialized Services - PASSR: 1. The comprehensive care plan must coordinate with and address any specialized services or specialized rehabilitation services the facility will provide or arrange as a result of PASRR recommendations .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43943 Based on observation, interview, and record review, the facility failed to ensure 1 of 22 sampled residents (Resident 12) received the appropriate range of motion (ROM - the distance and direction a joint can move) services to increase range of motion and/or to prevent further decrease in range of motion. This failure could have resulted in Resident 1's ability to use his right hand to his fullest capacity and could have led to a decrease in quality of life. Findings: Review of Resident 12's clinical record titled, ADMISSION RECORD, indicated Resident 12's diagnoses included a history of stroke (oxygen was deprived from the brain for a time that resulted in brain damage) and aphasia (a language disorder that made it difficult to understand or express language). A review of Resident 12's clinical record titled, Emergency Documentation - MD [Medical Doctor], dated 8/26/19, at 1:23 p.m., by Physician (PHYS) 1, indicated Resident 12 had a history of aphasia following cerebral infarction (also known as an ischemic stroke, occurs when blood flow to the brain is blocked, causing brain tissue to die) and was unable to care for himself. Resident 12 was discharged from the acute care hospital to the facility. During a concurrent observation and interview on 1/7/25 at 3:28 p.m., with Resident 12, Resident 12 was noted in his bed, his right hand was contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), and he had limited range of motion (LROM). Resident 12 stated nursing staff would occasionally perform Assisted Active ROM (AAROM - the use of the muscles surrounding the joint to perform the exercise but requires some help from the therapist) exercises with him. Resident 12 did not have a splint (a soft brace placed over the hand and used to treat joint stiffness and limited range of motion) on his right hand. A review of Resident 12's clinical record titled, Order Summary Report, dated 9/19/22, indicated Resident 12's orders included AAROM of Upper and Lower Extremities (arms, hands, feet, and legs) during Activities of Daily Living (ADL - brush teeth, brush hair, get dressed, toilet care) every day as tolerated. A review of Resident 12's clinical record titled, Care Plan, (a list of resident specific problems, goals, and interventions) dated 8/27/19, indicated Resident 12 had a self-care deficit with ADL functions related to history of stoke, aphasia, and weakness. Interventions included the Certified Nursing Assistants (CNA) would provide AAROM to bilateral upper and lower extremities each day as tolerated. A review of Resident 12's clinical record titled, Care Plan, dated 9/17/19, indicated Resident 12 had limited physical mobility related to weakness and history of stroke. The goal included Resident 12 remained free of complications related to contractures. Interventions included ROM with daily care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 12's clinical record titled, Care Plan, dated 3/5/21, indicated Resident 12 was at risk of pain related to contracture of the right arm. A review of Resident 12's clinical record titled, Section GG - Functional Abilities, (part of a comprehensive assessment) dated 11/20/24, indicated Resident 12 had a functional limitation in ROM in one arm and used a wheelchair as a mobility device. Resident 12 was dependent on staff for toileting hygiene, shower/bath, personal hygiene, and needed moderate assistance with dressing. A review of Resident 12's clinical records titled POC [Point of Care] Response History Task, dated 12/11/24 through 1/9/25, indicated the CNAs would document AAROM as: the amount of time AAROM was performed, Not Applicable, Not Available, or Resident Refused. The CNAs documented Not Applicable for AAROM on BUE and BLE on the following dates: 12/13/24 12/17/24 through 12/19/24 12/22/24 through 12/25/24 12/28/24 through 12/29/24 12/31/24 1/3/25 through 1/6/25 1/9/25 During an interview on 1/09/25, at 12:13 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated AAROM was supposed to be documented in Resident 12's Electronic Health Record (EHR). CNA 4 stated if/when Resident 12 refused AAROM, there was a section in the documentation that would have identified the refusal. CNA 4 stated she had not done AAROM with Resident 12 on 1/9/25 and AAROM was performed to help Resident 12 maintain function in his right hand. During a concurrent interview and review on 1/9/25, at 12:15 p.m., with Licensed Nurse (LN) 11, Resident 12's EHR was reviewed. LN 11 stated Resident 12's right hand was contracted. LN 11 stated it was important for the CNAs to perform AAROM to stimulate blood flow in the hand and to avoid worsening of the contractures. LN 11 stated if Resident 12 refused AAROM there should have been a nurse's note in Resident 12's EHR. LN 11 verified there was not a nurse's note indicating Resident 12 refused AAROM from 12/13/24 through 1/9/25. During a concurrent observation and interview on 1/9/25, at 12:28 p.m., with the Therapy Director (TD), the TD assessed Resident 12's ROM on the upper extremities. Resident 12 had full strength and ROM in his left hand and his right hand was weak and contracted. The TD stated she was unaware Resident 12's right thumb was so stiff and stated Resident 12 would benefit from a splint on the right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/9/25, at 3:16 p.m., with the Administrator (ADM) and the Director of Nursing (DON), the facility's policy and procedures (P&P) titled, Increase/Prevent Decline in ROM Mobility, dated 3/23, the facility's document titled, Certified Nursing Assistant (C.N.A) Job Description, dated 12/2016, and Resident 12's record titled, POC [Point of Care] Response History Task, was reviewed. The document titled, Increase/Prevent Decline in ROM Mobility, indicated, . 6. Reasons for residents with limited ROM, not receiving services, should be documented in the medical record . The document titled, Certified Nursing Assistant (C.N.A) Job Description, indicated, .Roles and Responsibilities .Assist with turning, lifting, positioning .residents Record entries in electronic format, notes, chart, etc The DON and the ADM reviewed Resident 12's records titled, POC Response History Task, and acknowledged there was no way to ensure Resident 12 received AAROM on 12/13/24, 12/17/24 through 12/19/24, 12/22/24 through 12/25/24, 12/28/24 through 12/29/24, 12/31/24, 1/3/25 through 1/6/25, and 1/9/25. The DON stated AAROM was important to assist Resident 12 in mainlining his ROM in the affected right hand. The ADM and the DON acknowledged the P&P and CNA Job Description was not followed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50598 Based on observation, interview, and record review, the facility failed to ensure protection from potentially hazardous items, when three shaving razors were left on the counter unattended in a shared bathroom of four unsampled residents (Resident 58, Resident 55, Resident 87, Resident 41). This failure placed the facility's residents at risk for an injury in the case of accidental access to sharp items. Findings: During an observation on 1/7/25, at 10:20 AM, in a resident bathroom, there were three shaving razors on the counter. The bathroom was shared by four residents. During a concurrent observation and interview on 1/7/25, at 10:21 AM, with Licensed Nurse (LN) 8, LN 8 confirmed the razors were left on the counter and accessible. LN 8 stated these placed residents at risk of injury and infection, especially if a confused resident was able to access the razors. During an interview on 1/9/25, at 3:40 PM, with the Director of Staff Development (DSD), the DSD stated razors were sharp objects and should not be left unattended on a shared bathroom counter. They should be disposed of in a designated container for sharp objects. The DSD stated this practice posed a risk for injury and infection from using someone else's razor. During an interview on 1/10/25 at 12:25 PM, with the Director of Nursing (DON), the DON stated leaving razors out could result in injury to a resident who was not alert and oriented. The DON stated this finding did not meet the facility's expectations. A review of a facility policy titled, ACCIDENTS PHYSICAL AND PLANT HAZARDS, dated March 2023, indicated, .The facility ensures the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision .GUIDELINES 1. Supervision and/or contaminant of hazards are needed to protect residents from harm .various materials in the resident environment can pose a potential hazard to residents .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49823 Based on observation, interview, and record review, the facility failed to ensure safe pharmaceutical services for a census of 104 when: 1. The emergency kit (E-kit, a box containing emergency medications for faster and easy access when needed) for oral medications was opened and resealed on 1/2/25 and had not been replaced as of 1/7/25; and, 2. Narcotic medication use was not accurately documented in the Medication Administration Record (MAR- a record of the residents' medications and treatments) when removed from the Controlled Drug Record (CDR- a paper record that kept track of narcotic opioid medication [medications used to treat pain that cause drowsiness, dull the senses, and are prone to abuse] use for accountability) sheet for Resident 73. The failure of an opened e-kit not being replaced could result in the unavailability of the medication when needed and unsafe storage of emergency drugs. The failure of not accurately documenting narcotic medications in the MAR could result in unsafe pain medication use and a risk for drug diversion. Findings: 1. During a concurrent observation and interview on 1/7/25, at 9:50 a.m., with Licensed Nurse (LN) 1 in the East Station Medication Storage Room, an e-kit with oral medications was labeled opened on 1/2/25 at 10 a.m., and oral antibiotic doses of Cefpodoxime (antibiotic medication for treating infection) 200 mg one tablet (milligram- unit of measure), and Sulfamethoxazole (antibiotic medication) 400mg/80ml (milligram per milliliter- unit of measurement) two doses were removed on 1/2/25. LN 1 stated once medications were removed, the e-kit was locked, and an e-kit report form was faxed to the pharmacy. LN 1 further stated once pharmacy sent the facility a confirmation fax receipt of the e-kit report form, the faxed receipt received from the pharmacy was placed in the binder. LN 1 stated when the e-kit was replaced, a LN signed for the receipt of the replacement e-kit, and the form was placed in the binder. LN 1 checked the binder, and there was no confirmation fax receipt from the pharmacy for the medications that were removed from the e-kit on 1/2/25. LN 1 stated that she needed to follow up with Medical Records to see if the confirmation faxed receipt was there. During a follow up interview on 1/7/25, at 3:05 p.m., with LN 1 regarding faxed confirmation from pharmacy for medications removed from the e-kit on 1/2/25, LN 1 stated the faxed confirmation was not found. LN 1 further stated that the request to refill the e-kit was faxed to the pharmacy today. LN 1 stated the risk of not confirming the request was received by the pharmacy when the medications were removed from the e-kit was that the medications would not be available if needed for another resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/9/25, at 10:58 a.m., with the Director of Nursing (DON), the DON stated when the e-kit was opened by staff and doses of medications were removed, staff needed to fax the form to pharmacy indicating which medication and dosage was removed from the e-kit. The DON further stated the form needed to be faxed to pharmacy within 24 hours of opening the e-kit. The DON stated the staff needed to follow up with the pharmacy to make sure that the form was received. The DON further stated the form was placed in the binder once receipt was confirmed by the pharmacy. The DON stated licensed staff needed to sign the delivery form when the new e-kit was delivered to confirm receipt. The DON confirmed the facility policy was not followed. 2. A review of Resident 73's Admission Record, indicated Resident 73 was admitted to the facility in 2022 with diagnoses which included intervertebral disc degeneration (the breakdown of one or more of the discs that separate the bones of the spine causing pain in the back of the neck and frequently in the legs and arms). During a concurrent interview and record review on 1/9/25, at 10:58 a.m., with the DON, Resident 73's CDR and January 2025 MAR, were reviewed. The DON acknowledged the CDR for Hydrocodone-Acetaminophen 325 (an opioid narcotic medication prescribed for pain) indicated one tablet was signed out on 1/6/25 at 5:16 a.m., and one tablet was signed out on 1/7/25 at 9:10 p.m. The DON further acknowledged the MAR indicated no dosage was documented on 1/6/25, and no dosage was documented on 1/7/25. The DON stated that she would follow up with the staff nurses who signed out the medications from the CDR. During a follow up interview on 1/9/25 at 3:08 p.m., with the DON, the DON stated she spoke with the staff nurses who signed out the doses from Resident 73's CDR, and both nurses stated the medications signed out on the CDR for Resident 73 were administered to Resident 73. The DON acknowledged the risk was that the medications were not given to the resident and could have been diverted. The DON stated that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, Administering Medications,, revised March 2023, indicated, .Purpose Statement: To provide employees with guidelines for the safe and timely administration of medications per physician order .4. Medications must be administered in accordance with state and federal guidelines .9. Following verification of the resident and scheduled medication, the licensed nurse follows the 'pour, pass, chart' standard of practice . A review of a facility P&P titled, 3.4 Emergency Pharmacy Service and Emergency Kits (E-Kits), dated January 2024, indicated, .Emergency pharmaceutical service is available on a 24-hour basis .Procedures .3. The provider pharmacy supplies emergency or stat medications/items according to the provider pharmacy agreement. Emergency supplies are kept secure, checked periodically for integrity, and dating and stored in accordance with State Board of Pharmacy and federal regulations .8. Upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy .The hard copy will be retained in the nursing care center .10. The faxed log sheet will inform the pharmacy of items used from the emergency kit. This will notify the pharmacy to replace the kit or item, as applicable per state law, if the provider pharmacy requires a faxed log sheet .12. When the replacement kit arrives, the receiving nurse gives the used kit to the pharmacy personnel for return to the pharmacy . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility P&P titled, 4.2 Controlled Medication Storage,dated January 2023, indicated, . Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances [a drug or chemical that is regulated by the government in terms of its manufacture, possession, and use] are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal, state, and other applicable laws and regulations .Procedures .1. The director of nursing and the consultant pharmacist monitor for compliance with federal and state laws and regulations in the handling of controlled medications .5. A controlled medication accountability record is prepared when receiving inventory of a Schedule II medication [drugs with a high abuse risk, but also have safe and accepted medical use in the United States] .Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately. The director of nursing or designee investigates and makes every reasonable effort to reconcile all reported discrepancies .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 50778 Based on interview, and record review, the facility failed to ensure 1 of 22 sampled residents (Resident 31) was free from unnecessary medications when, Resident 31 continued receiving an antibiotic for a urinary tract infection (UTI- an infection in any part of the urinary system) without having met established McGeer Criteria (a set of guidelines for identifying infections in long-term care facilities) for continued use of the antibiotic as specified in the facility's Antibiotic Stewardship Program (ASP- a federally mandated program with goals of monitoring, optimizing antibiotic use, and reducing misuse of antibiotics). This failure had the potential to result in unnecessary antibiotic side effects (an undesired effect from a medication) for Resident 31 and had the potential to result in the development of multi-drug resistant organisms (MDRO- germs that have developed the ability to survive antibiotics that were previously used to kill them; decreasing antibiotic resistance [when antibiotics become ineffective against infection]). Findings: Review of Resident 31's SBAR [Situation Background Assessment Recommendation] Change of Condition . dated 12/28/24, indicated, [Resident 31] .Situation .The Change in condition .pain upon urination .MD [medical doctor] notified .For RN [registered nurse] .Assessment Details .MD notified with order to start ABT [antibiotic therapy] and encourage fluids . During a concurrent interview and record review on 1/9/24, at 3:15 PM, Resident 31's electronic medical record (EMR) and the Antibiotic/Infection Surveillance, spreadsheet were reviewed with the Infection Preventionist (IP). The IP confirmed Resident 31 was started on an antibiotic (Ciprofloxacin) on 12/29/24 for a UTI. The IP stated the facility used SBAR as the assessment tool for the initial start of the antibiotic and McGeer Criteria for continuation of the antibiotic. The IP stated the Antibiotic Surveillance - UTI form was the electronic version of McGeer Criteria. The IP confirmed Resident 31's electronic form indicated Resident 31 had met both required criteria, having signs and symptoms of an infection and had a positive laboratory culture. The IP stated she marked Met McGeer Criteria on the Antibiotic/Infection Surveillance spreadsheet in error after confirming a urine specimen (the process of obtaining a biological sample from a patient for laboratory analysis) was not collected. The IP further stated she should not have indicated in the EMR on the Antibiotic Surveillance - UTI form results were obtained from specimen collection when a urine specimen was not collected. Review of Resident 31's medication order dated 12/29/24, indicated, Ciprofloxacin HCl [hydrochloric acid] Oral Tablet 500 MG [an abbreviation for milligram, a unit of measurement for mass in the metric system] . Give 1 tablet by mouth two times a day for UTI for 10 days .1/3/25 . Review of Resident 31's Care Plan initiated on 12/29/24, indicated, .Interventions .Give antibiotic therapy as ordered. Monitor/document side effects and effectiveness . During an interview on 1/10/25, at 2:45 PM, with the Director of Medical Records (DMR), the DMR stated she could not find any urinalysis results (a laboratory test that examines urine to detect and measure various substances such as bacteria) for the month of December for Resident 31. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 31's Physician Progress notes for the month of 12/2024 there were no physician progress notes for Resident 31 addressing the physician assessment for a new infection nor a review of antibiotic effectiveness. During an interview on 1/13/25, at 10:15 AM, with the Pharmacist Consultant (PC), the PC stated diagnostic tests needed to be done when antibiotics were prescribed because if not done, it would lead to antibiotic resistance. The PC stated drugs (antibiotics) were becoming resistant, new drugs (antibiotics) could not be created fast enough; the bacteria were evolving and adapting faster than new medication could be made leading to MDROs. The PC stated if the facility was not ordering culture and sensitivity (a laboratory test that checks for bacteria and determines which antibiotics will best treat the infection) laboratory tests when prescribing an antibiotic, they may be prescribing the incorrect medication. The PC confirmed, if he did not see the laboratory results for culture and sensitivity testing (when antibiotics are prescribed), he would say the facility was out of compliance with McGeer criteria. Review of a facility policy titled, INFECTION PREVENTION AND CONTROL PROGRAM, last revised 11/10/21 indicated, The facility must establish an Infection Prevention and Control Program under which it . maintains a record of incidents [an event or occurrence] and corrective actions related to infections .Review, establish, and monitor environment infection control approaches in accordance with CDC [Center for Disease Control and Prevention- the nation's leading science-based, data-driven, service organization that protects the public's health]/HICPAC [Healthcare Infection Control Practices Advisory Committee. It's a federal advisory committee that provides advice to the CDC]/OSHA [Occupational Safety and Health Administration- a regulatory agency in the United States Department of Labor that sets and enforces standards to ensure safe and healthy workplaces] guidelines .Surveillance .The Licensed Nurse will notify the attending physician to determine the treatment plan, including, but not limited to, laboratory tests .The identification of the infection is based upon standard, published definitions of infections, laboratory results, and surveillance data collected by the Facility . Review of a facility policy titled, Antibiotic Stewardship Interventions last revised 1/17 indicated, .All clinicians should perform a review of antibiotics 48 hours after antibiotics are initiated to answer these key questions . Does this patient have an infection that will respond to antibiotics .is the patient on the right antibiotic(s), dose, and route of administration .Can a more targeted antibiotic be used to treat the infection .Many patients who get antibiotics for UTI's actually have asymptomatic [without symptoms] bacteriuria [presence of bacteria in urine] and not infections .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49823 Based on observation, interview, and record review, the facility failed to ensure safe medication storage for a census of 104 when: The refrigerator in the Medication Storage Room containing liquid controlled substances (a drug or chemical that is regulated by the government in terms of its manufacture, possession, and use) was unlocked. This failure increased the risk of drug diversion. Findings: During an observation and concurrent interview on 1/7/25, at 3:10 p.m., with Licensed Nurse (LN) 5 in the [NAME] Unit Medication Storage Room, the medication refrigerator in the Medication Storage Room containing liquid narcotic (medications used to treat pain that cause drowsiness, dull the senses, and are prone to abuse) medications and an e-kit (emergency kit, a box containing emergency medications for faster and easy access when needed) was unlocked. LN 5 stated that the refrigerator should have been locked, and quickly locked the refrigerator. LN 5 stated the risk was that someone who was not supposed to have access to the medications could open the refrigerator. During an interview and concurrent record review on 1/9/25, at 10:58 a.m., with the Director of Nursing (DON), the DON stated that medication refrigerators in the medication storage rooms should be locked because they contained controlled substances. The DON stated the risk was that anyone could access the controlled substances if the refrigerators were unlocked. The DON confirmed that the facility policy was not followed. During a review of a facility policy and procedure (P&P) titled, 4.1 Storage of Medication, dated January 2023, the P&P indicated, .Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .2. Controlled medications should be stored separately from non-controlled medications .Schedule II medications (drugs with a high abuse risk, but also have safe and accepted medical use in the United States) and preparations must be stored in a separately locked permanently affixed compartment .3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications are allowed access .Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility P&P titled, 4.2 Controlled Medication Storage, dated January 2023, the P&P indicated, . Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations .Procedures .1. The director of nursing and the consultant pharmacist monitor for compliance with federal and state laws and regulations in the handling of controlled medications. 2. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. The medication nurse on duty maintains possession of the key to controlled medication storage areas .4. Controlled medications requiring refrigeration are stored within a locked, permanently affixed box within the refrigerator .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Gardens Post Acute, LLC	537 E. Fulton Street Stockton, CA 95204

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50598 Based on observation, interview, and record review, the facility failed to ensure the menu and recipes were followed during the lunch meal preparation on 1/8/25, for 94 residents who received food prepared in the facility kitchen when: 1. The recipe for Asian Cucumber Salad was not followed; 2. The recipe for Asian [NAME] Rice was not followed; and, 3. The Asian smooth sauce was not prepared. These failures had the potential to affect the flavor of the food, with the potential for inadequate food intake, and could negatively affect the residents' dining experience. Findings: 1. Review of the facility document titled, Winter Menu, for Wednesday 1/8/25 indicated, .Beef & Broccoli Asian [NAME] Rice Asian Cucumber Salad Pot Sticker Glazed Apricots . During a concurrent observation and interview on 1/8/25, at 10:26 AM, with the Dietary Service Supervisor (DSS) during lunch preparation, the DSS stated the facility had eight cucumbers available, which were not enough to make 100 servings of Asian Cucumber Salad as listed on the menu. The DSS cut and peeled approximately eight cucumbers, then mixed those cucumbers with sliced red bell peppers, white onions, and two cans of three bean salad. After all items were mixed, the DSS added Italian dressing. The DSS stated when items ran out, they substituted them for something they had in stock. A review of a facility document titled, Standard Winter 2025 Salad, Asian Cucumber, listed the recipe and ingredients. The document indicated for 100 servings, 3 gallons of cucumbers sliced and peeled were needed. In addition to the cucumbers the following items were listed in the recipe: rice vinegar, honey, sesame oil, red crushed pepper, and salt. During an interview on 1/9/25, at 12:11 PM, with the DSS, when asked about the substitution of ingredients, the DSS stated the changes to the menu needed to be approved by the RD to assure a balanced diet was provided for the residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25, at 1:35 PM, with the Registered Dietician (RD), the RD stated when there were necessary changes to the meals, they needed to be approved by the RD. The RD stated adding the three-bean salad to the residents' lunch was not approved by him, and this practice did not meet his expectations. The RD stated not following the recipe could result in poor intake and weight loss. A review of a facility provided document titled, Menu Changes, indicated, .The Dining Services Director is responsible for the supervising meal preparation and service to assure the menu is followed and served as planned .The substitution must be of equal nutritional value . 2. During a concurrent observation and interview on 1/8/25, at 10:21 AM, with the DSS, the DSS explained the rice located in a large metal pan in the steamer was prepared with brown rice and seven quarts of water. The DSS stated once the rice was finished steaming in the water, it would be done and ready to serve. During an observation on 1/8/25, at 12:10 PM, of the lunch tray line, the Asian [NAME] Rice was served without adding the other ingredients. A review of a facility provided document titled, Standard Winter 2024-25 Rice, Asian Brown, indicated, . Ingredients: Low sodium chicken stock, brown rice, low sodium soy sauce, sesame oil, and sliced green onions . A review of a facility document titled, Menu, dated 1/1/2019, indicated, .Menus are planned to meet the state and federal guidelines .Menus are written following the guidelines for persons 51+ years of age .Menus are reviewed and approved by the consultant dietician indicating that the menu is nutritionally adequate. The Dining Services Director is responsible for supervision meal preparation and service to assure the menu is followed and served as planned. 3. During a concurrent observation and interview on 1/8/25 at 11:30 AM, with the DSS after the food preparation was completed, the DSS was asked if the menu item Asian Smooth Sauce was prepared. The DSS stated they did not prepare the sauce. During an observation on 1/8/25, at 12:10 PM, of the lunch tray line, there was no Smooth Sauce, or an alternative placed on the trays for residents who required soft, bite sized, minced, moist, and ground consistency. A review of a facility provided document titled,Standard Winter 2024-25 Rice, Asian Brown, indicated, Soft & Bite Size, Minced and Moist, Ground .Mix Extremely Thick, Smooth Sauce that keeps the rice from separating into individual grains.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 50598 Based on observation, interview, and record review, the facility failed to ensure food was prepared and served to meet the needs of 94 residents who received food from the kitchen during the lunch meal on 1/8/25 when: 1. Residents on regular portion diet received less than the required amount; 2. 12 Residents with orders for chopped and easy to chew, soft bite-sized, and minced and moist textured diets did not receive the correct amount of Beef and Broccoli; 3. Residents on a pureed diet received the incorrect portion of Asian Beef and Broccoli, and did not receive Potstickers; 4. Three Residents on a large portion diet did not receive the correct amount of Asian Beef and Broccoli and Asian [NAME] Rice; 5. Residents with orders for Consistent Carbohydrate Diet (CCHO-helps manage blood sugar levels) received the incorrect portion size of Asian [NAME] Rice; and, 6. 14 Residents requiring fortified (added calories) diet did not receive the added items to increase calories. These failures had the potential to result in residents not receiving adequate nutrients, which could lead to unplanned weight loss or gain, vitamin imbalances, and further compromise their medical status. Findings: 1. During an observation on 1/8/25, at 12:10p.m., of the lunch tray line, residents with an ordered regular diet received their Beef and Broccoli serving via tongs and kitchen staff used a #10 (3/8 cup) scooper for the Asian [NAME] Rice. During an interview on 1/9/25, at 11:29 AM, with the Dietary Aide (DA) 1, DA 1 stated during tray line the spreadsheet with serving sizes should be followed. DA 1 stated the spreadsheet indicated the #8 (1/2 cup) scoop should be used to serve the starch item for residents on a regular diet. A review of a facility document titled, Daily [NAME] Menu Meal: Noon, indicated serving directions for residents on regular portion diets should receive 2/3 cup of Asian Beef and Broccoli and scooper #8 (1/2 cup) portion of Asian [NAME] Rice. 2. During an observation on 1/8/25, at 12:10 PM, of the lunch tray line, kitchen staff placed broccoli on the plate using tongs and Asian Beef using a 3/8 cup scoop for residents requiring chopped and easy to chew and soft bite sized diets. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility document titled, Daily [NAME] Menu Meal: Noon, indicated the portion size for Asian Beef and Broccoli for residents on an ordered chopped and easy to chew and soft bite sized was a #6 scoop (2/3 cup). For the residents on minced and moist diets, the scoop size was #8 (1/2 cup). 3. During an observation on 1/8/25, at 12:10 PM, of the lunch tray line, residents with an ordered puree texture diet received a #12 scoop (1/3 cup) of Asian Beef, 1/3 cup Broccoli, 1/3 cup of mashed potatoes, and no potstickers. A review of the facility document titled, Daily [NAME] Menu Meal: Noon, indicated the serving size for residents on a pureed diet was a #8 scoop (1/2 cup) for Asian Beef and Broccoli, and Potstickers #20 scoop (3 tablespoons). 4. During an observation on 1/8/25, at 12:10 PM, of the lunch tray line, plates were prepared for three residents requiring large servings. Kitchen staff used a #10 (3/8 cup) scooper for Asian Beef, Asian [NAME] Rice, and added one tong of broccoli for each plate. A review of the facility document titled, Daily [NAME] Menu Meal: Noon, for the meal served on 1/8/25, indicated the portion size for residents requiring a large portion diet was two #8 scoops (total one cup) of Asian Beef and Broccoli, and two #8 scoops of Asian [NAME] Rice. A review of a facility policy titled, Menu Planning, dated 1/1/2019 indicated, .The Large Portion diet provides for the normal nutritional needs of residents .Additional servings of basic foods and other foods such as fats, sugars, and sweets are added to complete the menu and meet caloric needs of the individual .Meat .at least 6 meat or meat alternatives .Fruits and Vegetables .5 or more servings . 5. During an observation ,on 1/8/25 at 12:10 PM, of the lunch tray line, plates were prepared for residents with an ordered CCHO diet. Kitchen staff placed Asian [NAME] Rice on the plates using a #10 (3/8 cup) scoop. During an interview on 1/9/25, at 11:29 AM, with the Dietary Aide (DA) 1, DA 1 stated during tray line the spreadsheet with serving sizes should be followed. DA 1 stated the #8 (1/2 cup) scoop was to be used to serve the starch for residents on a regular diet, not for those requiring controlled carbohydrates. A review of the facility document titled, Daily [NAME] Menu Meal: Noon, for the meal served on 1/8/25, indicated the portion size for residents requiring CCHO was a #12 scoop (1/3 cup) of Asian [NAME] Rice. 6. During a concurrent observation and interview on 1/8/25, at 12:10 PM, during the lunch tray line, staff prepared the trays for residents with an ordered fortified diet. No items were added to provide additional calories. The Registered Dietician (RD) confirmed the findings and asked DA 2 to call out to the cook when making trays, however the fortified diets continued to be prepared without additional calories. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25, at 12:11 PM, with the DSS, the DSS confirmed the residents on a Fortified diet did not receive their lunch as ordered. The DSS stated this did not meet his expectations. A review of a facility document titled, Fortified Diet, dated 2017, indicated, The Fortified diet provides nutrient dense foods for residents requiring extra protein and calories who are unable to consume adequate amounts of food .Additional servings of basic foods and other foods such as fats, sugars, and sweets are added to complete the menu and meet the caloric needs of the individual .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50716 Based on observation, interview, and record review, the facility failed to provide safe food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 94 residents who ate facility prepared meals when: 1. Stove and oven contained grease, build-up of food particles, and white, black, and brown colored grimy areas; 2. Over-ripe and spoiled produce was available for use in the walk-in refrigerator; 3. Food was stored in the refrigerator beyond the use by date (UBD) and food marked on the box Keep Frozen was stored in the refrigerator; 4. Food was not stored and maintained at the proper temperatures in the walk-in refrigerator and walk-in freezer; 5. Food was not stored and maintained at the proper temperatures at the East Station refrigerator designated as Unit Refrigerator/Resident Outside Food and freezer temperatures were not monitored; 6. Unit Refrigerator/Freezer located at the [NAME] Station was not clean and was broken with missing parts. Resident food inside the refrigerator was not labeled properly, and freezer temperatures were not monitored; 7. A visibly ill employee was preparing food for use and was not performing hand hygiene after coughing into hands; and, 8. Unwashed mushrooms with visible dirt was prepared and served. These failures placed residents at risk for foodborne illnesses. Findings: 1. During a concurrent observation and interview on 1/7/25, at 7:57 AM, with the Lead Cook/Dietary Aid (DA) 1, the stove was noted to have layered black, white, and yellow debris with various types of food particles. The silver-colored back portion of the stove had a dark brown substance that appeared to be dripping down toward the stove burners. Below the stove the two-compartment oven was observed with aluminum foil on the bottom of each compartment and layers of splattered drippings and food particles that were tan, white, brown, and black found inside ovens. The side of the oven/stove was observed to have layers of a dark liquid type of substance. DA 1 confirmed the oven and stove were not clean. DA 1 stated the stove and oven were usually cleaned weekly but due to staffing they had not been cleaned on schedule. DA 1 further stated it was last cleaned the week of 12/9/24 - 12/15/24 and should be cleaned weekly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/7/25, at 9:07 AM, with the Dietary Service Supervisor (DSS), the DSS confirmed the stove and oven was not clean and did not meet his expectation. The DSS obtained and reviewed the cleaning log for the kitchen. The DSS further stated the stove, and oven was supposed to be cleaned weekly and was last cleaned on 12/9/24 according to the log titled Daily Cleaning Schedule. The DSS further stated it was not cleaned on schedule due to staffing issues. Review of the facility policy titled, Infection Control -Principles of Sanitation, revised 1/19, indicated, .the purpose of sanitation is to remove soil .the most common of soils - dirt, grease, food particles, etc .Follow proper sanitary procedures in cleaning equipment . Review of the facility policy titled, Infection Control -Cleaning Procedure -Range, revised 1/19, indicated, . Range .Person responsible for cleaning: [NAME] .When to clean: Weekly . Review of the FDA 2022 Food Code, under section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils indicated, .(A) Equipment Food-Contact surfaces and utensils shall be clean to sight and touch. (B) The Food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris 2. During the initial kitchen tour on 1/7/25, at 8:24 AM, the walk-in refrigerator had the following items observed available for use. The findings were confirmed with the DSS: a. 10 of approximately 75 tomatoes were mushy to touch, had broken skin, and had a fuzzy black and green substance on them. b. 4 of approximately 30 lemons were discolored, noted to be decreased size and had a white and green fuzzy substance on them. c. 3 of approximately 50 oranges had a black and green fuzzy substance on the stems, and brown spots on them. 3. During the initial kitchen tour on 1/7/25, at 8:24 AM, the following items were observed stored in the walk-in refrigerator. The findings were confirmed with the DSS: a. A left over cherry pie dated 12/29/24 was available for use. The DSS stated it should have been disposed of after three days. b. An opened box of Garlic Texas Toast and an unopened box of breadsticks which stated Keep Frozen was observed in the refrigerator. The box was not labeled with a date when it was removed from the freezer. c. One large clear container labeled marinara sauce with a UBD of 12/30/24 - 1/2/25 was observed in the refrigerator. d. One large clear container labeled cranberry sauce with a UBD of 11/24/24 was observed in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25, at 1:35 PM, with the Registered Dietician (RD), the RD stated the status of the over ripe, mushy, tomatoes, lemons and oranges did not meet his expectations. The RD further stated the foods in the refrigerator which were over ripe or were past the UBD, and foods that were labeled to keep frozen and not dated with the removed date from the freezer, were not safe for consumption. The RD explained the risk to the residents was foodborne illness. Review of the facility policy, Food Management Services -Dining Services, revised 1/19, indicated, .All food items in refrigerators are properly dated, labeled .Once opened, frozen food is dated, labeled, and wrapped . Frozen food will be cooked from the frozen state unless thawing is necessary .Canned fruits, vegetables, and juices are not stored in open cans. After opening, the food is transferred to non-corrosive containers with tight fitting lids, dated and labeled. Discard after 72 hours .Sort stored produce regularly and discard any damaged or spoiled pieces .Sort stored produce regularly and discard any damaged or spoiled pieces . Review of The Food and Drug Administration (FDA) Food Code 2022, under section 3-501.17 (A) (B) (C) (D), indicated, .the day the original container was opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises . (https://www.fda.gov/media/164194/download) 4. During the initial kitchen tour on 1/7/25, at 8:23 AM, the following temperatures were observed for the walk-in refrigerator and the walk-in freezer. All findings were confirmed with the DSS. a. On 1/7/25, at 8:23 AM, the external thermometer of the walk-in refrigerator read: 42 degrees Fahrenheit (F - a unit of temperature measure). The internal thermometer of the walk-in refrigerator read: 44 degrees F. (Normal refrigerator temperature 32-41 degrees) b. On 1/7/25, at 8:35 AM, the external thermometer of the walk-in freezer read: 8 degrees F. The internal thermometer of the walk-in freezer read: 6 degrees F. (Normal freezer temperature 0 degrees or below) c. On 1/7/25, 9:13 AM, a subsequent observation of the external thermometer of the walk-in refrigerator read: 44 degrees F. The internal thermometer of the walk-in refrigerator read: 46 degrees F. d. On 1/8/25, at 3:02 PM, a follow-up observation of the external thermometer of the walk-in refrigerator read: 44 degrees F. The internal thermometer read: 44 degrees F. e. On 1/8/25, at 3:03 PM, a third observation of the external thermometer of the walk-in freezer read: 10 degrees F. The internal thermometer read: 6 degrees F. During an observation and interview on 1/8/25, at 3:01 PM, with the DSS, the DSS confirmed the temperatures were still out of safe food storage range and stated the commercial walk-in refrigerator and freezer maintenance company was contacted and was coming out to see why the temperatures were out of range. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/25, at 4:18 PM, with the Maintenance Service Director, the MSD stated the servicing agency had to calibrate the refrigerator and freezer condensers to activate at a 2-degree difference rather than the 5 to 10 degrees difference the condensers were set to. The MSD also stated the sensor probe thermometer for the freezer was in the far back behind a box and was not open to free-flowing air. During an interview on 1/9/25, at 1:35 PM, the RD stated the walk-in refrigerator and walk-in freezer temperatures did not meet his expectation and needed to be in the required temperature ranges. The RD further explained the risk to the residents was spoiled food that can cause foodborne illness. Review of the facility policy Food Service Management -Perishable Storage, revised 1/19, indicated, .The refrigerator is maintained in a temperature range of 34 degrees to 41 degrees F .A thermometer is displayed in each refrigerator and freezer . Review of an online document published by the Center for Disease Control (CDC) titled, About Four Steps to Food Safety, dated 4/24, indicated, .Keep your refrigerator at 40 degrees F or below and your freezer at 0 degrees F or below . https://www.cdc.gov/food-safety/prevention/index.html#:~:text=Bacteria%20can%20multiply%20rapidly%20if,food%20that%20reach%20room%20temperature 5. During observations of the unit refrigerator and freezer located at the East Nurse station, in a room labeled Oxygen Supply, on 1/8/25, at 12:52 PM, the following was observed and confirmed by the DSS and Assistant Administrator (AADM): a. Temperature in the refrigerator was out of range reading 55 degrees F. b. No temperature monitoring or log for the freezer. c. No thermometer inside the freezer. During an interview on 1/8/25, at 12:55 PM, the DSS observed and confirmed the temperature at 55 degrees F, was unsafe and out of range. The DSS and AADM confirmed there was no thermometer inside the freezer and no monitoring or log of monitoring of the freezer temperature. The DSS stated nursing was responsible to monitor and log the temperatures for the unit refrigerators and freezers. The DSS and AADM also confirmed a singular ice cream sandwich was unlabeled and undated inside the freezer. The DSS stated it should have the residents name and date labeled on it. During an interview on 1/9/25, at 1:35 PM, the RD stated temperature of the East Station unit refrigerator did not meet expectations. The RD further stated the risk to the residents was foodborne illness. The RD stated it was best practice to monitor the freezer temperature with a thermometer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/10/25, at 12:14 PM, with the Director of Nursing (DON), the DON stated it was the expectation for food to always be labeled with resident name and date received prior to going into the unit/resident refrigerators. The DON explained nurses check the unit refrigerators and freezers, but they did not monitor the freezer temperature. The DON expected monitoring of the unit's refrigerator and freezer temperatures. The DON further stated the temperature of the East unit refrigerator was not acceptable because it was too warm. The DON explained food was expected to be thrown out after three days to prevent foodborne illness. Review of the facility policy titled, Menu Planning -Food from Outside Source, revised 1/18, indicated, .hold or transport foods containing perishable ingredients at 41 degrees F or less . Review of the facility policy titled, Food Service Management -Perishable Storage, revised 1/19, indicated, . The refrigerator is maintained in a temperature range of 34 degrees F to 41 degrees F .A thermometer is displayed in each refrigerator and each freezer .The temperature of all cold storage equipment is checked and recorded daily .all food items in refrigerators are properly dated, labeled . 6. During observations of the unit refrigerators and freezer located at the [NAME] Nurse station in a room labeled Utility on 1/8/25, at 12:59 PM, the following items were observed and confirmed by the DSS: a. No temperature log for temperature monitoring posted for the freezer. b. The freezer contained approximately 15 frozen TV dinners which were not labeled with the received date. A poster on the door to the refrigerator indicated, .Residents food needs to have name and date . c. The refrigerator and freezer were not clean with splattered unidentifiable brown liquid, multiple layers of food particles, dirt, caked on debris and hair observed inside the refrigerator and freezer. d. The refrigerator had a broken shelf with missing parts, and the freezer had a broken piece of plastic inside the door. During an interview on 1/8/25, at 12:59 PM, the DSS confirmed the unit refrigerator and freezer located at the [NAME] Nurse station utility room was dirty and needed to be cleaned. The DSS confirmed the resident food in the freezer was not labeled properly, missing the date. The DSS confirmed there were missing and broken pieces of the refrigerator and freezer. The DSS stated he did not see a log monitoring the freezer temperatures and explained nursing staff was responsible for monitoring and cleaning the unit refrigerator and freezers. During an interview on 1/9/25, at 1:35 PM, the RD stated the dirty unit refrigerator and freezer should be cleaned and does not meet expectations due to the risk for foodborne illness to the residents. The RD stated it was best practice to monitor the freezer temperature with a thermometer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25, at 3:18 PM, the MSD stated the refrigerator and freezers were supposed to be cleaned by the janitor once a week, but no longer than two weeks. The cleaning process for the unit refrigerators and freezers included a food safe cleanser, where all the shelves and surface areas were cleansed. The MSD confirmed the dirty unit refrigerator at the [NAME] Nurses station does not meet expectations. The MSD further stated the dirt and debris in it could cause contamination. During an interview on 1/10/25, at 12:14 PM, with the Director of Nursing (DON), the DON stated it was the expectation for food in the unit refrigerator and freezer to be labeled with resident name and date received. The DON explained nurses check the unit refrigerators and freezers, but they did not monitor the freezer temperature. The DON expects monitoring of the refrigerator and freezer temperatures and stated monitoring was important to prevent spoiled food, especially foods that need to be frozen. Review of the facility policy titled, Daily Cleaning Schedule, dated 12/9/24 to 12/15/24, indicated .Item: Reach in Fridge .Reach in Freezer .Frequency .Daily . Review of the facility policy titled, Food Service Management -Perishable Storage, revised 1/19, indicated, .A thermometer is displayed in each refrigerator and each freezer .The temperature of all cold storage equipment is checked and recorded daily .all food items in refrigerators are properly dated, labeled . Review of the facility policy titled, Food Service Management -Equipment Maintenance, revised 1/19, indicated, .The Dining Services Director will periodically check all equipment and report items needing repair to the maintenance .The maintenance department routinely monitors all equipment for proper functioning and safety . Review of the FDA 2022 Food Code, under section 4-601.11, indicated, .Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, version 1/23, indicated, (A) Equipment Food-Contact Surfaces and utensils shall be clean to sight and touch. (B) The Food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris . 7. During observation and interview on 1/8/25, at 9:20 AM, DA 1 was observed with red eyes, coughing, and runny nose while preparing the residents lunch meal. DA 1 stated she did not feel well today still. DA 1 was observed coughing into her hands. DA 1 stated she became ill last week and was taken off work by her doctor for three days and put on antibiotics. DA 1 further stated they were currently short staffed in the kitchen. DA 1 was observed touching her eyes and eyeglasses while sniffling, DA 1 did not wash her hands after touching her face or personal items and continued food preparation. During an interview on 1/8/25, at 9:54 AM, the DSS was advised by DA 1 she did not feel well. The DSS stated he would move DA 1 to another area of the kitchen. During a follow up interview with the DSS on 1/9/25, at 12:10 PM, the DSS stated they did not have a kitchen sick policy, they left it up to the individual staff member to self-screen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25, at 8:05 AM, with the Infection Preventionist (IP), the IP stated it was her expectation for staff who work in the kitchen and prepare food to use their own judgement regarding coming to work. The IP further stated if they were showing signs of illness like coughing, sneezing, runny nose to test for Covid and to not show up to work sick. The IP further explained it was important for staff to follow protocol and guidelines for hand washing, it was important because it lowered the risk for residents and staff getting sick, and then being short staffed. Review of facility policy titled, Infection Control -Dining Services Employee Health Standards, revised 1/19, indicated, .Each dining services employee shall report the information about their health and activities as it relates to diseases that are transmissible through food in a manner that allows the Dining Services Director (DSD) to reduce the risk of foodborne disease transmission .Proper hand washing procedures .The PIC [person in charge] must understand the requirements for excluding and reinstating food employees who work with food and with highly susceptible populations with increased risk .older adults with compromised immune systems .According to FDA Food Code, food establishments in health care .nursing homes .are required to take additional precautions to prevent the transmission of foodborne illness . Review of the FDA 2022 Food Code, under Section 2-401.12, titled, Food Contamination Prevention, indicated, .Food employees experiencing persistent sneezing, coughing, or a runny nose that causes discharges from the eyes, nose, or mouth may not work with exposed food . Review of the FDA 2022 Food Code, under Section 2-301.14, titled, When to Wash, indicated, .(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms .(D) Except as specified in 2-401.11(B), after coughing, sneezing .(I) After engaging in other activities that contaminate the hands . 8. During an observation and interview in the kitchen on 1/8/25, at 9:20 AM, DA 1 was observed preparing mushrooms from a cardboard box. The mushrooms had visible layers of dark brown dirt particles. DA 1 stated she diced them and planned to wash them after they were diced. At 10:25 AM the unwashed diced mushrooms were observed being added to the beef mixture on the stove by the DSS. During an interview on 1/9/25, at 11:29 AM, DA 1 stated the mushrooms were supposed to be washed prior to being cut. DA 1 explained she forgot to tell the DSS she did not wash them. During an interview on 1/9/25, at 12:11 PM, the DSS stated the unwashed mushrooms did not meet his expectation. The DSS further stated all fruits and vegetables should be washed prior to being prepared. During an interview on 1/9/25, at 1:35 PM, the RD stated the expectation was for the produce to be fully washed prior to resident consumption. Review of the facility policy titled, Food Service Management -Refer to Food Preparation-General, revised 1/19, indicated, .Wash all vegetables in cold water and chill before preparing. Use only vegetables in good condition . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the FDA Food Code 2022, under Section 3-302.15 indicated, .Washing fruits and vegetables .raw fruits and vegetables shall be thoroughly washed in water to remove soil and other contaminants before being cut, combined with other ingredients, cooked, served, or offered for human consumption .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 50598 Based on observation, interview, and record review, the facility failed to maintain a closed garbage (dumpster) bin. This failure had the potential to lead to insect and rodent infestation. Findings: During a concurrent observation and interview on 1/7/25, at 8:56 AM, with the Dietary Service Supervisor (DSS) in the area where the garbage bins were kept outside, the lids of the bins were not in place. The dumpsters were noted to open. The DSS stated the garbage dumpsters should be kept closed in order to avoid pests. A review of a facility policy titled, Adequate Sewage Disposal and Plumbing, dated 2019, indicated, .Sanitary garbage disposal. Improperly disposed of garbage is an excellent source of unsanitary practices and unpleasant odors. The real dangers are: Harboring place for vermin, flies, rodents, and cockroaches .To prevent this, follow these easy practices: a. Provide garbage containers that are .Are in adequate supply to hold all garbage between collections. b. Lids must be tight fitting .Secure garbage tightly .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43943 Based on interview, and record review, the facility failed to maintain the confidentiality of 1 of 22 sampled residents (Resident 19), when portions of Resident 19's medical records were discovered in Resident 001's medical record. This failure had the potential for exposure of Resident 19's private and confidential information to unauthorized individuals. Findings: During a concurrent interview and record review on 1/13/25, at 4:20 p.m., with the Director of Medical Records (DMR), the DMR confirmed that Resident 19's Preadmission Screening and Resident Review, (PASSR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) PASSR negative level 1 (the initial assessment did not show any signs of a serious mental illness or intellectual disability), and PASSR negative level 2 (Indicates the individual does not meet the criteria for having a condition requiring specialized services based on the comprehensive Level 2 assessment), forms were found in Resident 001's Electronic Health Record (EHR). The DMR stated the medical records assistant used a program called [SOFTWARE COMPANY NAME] to scan the records into the resident's EHR. The DMR stated that this had been an on ongoing problem and she had been correcting the issues as she found them. The DMR acknowledged that finding Resident 19's records in Resident 001's chart was a Health Insurance Portability and Accountability Act (HIPAA - a federal law that protects the privacy and security of health information) issue. The DMR stated that it would also be a concern if she tried to find a record for a resident and could not find it because it was in another resident's chart. During a concurrent interview and record review on 1/9/25, at 4:24 p.m., with the Administrator (ADM), the ADM acknowledged that Resident 19's records were in Resident 001's EHR. The ADM stated the facility used the program called [SOFTWARE COMPANY NAME] for a year, which made it easier to scan medical records into the resident's EHR. The ADM further stated even with the new program, the records were uploaded incorrectly. The ADM stated that having Resident 19's records in Resident 001's EHR was a HIPAA concern. During a concurrent interview and record review on 1/9/25, at 5 PM, with the ADM, Resident 19's PASSR, PASSR negative level 1, and PASSR negative level 2, forms were already out of Resident 001's chart and were uploaded to Resident 19's chart. The ADM confirmed that Resident 19's three records were in the wrong chart and medical records already deleted them from Resident 001's chart. The ADM acknowledged the facility's Privacy and Confidentiality Policy, was not followed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Privacy and Confidentiality, dated 3/23, indicated, .The resident has a right to personal privacy and confidentiality of his or her personal and medical records, including all provisions of the HIPAA Privacy Rule .The HIPAA Privacy Rule: Established national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as protected health information) .6. Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated, electronic, or other .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 51285 Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) who received hospice care (end of life care) had care coordinated between the facility and the hospice agency, when the facility requested a medication review recommended on 12/10/24 for Resident 2, and did not follow up on the outcome of the review. This failure resulted Resident 2's medication review not available in Resident 2's clinical record and had the potential for not providing quality care to a terminally ill resident (Resident 2). Findings: A review of Resident 2's clinical record titled, ADMISSION RECORD, indicated Resident 2 was admitted to the facility with diagnoses which included, palliative care (comfort measures) and alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). A review of Resident 2's hospice care plan initiated on 7/14/24 indicated, .On HOSPICE CARE .Facility staff and Hospice Staff are coordinating together for resident's centered care and communicating together to promote comfort, privacy and dignity .Interventions .Care coordination between Hospice Care & facility team and Resident/Resident representative . Review of Resident 2's IDT [interdisciplinary team- a group of professionals from different disciplines who work together to achieve a common goal] PROGRESS NOTES-INCIDENT/ACCIDENT, dated 12/10/24, indicated, .res [Resident 2] .scratched face of res [another resident] .IDT rec [recommendation] .review meds by hospice . During a concurrent interview and record review on 1/9/25, at 9:37 a.m., Resident 2's IDT note dated 12/10/24 was reviewed with the Director of Nursing (DON). The DON confirmed the IDT recommended Resident 2's medications were to be reviewed by hospice. The DON was unable to find in Resident 2's record that her medications were reviewed by the hospice agency. The DON stated she did not know if Resident 2's medications were reviewed by hospice as recommended in the IDT note. During a phone interview on 1/9/25, at 11:15 a.m., the Hospice Director of Nursing (DON) stated Resident 2's medications were reviewed on 12/10/24 as recommended by the facility IDT. The Hospice DON further stated they faxed Resident 2's reviewed medication report to the facility. The Hospice DON stated sometimes the facility staff specifically during the shifts' change did not receive faxes from the hospice agency. During a concurrent interview and record review on 1/9/25 at 3:10 p.m., the facility's service agreement with the hospice agency was reviewed with the DON. The Nursing Facility Service Agreement dated 2020, indicated, .(D) COORDINATION OF CARE (i) General .Hospice and Facility shall communicate with one another and as needed for each particular Hospice Patients. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day . The DON stated that the Nursing Facility Service Agreement with the hospice agency was not followed. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/9/25, at 3:10 p.m., the facility policy and procedure (P&P) titled, HOSPICE SERVICES, dated March 2023, was reviewed with the DON. The P&P indicated, . GUIDELINES .5. D. a process for communicating needs and changes in condition, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day . The DON stated the facility P&P was not followed. The DON further stated the medication review report by the hospice agency should have been available/documented in Resident 2's medical record to meet Resident 2's needs and safety.

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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. 50716 Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 104, when: 1. Licensed Nurse (LN) 1 did not wear the required personal protective equipment (PPE -gown, gloves, eye protection, and/or facemasks used to prevent the spread of germs) for Resident 72 on Enhanced Barrier Precautions (EBP - infection control intervention to reduce transmission of resistant germs through gown and glove use during high-contact resident care activities) while providing gastrostomy tube (G-tube - a feeding tube that was surgically inserted into the resident's stomach to allow access for food, fluids, and medications) care; 2. A sterile wound dressing was stored open in a treatment cart; 3. Resident 89's room did not have an EBP sign posted, and the PPE supplies were not available outside the door to the room; and, 4. LN 9 did not wear the appropriate PPE when accessing a peripherally inserted central catheter (PICC- a tube inserted into a vein and guided into a large vein above the heart, used to administer intravenous medication) for Resident 77. These failures had the potential to spread infection and cause health problems to the residents in the facility. Findings: 1. During a concurrent observation and interview on 1/7/25, at 12:11 PM, in Resident 72's room, LN 1 was observed preparing to care for Resident 72's G-tube. LN 1 entered Resident 72's room, washed her hands, applied gloves, and began the procedure. After the procedure, LN 1 removed her gloves and was shown the sign posted on the door that indicated EBP Isolation. LN 1 confirmed she did not wear the required PPE when she cared for Resident 72's G-tube. LN 1 stated they were supposed to wear a gown and gloves when caring for G-tubes to prevent infection. During an interview on 1/9/25, at 8:05 AM, with the Infection Preventionist (IP), the IP stated the expectation was for staff to wear the required PPE while they rendered care to the residents. The IP explained the purpose for PPE was to prevent the transmission of bacteria from staff to resident, or from resident to staff. The IP further stated it was important for staff to follow guidelines to prevent the spread of infection. During an interview on 1/10/25, at 7:53 AM, with the Director of Nursing (DON), the DON stated her expectation was for the staff to wear the required PPE when providing care to residents with G-tubes and other indwelling devices (relating to a device that is left inside the body, such as a tube). The DON further stated the risk to residents and staff was cross- contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another). The DON explained it was important to wear PPE to prevent infection and the spread of multi-drug resistant organisms (MDRO- infections that are resistant to three or more drugs that kill infections). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy and procedure (P&P) titled, Enhanced Barrier Precautions, implemented 4/24, indicated, .refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .For all residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Device care or use: feeding tube . 2. During a concurrent observation and interview on 1/8/25, at 11:35 a.m., with LN 7 at the [NAME] Unit Treatment Cart, an opened [Brand Name] sterile dressing package was found in the second drawer of the treatment cart. LN 7 stated that she opened the package and prepped to do a dressing change on a resident, but the resident went to take a shower. LN 7 further stated the dressing should have been discarded. LN 7 explained that if the opened dressing was used to do a resident wound dressing change, the risk was infection because the dressing was not sterile. LN 7 then discarded the opened dressing. During an interview on 1/9/25, at 8:24 a.m., with the IP, the IP stated staff followed EBP guidelines during wound care. The IP further stated that opened dressings should be discarded (thrown away) if not used. During an interview on 1/9/25, at 10:58 a.m., with the DON, the DON stated the expectation was that when wound care was done, staff would throw away any opened dressings that were unused. The DON stated the risk of using opened dressings for wound care was infection by cross- contamination. The DON confirmed the facility policy was not followed. A review of the facility P&P titled, Dressing Change Clean-Aseptic, dated December 2024, indicated, .15. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface .25. Discard disposable items . A review of the facility P&P titled, Infection Prevention and Control Program, revised 10/24/22, indicated, .the facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements . Review of the online manufacturer instructions for [Brand Name] titled, [Brand Name] Waterproof Foam Island Dressing for Senior Care Facilities, indicated, .Waterproof Bordered Foam Dressing .sterile unless opened or damaged . http://dermarite.com/product/bordered-foam/ A review of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings Module 8: Wound Care Facilitator Guide, last updated 4/12/24, indicated, .Any unused disposable supplies that enter the patient's/resident's care area should remain dedicated to that patient/resident or be discarded. They should not be returned to the clean supply area .If supplies are dedicated to an individual patient/resident, they should be properly labeled and stored in a manner to prevent cross-contamination or use on another patient/resident (e.g., in a designated cabinet in the patient/resident's room) . https://www.cdc.gov/healthcare-associated-infections/php/toolkit/icar.html (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 89's ADMISSION RECORD, indicated Resident 89 was admitted to the facility in 2024 with diagnoses which included end stage renal disease (a condition when the kidneys have completely stopped working) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed). Review of Resident 89's care plans, initiated on 1/4/25, indicated .Enhanced Barrier Precaution Related to PERMACATH RUC .Goal .Will minimize risk and complications of infection .Interventions .Promote proper EBP signage .Health Teaching to resident, family members and staff about importance of Enhanced Barrier Precaution including proper hand hygiene and wearing of personal protective equipment (PPE) during high-contact resident activities . A review of Resident 89's orders, dated 1/6/25, indicated .Enhanced Barrier Protection due to PERMACATH RUC [right upper chest] every shift . During a concurrent observation and interview on 1/10/25, at 11:44 AM, with Certified Nurse Assistant (CNA) 2, CNA 2 confirmed Resident 89's door did not have a sign for EBP. CNA 2 further stated that she did not wear gloves or any PPE when she changed or assisted Resident 89. CNA 2 stated that she was never told by staff to take any EBP precautions when taking care of Resident 89. CNA 2 explained that a resident without EBP in place would be at risk of getting infections and cross- contamination if EBP were not followed. During a concurrent observation, interview, and record review on 1/10/25, at 11:55 AM, with LN 3 outside Resident 89's room, LN 3 confirmed there was no signage posted on Resident 89's door for EBP. LN 3 further confirmed the PPE bin was currently located inside; in the middle of Resident 89's room. LN 3 stated Resident 89's EBP sign should have been posted on the door and the PPE bin needed to be placed outside of the resident's room by the doorway. LN 3 acknowledged Resident 89's had an order for EBP due to his permacath. LN 3 stated that if EBP were not in place then Resident 89 would be at risk of infection. LN 3 further stated that hand hygiene and PPE were important to avoid cross- contamination and infection. During an interview on 1/10/25, at 12:03 PM, with the IP, the IP stated that EBP was mainly in place for residents with indwelling devices (medical device, such as a tube or catheter, that is inserted into the body and left there for a period of time to drain fluids or deliver medication), chronic (long term) open wounds, catheters, G-tubes, PICC lines, wound vac (a treatment that uses suction to help wounds heal) and exposed dialysis ports. The IP further stated Resident 89 was the only resident with a permacath in the facility. The IP explained if a resident was on EBP then the EBP sign should be posted on the door. The IP stated if a resident was on isolation, the PPE supplies should be placed outside of the resident's room near the door. The IP further stated she expected staff to follow the guidelines for EBP. During on 1/10/25, at 12:41 PM, with the DON, the DON stated if an order for EBP was in place then there should have been signage for EBP placed on the resident's door. The DON further stated the PPE bin needed to be close to the door for staff to wear PPE upon seeing the EBP sign. The DON stated the risk of not following the EBP was the potential for infection and cross- contamination due to Resident 89 having an exposed dialysis port. The DON stated all staff members who took care of Resident 89 should have been aware of the EBP order in place and should have followed the precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Enhanced Barrier Precautions, dated 4/1/24, indicated .Purpose .to ensure the use of Enhanced Barrier Precautions as required in the care of residents .Procedure .EBP are used in conjunction with standard precautions and expand the use of PPE to donning [to put on] of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .VIII. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: A. Dressing .B. Bathing/showering .C. Transferring .F. Changing briefs or assisting with toileting . Review of an online document published by the Centers for Disease Control (CDC) titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 4/2/24, indicated .When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies .Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) .For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves .Make PPE, including gowns and gloves, available immediately outside of the resident room . https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html 4. During a concurrent observation and interview on 1/8/25, at 11:40 AM, with LN 9 in Resident 77's room, an EBP sign was posted on the door. LN 9 was observed accessing Resident 77's PICC line wearing a mask and gloves. After accessing the PICC line, LN 9 removed her gloves and washed her hands. LN 9 was shown the EBP sign posted on the door which indicated, .ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: DON [put on] GOWN .caring for devices and giving medical treatments . LN 9 stated she was supposed to have worn a gown when accessing Resident 77's PICC line. LN 9 specified the risk of not wearing correct PPE was cross- contamination to other residents and staff. LN 9 confirmed she did not wear the required PPE when accessing Resident 77's PICC line. During an interview on 01/9/25, at 8:12 AM, with the IP, the IP stated staff should wear gown and gloves when accessing a PICC line. The IP further stated the risk of not following EBP guidelines was transmitting infection to other residents and staff. A review of the facility policy titled, Infection Prevention and Control Program, revised 11/10/21, indicated, . Infection Control Policies and Procedures .Prevent, detect, investigate, and control infections in the Facility . Prevent the further spread of infection . A review of the facility policy titled, Enhanced Barrier Precautions, implemented 4/24, indicated, .EBP . expand the use of PPE to donning of gown and gloves during high-contact resident care activities .are indicated for residents with any of the following .indwelling medical devices .Indwelling medical device examples include central lines .EBP should be used for any residents who meet the above criteria .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055833	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Gardens Post Acute, LLC	537 E. Fulton Street Stockton, CA 95204

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 50778 Based on interview and record review, the facility failed to ensure the Antibiotic Stewardship Program (ASP- a federally mandated program with goals of monitoring, optimizing antibiotic use, and reducing misuse of antibiotics) was followed based on facility policy and national standards for a resident census of 104 when: 1. McGeer Criteria (a set of guidelines for identifying infections in long-term care facilities) was not followed for prescribing antibiotic(s) for Resident 31; and, 2. Antibiotic outcomes (the result of antibiotic use for the infection) were not measured. During a concurrent interview and record review on 1/9/25, at 3:17 PM, with the Infection Preventionist (IP), an ASP spreadsheet titled, ANTIBIOTIC/INFECTION SURVEILLANCE, dated 12/24, was reviewed. The IP stated the spreadsheet was maintained by adding residents' names and information to the document when residents were prescribed antibiotics. The IP further stated McGeer Criteria was used for infection surveillance (the systematic collection, analysis [detailed examination of the elements of something], and interpretation of data about infections). The IP confirmed all 28 boxes (for each line corresponding to a resident's name) under the heading Met McGeer Criteria and Physician Justification for Prescribing were marked. The IP confirmed 11 boxes were marked under the column heading Diagnostic Tests Ordered. The spreadsheet logged the name of residents' admitted (date resident admitted to the facility), onset date (the date infection was noticed), date ordered (the date of the antibiotic order), Antibiotic Name/Dose/Route/Days (antibiotic order details). The log did not consistently include the duration of the antibiotic (or total days of antibiotic therapy) for every antibiotic ordered, did not include the date of Diagnostic Tests Ordered (a biological sample sent to a laboratory to determine the type of germ causing the infection), and did not include an outcome (tracking antibiotic prescribing, side effects, and resistance patterns) or stop date for the antibiotic. The IP stated the duration (how long a medication should be taken) of antibiotic therapy was not consistently documented as it was specified by a doctor as part of the medication order. The IP stated she did not monitor for outcome of antibiotic use. The IP stated this information used to be part of the spreadsheet specified in the facility's ASP (IC - 02 - Form B - Antibiotic Tracking Sheet) but was no longer included on the spreadsheet currently in use. During a concurrent interview and record review on 1/9/25, at 3:17 PM, with the IP, an Infection Prevention and Control Summary Record, dated 1/2/25, was reviewed. The Infection Prevention and Control Summary Record indicated .Number of total infections .28 .Number of infections cultured (a biological sample sent to a laboratory to determine the type of germ causing the infection): 6 . During a concurrent interview and record review on 1/9/25, at 3:17 PM, with the IP, Resident 31's Antibiotic Surveillance - UTI [urinary tract infection-an infection in any part of the urinary system] (Without Catheter [a tube inserted into the bladder to drain urine]), assessment form was reviewed in the facility's computer system. The IP stated the Antibiotic Surveillance assessment form indicated two criteria for infection must be met to meet McGeer Criteria. The IP confirmed Resident 31's assessment indicated she had met both required criteria, having signs and symptoms of an infection and a positive laboratory culture, but no laboratory specimen was sent out for testing. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/10/25, at 9:35 AM, with the IP, an ASP spreadsheet titled, ANTIBIOTIC/INFECTION SURVEILLANCE, dated 1/2/25, was reviewed for Resident 31. The IP stated no outcome monitoring was documented. The IP stated a specimen was not collected for this course of antibiotics even though Met McGeer Criteria was marked on the spreadsheet. The IP stated the McGeer Criteria marked as met on the spreadsheet was marked in error. The IP confirmed outcomes or follow-up activity responses for antibiotic use was not currently followed in the facility. During an interview on 1/13/25, at 10:15 AM, with the Pharmacist Consultant (PC), the PC stated diagnostic tests needed to be done when antibiotics were prescribed because if not done, it could lead to antibiotic resistance (when bacteria or other microorganisms develop the ability to survive antibiotics or other drugs that are used to treat them). The PC stated drugs (antibiotics) were becoming so resistant new drugs (antibiotics) could not be created fast enough; the bacteria were evolving and adapting faster than new medication could be made, leading to Multiple Drug Resistant Organisms (MDRO - a microorganism that is resistant to multiple antibiotics increasing risk of a more severe infection). The PC stated if the facility was not ordering culture and sensitivity (a laboratory test that checks for bacteria and determines which antibiotics will best treat the infection) laboratory tests when prescribing antibiotic medication they may be prescribing the incorrect medication. The PC confirmed if he did not see the laboratory results for culture and sensitivity testing (when antibiotics are prescribed), he would say the facility was out of compliance with the McGeer criteria. Review of a facility policy titled, Antibiotic Stewardship Program, revised 1/1/17, indicated, .Purpose .To limit antibiotic resistance in the post-acute care setting, improve treatment efficacy and resident safety .Policy . designed to promote appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use .The IP will collect and analyze infection surveillance data and monitor the adherence to the ASP .Recommendations will be communicated to the Attending Physician .Tracking .The IP will be responsible for infection surveillance and MDRO tracking .The IP will utilize IC - 02 - Form B - Antibiotic Tracking Sheet .The IP will measure and report outcomes and success rate at monthly/quarterly ICC meetings . Review of a facility policy titled, Antibiotic Stewardship Interventions revised 1/17 indicated, .Broad Interventions .All clinicians should perform a review of antibiotics 48 hours after antibiotics are initiated to answer these key questions .Does this patient have an infection that will respond to antibiotics .is the patient on the right antibiotics .Can a more targeted antibiotic be used to treat the infection (de-escalate) .Infection and Syndrome Specific Interventions .Urinary Tract Infections (UTI's) .Many patients who get antibiotics for UTI's actually have asymptomatic [without symptoms] bacteriuria [presence of bacteria in urine] and not infections . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an online document published by the Centers for Disease Control and Prevention (CDC) in 2015, titled, Core Elements of Antibiotic Stewardship for Nursing Homes indicated, . Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics [antibiotics that are taken to treat infections throughout the body] when followed over a year .studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate .Harms from antibiotic overuse are significant for the frail and older adults receiving care .These harms include risk of serious diarrheal infections from Clostridium difficile (a bacteria that causes diarrhea and inflammation of the colon-the longest part of the large intestines, which is an organ in the digestive system) increased adverse drug events (harm caused by appropriate or inappropriate use of a drug) and drug interactions (a change in the way a drug acts in the body when taken with certain other drugs), and colonization (when bacteria are present on or inside a person's body, growing and multiplying, but without causing any noticeable symptoms or illness) and/or infection with antibiotic-resistant organisms . (https://www.cdc.gov/antibiotic-use/media/pdfs/core-elements-antibiotic-stewardship-508.pdf)