STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East Orangeburg Avenue Modesto, CA 95350

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 52219 Based on interview and facility document and policy review, the facility failed to protect Resident #44's right to be free from physical abuse perpetrated by another resident (Resident #259). This deficient practice affected 1 (Resident #44) of 2 sampled residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 04/2021, revealed, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. An Admission Record revealed the facility admitted Resident #44 on 10/01/2024. According to the Admission Record, the resident had a medical history that included diagnoses of depression, major depressive disorder with severe psychotic symptoms, and legal blindness. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #44's Care Plan Report included a focus area, initiated 10/28/2024, that indicated on 10/26/2024, Resident #44's roommate (Resident #259) approached Resident #44 in their room as the resident sat in the wheelchair and suddenly slapped Resident #44 on the right side of their face. Resident #44's Progress Notes revealed a Health Status note, dated 10/26/2024, that indicated Certified Nursing Assistant (CNA) #1 brought Resident #44 to the nursing station and reported they witnessed Resident #259 strike Resident #44 on the face. An Admission Record revealed the facility admitted Resident #259 on 09/28/2024. According to the Admission Record, the resident had a medical history that included diagnoses of anoxic brain damage, schizophrenia, depression, and anxiety disorder. An admission MDS, with an ARD of 09/30/2024, revealed Resident #259 had a BIMS score of 9, which indicated the resident had moderate cognitive impairment. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An untitled facility document summarizing the facility's investigation into the incident involving Resident #44 and Resident #259, dated 10/30/2024, revealed CNA #1 witnessed Resident #259 walk over to Resident #44 and slap Resident #44 on the face on 10/26/2024 at approximately 1:15 PM. According to the document, the facility concluded Resident #44 nor Resident #259 had any previous reports of aggression, and the unfortunate event between these 2 [two] residents was an isolated occurrence. A typed statement from CNA #1, dated 10/28/2024, revealed the CNA witnessed Resident #259 slap Resident #44 across the face. According to the statement, when Resident #259 slapped Resident #44, their hand contacted Resident #44's right cheek and right ear. During an interview on 03/14/2025 at 6:14 PM, the Director of Nursing (DON) stated Resident #44 and Resident #259 had not had any incidents prior to this event.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46659 Based on interview, record review, and facility policy review, the facility failed to ensure Level I Preadmission Screening and Resident Review (PASARR) accurately reflected the presence of a diagnosed serious mental illness for 1 (Resident #35) of 1 sampled resident reviewed for PASARR requirements. Specifically, the facility failed to ensure Resident #35's initial PASARR reflected that the resident had a diagnosis of depression. Findings included: A facility policy titled, Pre-Admission Screening and Resident Review, revised 12/2016, indicated, The objective of the PASARR policy is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. An Admission Record indicated admitted Resident #35 on 11/30/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of depression (onset date 11/30/2024). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident's active diagnoses at the time of the assessment included depression. Resident #35's Level I PASARR, dated 11/30/2024, indicated Section III - Serious Mental Illness, question 9. diagnosed Serious Mental Illness. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance was answered, No. The resident's Level I PASARR indicated the results were negative, a Level II evaluation was not required, and the case was closed. During an interview on 03/13/2025 at 12:55 PM, the MDS Coordinator stated that when a resident was admitted to the facility, it was her responsibility to ensure their PASARR was accurate. After reviewing Resident #35's Level I PASARR, dated 11/30/2024, the MDS Coordinator stated it was inaccurate. The MDS Coordinator stated if a PASRR was not completed accurately, the resident might not get the care needed to help with their mental health diagnoses. During an interview on 03/14/2025 at 4:54 PM, the Administrator stated he expected staff to follow the facility's policy for PASSARs.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46659 Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure staff assisted a dependent resident with activities of daily living (ADLs) for 1 (Resident #7) of 5 sampled residents reviewed for ADLs. Specifically, the facility failed to provide nail care for Resident #7. Findings included: A facility policy titled, Activities of Daily Living (ADLs), Supporting, revised 03/2018, indicated, Residents will [sic] provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. An Admission Record revealed the facility originally admitted Resident #7 on 02/02/2022 and most recently admitted the resident on 10/01/2024. According to the Admission Record, the resident had a medical history that included diagnoses of quadriplegia (loss of function in all four limbs), hemiplegia (a condition characterized by paralysis or weakness on one side of the body), and hemiparesis (weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting the right dominant side. The Admission Record did not reflect the resident had a diagnosis of diabetes. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/2024, revealed Resident #7 had short- and long-term memory problems and severely impaired cognitive skills for daily decision-making per a Staff Assessment for Mental Status (SAMS). The MDS indicated the resident was dependent on staff for personal hygiene. Resident #7's Care Plan Report included a focus area, initiated 07/25/2023, that indicated the resident was dependent on staff for meeting their emotional, intellectual, physical, and social needs. The focus area further indicated the resident was non-verbal and unable to ambulate. An observation on 03/10/2025 at 2:38 PM revealed Resident #7 had long fingernails on both hands. The observation revealed Resident #7 had bilateral hand contractures, and their fingernails were close to touching the inner palm of both hands. An observation on 03/11/2025 at 12:51 PM revealed Resident #7's fingernails remained long. During an interview on 03/12/2025 at 1:05 PM, Certified Nursing Assistant (CNA) #11 stated CNAs were responsible for trimming non-diabetic residents' fingernails. CNA #11 stated Resident #7 received showers or baths twice a week and should have had their fingernails trimmed. During a concurrent observation and interview on 03/12/2025 at 1:32 PM, Registered Nurse (RN) #9 confirmed Resident #7's fingernails were long and needed to be trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 03/12/2025 at 2:01 PM, CNA #18 stated the CNAs were responsible for cleaning and trimming fingernails for non-diabetic residents. CNA #18 observed Resident #7's fingernails and stated they were too long and needed to be trimmed. During an interview on 03/12/2025 at 2:33 PM, CNA #13 stated Sunday was nail care day, and the CNAs should be checking the fingernails every day and keeping them clean and trimmed. During an interview on 03/13/2025 at 9:41 AM, Restorative Nursing Assistant (RNA) #17 stated she tried to pay attention to the residents' fingernails when she put on their splints. RNA #17 stated she should have trimmed Resident #7's fingernails. During an interview on 03/14/2025 at 4:11 PM, the Director of Nursing (DON) stated she expected the staff to trim and cut residents' fingernails. During an interview on 03/14/2025 at 4:54 PM, the Administrator stated he expected staff to keep the residents' nails trimmed per their policy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 22445 Based on interview, record review, and facility policy review, the facility failed to provide indwelling urinary catheter care per the facility's policy and accepted infection control standards and failed to maintain an indwelling urinary catheter bag below the level of the bladder for 1 (Resident #111) of 3 residents reviewed with an indwelling urinary catheter. Findings included: A facility policy titled, Catheter Care, Urinary, revised 08/2022, revealed the section titled Maintaining Unobstructed Urine Flow, included, 3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. The policy revealed the section titled Steps in the Procedure Routine Perineal Hygiene, included, c. Change the position of the washcloth (or wipe) with each cleansing stroke. d. With a clean washcloth (or wipe), rinse using the above technique. Further review revealed, 15. Use a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from insertion site to approximately four inches outward. An Admission Record revealed the facility admitted Resident #111 on 01/22/2025 and most recently on 03/04/2025. According to the Admission Record, Resident #111 had a medical history that included hemiplegia (total or nearly complete inability to use one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, generalized muscle weakness, and unspecified malignant neoplasm of the colon (colon cancer). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/24/2025, revealed Resident #111 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #111 was dependent on staff for toileting hygiene and required substantial/maximal assistance from staff with showering/bathing, personal hygiene, and dressing of the upper body and lower body. The MDS also indicated Resident #111 required substantial to moderate assistance from staff to roll from side to side in bed and was dependent on staff for transferring to and from bed. The MDS also indicated Resident #111 was always incontinent of bowel and bladder. Resident #111's Care Plan Report included a focus area initiated 03/05/2025, that indicated Resident #111 had an indwelling urinary catheter due to urinary retention. Interventions directed staff to position the catheter bag below the level of the bladder (initiated 03/05/2025). Resident #111's Order Summary Report with active orders as of 03/12/2025, contained an order dated 03/05/2025 for a Foley catheter 16 FR (French)/10 milliliters (ml) with instructions for staff to change the Foley catheter every month and as needed for displacement or non-functioning. The Order Summary Report revealed an order dated 03/05/2025 directing staff to change the resident's Foley catheter bag every week on the night shift. The order Summary Report revealed an order dated 03/12/2025 directing staff to change the resident's Foley catheter bag as needed. The Order Summary Report revealed an order dated 03/05/2025 directing staff to provide Foley catheter care every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/11/2025 at 11:35 AM, Resident #111's urinary catheter drainage bag was hanging on the footboard of the resident's bed above the level of the resident's bladder. During an interview on 03/11/2025 at 11:40 AM, Certified Nursing Assistant (CNA) #1, who was assigned to care for Resident #111, stated he had placed the urinary catheter drainage bag on the footboard of the bed when the room had been cleaned earlier and had forgotten to move the drainage bag to the side of the bed onto a lower rail. CNA #1 stated he had been taught that the urinary catheter drainage bag should be placed lower than the resident's bladder but was unsure why. Licensed Vocational Nurse (LVN) #14 was interviewed on 03/11/2025 at 11:50 AM. LVN #14 stated she had not noticed the positioning of Resident #111's urinary catheter drainage bag when she had been in the resident's room. LVN #14 stated the danger of having the urinary catheter drainage bag higher than the resident's bladder would be the potential for the catheter tubing to be pulled, harming the resident's genital area or could potentially cause an infection. The Director of Nursing (DON) was interviewed on 03/11/2025 at 12:00 PM. The DON stated the urinary catheter drainage bag for Resident #111 should not have been hanging on the foot of the bed since a urinary catheter drainage bag that was placed higher than the resident's bladder could cause a backflow of urine, resulting in a urinary tract infection (UTI). Medical Doctor (MD) #5 was interviewed on 03/14/2025 at 9:19 AM. He stated a resident's urinary catheter drainage bag was expected to be kept below the level of the bladder to prevent infection from urine backflow. An observation was made on 03/12/2025 at 9:11 AM of CNA #1 providing a bath and catheter care to Resident #111. CNA #1 used a towel and poured water over the resident's genital area, covering the area where the urinary catheter tubing entered the resident's body. CNA #1 then took another damp towel and washed the resident's face and upper body. When CNA #1 completed washing the resident's upper body, he used a disposable cloth to clean the resident's genital area where the catheter was located. CNA #1 stated he had been taught to use a different part of the cloth for each cleansing stroke and stated, Oh, when it was pointed out that he had not changed the position of the disposable cloth while cleaning the resident's genital area. CNA #1 washed back and forth across the catheter entry site. When cleaning the catheter tubing, CNA #1 started at the distal part of the tubing and cleaned toward the catheter's entry point into the resident's body. CNA #1 stated he was unaware he was to start at the entry point and clean outward. The DON was interviewed on 03/12/2025 at 9:58 AM. The DON stated that when catheter care was provided, staff were expected to wipe from the cleanest area, which was near the insertion site, and use a clean part of the cloth for each cleansing wipe. The Administrator was interviewed on 03/13/2025 at 1:22 PM. The Administrator stated he expected the facility's policy for catheter care to be followed to decrease the risk of UTIs for Resident #111.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to administer oxygen according to physician orders for 3 (Residents #6, #24, and #111) of 4 residents reviewed for respiratory therapy. Findings included: A facility policy titled, Oxygen Administration, revised October 2010, revealed, Preparation included, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 1. An Admission Record revealed the facility admitted Resident #111 on 01/22/2025 and most recently on 03/04/2025. According to the Admission Record, Resident #111 had a medical history that included diagnoses of hemiplegia (total or nearly complete inability to use one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, a history of coronavirus disease 2019 (COVID-19) (onset date 01/22/2025), unspecified heart failure, unspecified anemia, and morbid obesity. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/24/2025, revealed Resident #111 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #111 received continuous oxygen therapy. Resident #111's Care Plan Report included a focus area initiated on 03/04/2025, that indicated the resident had congestive heart failure. Interventions directed staff to monitor the resident's vital signs every shift and to notify the physician of significant abnormalities (initiated 03/04/2025). Resident #111's Order Summary Report, with active orders as of 03/12/2025, revealed an order, with a start date of 03/04/2025, that indicated Resident #111 was to receive supplemental oxygen at 1 liter per minute (L/min) via nasal cannula (NC) as needed for shortness of breath. The Order Summary Report also revealed an order, with a start date of 03/04/2025, for supplemental oxygen to be administered at 2 L/min as needed for wheezing/shortness of breath. The Order Summary Report revealed an order, with a start date of 03/04/2025, that indicated staff were to check the resident's oxygen saturation every shift, and if it was less than 92%, staff were to apply supplemental oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #111's medication administration record (MAR), for the timeframe from 03/04/2025 through 03/11/2025, revealed a transcription of an order dated 03/04/2025, instructing staff to check the resident's oxygen saturation every shift, and if the value of the oxygen saturation was less than 92%, supplemental oxygen was to be applied. The MAR revealed staff documented that the order was followed from 03/05/2025 through 03/10/2025. The MAR also included a transcription of an order dated 03/04/2025, to check the resident's vital signs every shift and included a space to record the oxygen saturation. The MAR revealed that for the timeframe from 03/04/2025 through 03/10/2025, staff documented Resident #111's oxygen saturation ranged between 94% and 100%. The MAR revealed no values were recorded less than 92% in that portion of the MAR. The MAR revealed a transcription of an order dated 03/04/2025, for the resident to receive supplemental oxygen at 2 L/min via nasal cannula (NC) as needed for wheezing. The MAR revealed staff documented that the resident received oxygen therapy on 03/07/2025 at 12:42 AM for an oxygen saturation of 82%. Resident #111's O2 [Oxygen] Sats [Saturations] Summary, for the timeframe from 03/04/2025 through 03/12/2025, revealed staff documented Resident #111 received oxygen via NC on six of those days, and did not document an oxygen saturation lower than 92%, except on 03/07/2025 at 12:42 AM. Resident #111's Progress Notes, for the timeframe from 03/04/2025 through 03/11/2025, revealed no documentation that indicated the resident had a low oxygen saturation. An observation on 03/10/2025 at 10:57 AM revealed Resident #111's oxygen concentrator was set on 2.5 L/min, and the resident was receiving supplemental oxygen via NC. The residents MAR did not reflect this administration. An observation on 03/12/2025 at 12:48 PM revealed the resident's oxygen concentrator was set on 3.5 L/min, and the resident was receiving supplemental oxygen via NC. Licensed Vocational Nurse (LVN) #14 was interviewed on 03/12/2025 at 12:58 PM. LVN #14 stated the setting on an oxygen concentrator was determined by the physician's order. LVN #14 stated if increasing a resident's oxygen was needed, she would notify the physician regarding the resident's change in condition. LVN #14 reviewed Resident #111's physician orders and confirmed the resident had two orders for supplemental oxygen; one order was for 1 L/min and the other order was for 2 L/min. LVN #14 stated if the nurse followed the physician's order, the maximum amount of supplemental oxygen ordered for Resident #111 was 2 L/min. LVN #14 stated she had checked the resident's oxygen concentrator on 03/11/2025, and stated Resident #111 was receiving either 2.5 L/min or 3.5 L/min. She stated that she did not check the physician's orders since the resident was stable and the amount of supplemental oxygen the resident was receiving had not jumped out at her. LVN #14 went to the resident's room and confirmed the resident's concentrator was set at 3.5 L/min. LVN #14 then checked the resident's oxygen saturation, which was at 100%. The Director of Nursing (DON) was interviewed on 03/12/2025 at 2:07 PM. The DON stated that when a resident received an order for supplemental oxygen, she expected the nurses to follow the order given. The DON stated nurses were only able to increase and decrease supplemental oxygen within parameters given by the physician. The DON stated the oxygen concentrator should be set on the amount ordered by the physician. The DON stated that the nurse who took the two orders for supplemental oxygen on the same day should have clarified the orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #111's Order Summary Report, with active orders as of 03/12/2025, revealed an active order that the resident was to receive supplemental oxygen at 2 L/min via NC as needed for shortness of breath, with a start date 03/12/2025. The order indicated if the resident's oxygen saturation was less than 90%, the supplemental oxygen could be increased to 3 to 5 L/min via NC. An observation on 03/13/2025 at 10:08 AM revealed Resident #111 was in bed resting and receiving 3 liters of supplemental oxygen via NC. Resident #111's O2 Sats Summary, for the timeframe from 03/13/2025 through 03/14/2025, revealed staff documented Resident #111 received supplemental oxygen via NC on both days and did not document an oxygen saturation lower than 90%. LVN #4 was interviewed on 03/13/2025 at 10:19 AM. LVN #4 stated that she was assigned to provide care to Resident #111 that day. LVN #4 stated she usually checked the settings on oxygen concentrators during medication administration to make sure residents received the correct amount of supplemental oxygen. LVN #4 stated if a resident's oxygen saturation dropped, making it necessary to increase the flow of supplemental oxygen, the expectation was for the nurse to write a progress note about the respiratory assessment and the need to increase the supplemental oxygen. LVN #4 stated she would also notify the physician about the resident's change in condition. LVN #4 stated that when she received report that morning, she had not received any information that Resident #111 had a change in condition that made increasing the supplemental oxygen the resident received necessary. LVN #4 reviewed Resident #111's supplemental oxygen order and stated if the oxygen saturation were less than 90%, the supplemental oxygen could be increased, but added that if there had been no change in the resident's condition and the oxygen saturation was greater than 90%, then the oxygen concentrator should be set on 2 L/min. LVN #4 stated she had not looked at the resident's oxygen concentrator that morning to confirm the setting of how much supplemental oxygen the resident received. LVN #4 went to Resident #111's room and stated the oxygen concentrator was set to 3 L/min. LVN#4 reviewed the oxygen saturation values and progress notes and stated there had been no change in the resident's condition to warrant the concentrator being set on 3 L/min. LVN #4 stated the oxygen concentrator should be set to deliver 2 L/min to the resident. Medical Doctor (MD) #5 was interviewed on 03/14/2025 at 9:19 AM. MD #5 stated he expected orders for supplemental oxygen delivery to be followed. MD #5 stated giving too much oxygen could increase the resident's carbon dioxide level and depress the respiratory system, causing the resident harm. MD #5 stated oxygen should be titrated to keep the oxygen saturation greater than 90%. The DON was interviewed on 03/13/2025 at 1:00 PM. The DON stated she was disappointed the physician's oxygen orders for Resident #111 was still not followed. The Administrator was interviewed on 03/13/2025 at 1:21 PM. The Administrator stated he expected the physician's orders to be followed for the administration of supplemental oxygen for Resident #111 and stated that he expected staff to call the physician if clarification was needed. 46659 2. An Admission Record revealed the facility admitted Resident #24 on 02/18/2025. According to the Admission Record, the resident had a medical history that included acute respiratory failure with hypoxia, sleep apnea, and dependence on supplemental oxygen. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East Orangeburg Avenue Modesto, CA 95350

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2025, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #24 received respiratory treatments through a non-invasive mechanical ventilator. Resident #24's Care Plan Report included a focus area initiated 02/18/2025, that indicated the resident had shortness of breath related to hypoxia. Interventions directed staff to use a bilevel positive airway pressure (BiPAP) machine as appropriate and monitor for effectiveness (initiated 02/18/2025). Resident #24's Order Summary Report, with active orders as of 03/12/2025, revealed an order dated 02/18/2025, for supplemental oxygen at 2 liters per minute (L/min) via nasal cannula (NC) to be administered as needed when the resident's oxygen saturation was below 92%. The Order Summary Report also revealed an order dated 02/18/2025, for supplemental oxygen at 5 L/min via face mask every shift; and an order dated 02/18/2025, for supplemental oxygen at 5 L/min via NC when the resident's oxygen saturation level was below 92%. Resident #24's medication administration record (MAR), for the timeframe from 03/01/2025 through 03/14/2025, revealed staff documented the resident received supplemental oxygen at 5 L/min via face mask. The MAR revealed staff documented the resident's oxygen saturation was between 94% and 100% during that timeframe. An observation on 03/11/2025 at 2:20 PM revealed Resident #24 receiving supplemental oxygen via facemask, the supplemental oxygen setting was at 8 L/min. An observation on 03/13/2025 at 9:53 AM revealed Resident #24 receiving supplemental oxygen via NC, the supplemental oxygen setting was at 8-9 L/min. At 9:56 AM, Registered Nurse (RN) #9 confirmed the resident's supplemental oxygen was set between 8 L/min and 9 L/min. During an interview on 03/13/2025 at 9:59 AM, RN #9 stated Resident #24's supplemental oxygen order was 5 L/min. RN #9 stated the resident struggled the day prior after returning from dialysis, so he increased the supplemental oxygen to 8 to 9 L/min. During an interview on 03/13/2025 at 10:04 AM, RN #9 stated that the danger of too much oxygen was oxygen toxicity. RN #9 stated staff had to have an order to change the supplemental oxygen amount. RN #9 stated he did not talk to the doctor about changing the amount of supplemental oxygen for Resident #24. RN #9 stated it was important to follow the doctor's orders. During an interview on 03/14/2025 at 9:08 AM, Medical Doctor (MD) #5 stated that if a resident had an order for supplemental oxygen, then he expected staff to ensure the supplemental oxygen was set at the correct level. MD #5 stated if a resident got too much oxygen, it could be dangerous. MD stated 8-9 L/min should not be the normal amount of supplemental oxygen for Resident #24 unless there were orders to monitor and adjust the amount to keep the resident's oxygen saturation at 90%. He stated if the resident's oxygen saturation remained in the high 90s, then the supplemental oxygen should be lowered back down. MD #5 stated staff should always follow physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/14/2025 at 4:11 PM, the Director of Nursing (DON) stated she expected staff to follow physician orders, and the physician had to be called before staff could change the supplemental oxygen settings. During an interview on 03/14/2025 at 4:54 PM, the Administrator stated he expected staff to follow the facility policy related to physician orders for oxygen therapy. 52219 3. An Administration Record revealed the facility admitted Resident #6 on 06/04/2024 and readmitted the resident on 01/28/2025. According to the Admission Record, the resident had a medical history that included diagnoses of polymyositis with respiratory involvement, acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, toxic effect of carbon dioxide, other pulmonary embolism (blood clot in a lung) without acute cor pulmonale (right side heart failure), unspecified systolic (congestive) heart failure, pleural effusion, shortness of breath, and unspecified asthma. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/03/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #6 had shortness of breath with exertion, when sitting at rest, and when lying flat. The MDS indicated the resident utilized a non-invasive mechanical ventilator for respiratory treatments while a resident. Resident #6's Care Plan Report included a focus area dated 09/10/2024, that indicated the resident had ineffective breathing, and indicated the resident used a bilevel positive airway pressure (BiPAP) machine. Interventions directed staff to check the resident's vital signs every shift and as needed (initiated 08/19/2024). Resident #6's Order Summary Report, with active orders as of 03/14/2025, revealed an active order dated 01/27/2025, to check the resident's oxygen saturation every shift and if less than 92%, supplemental oxygen was to be administered. The order did not include the amount of supplemental oxygen to be administered. Resident #6's medication administration record (MAR) for the timeframe from 03/01/2025 through 03/13/2025, revealed staff documented that they checked the resident's oxygen saturation. The MAR revealed staff documented the resident's oxygen saturation was 89% on 03/13/2025 during the 7:00 AM and 7:00 PM shift. The MAR revealed staff did not document the resident's oxygen saturation being lower than 92% on any other day. Resident #6's O2 [Oxygen] Sats [Saturations] Summary, revealed that Certified Nursing Assistant (CNA) #6 documented that Resident #6's oxygen saturation was 100% while receiving supplemental oxygen via nasal cannula (NC) on 03/09/2025 at 7:50 PM. Staff documented the resident received supplemental oxygen on 03/10/2025 at 6:56 AM and 7:20 PM, 03/12/2025 at 7:13 AM and 7:25 PM, and 03/13/2025 at 6:53 AM. Per the record, the resident's oxygen levels were only below 92% on 03/13/2025 at 6:53 AM. An observation on 03/11/2025 at 12:53 PM revealed Resident #6 in their room, seated in a wheelchair, eating lunch, and receiving supplemental oxygen via a NC. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 03/12/2025 at 11:22 AM revealed Resident #6 in bed sleeping and receiving supplemental oxygen via a NC. Resident #6's Care Plan Report included a focus area dated 03/14/2025, that indicated the resident received supplemental oxygen at 2 liters via NC to keep the resident's oxygen saturation above 94%. Resident #6's Order Summary Report, with active orders as of 03/14/2025, revealed an active order with a start date of 03/14/2025, to administer supplemental oxygen via NC at 2 liters per minute (L/min) every shift, for shortness of breath, if the resident's oxygen saturation level was less than 92%. Resident #6's MAR revealed staff documented the resident's oxygen saturation on 03/14/2025 during the first shift was 99%. Resident #6's O2 Sats Summary revealed staff documented the resident's oxygen saturation on 03/14/2025 at 6:40 AM was 99% on room air. During a concurrent observation and interview on 03/14/2025 at 11:07 AM, Resident #6 was in bed and receiving supplemental oxygen via a NC at 2 L/min. Resident #6 stated they always received supplemental oxygen. Resident #6 stated it should be set at 2 L/min, and stated the nurses were the ones who administered the supplemental oxygen. During an interview on 03/12/2025 at 1:22 PM, CNA #6 stated Resident #6 always received supplemental oxygen. She stated that she always sees the resident receiving supplemental oxygen. During an interview on 03/14/2025 at 12:55 PM, Licensed Vocational Nurse (LVN) #7 stated she would know how much supplemental oxygen a resident should receive by reviewing the physician's order. LVN #7 stated she believed Resident #6 received 2 L/min. She stated if a physician's order did not provide the L/min, she would call the doctor to clarify the order. Medical Doctor (MD) #5 was interviewed on 03/14/2025 at 9:19 AM. MD #5 stated he expected orders for oxygen delivery to be followed. MD #5 stated giving too much oxygen could increase the resident's carbon dioxide level and depress the respiratory system, causing the resident harm. MD #5 stated oxygen should be titrated to keep the oxygen saturation greater than 90%. The Director of Nursing (DON) was interviewed on 03/12/2025 at 2:07 PM. The DON stated that when a resident received an order for supplemental oxygen, she expected the nurses to follow the order given. The DON stated nurses were only able to increase and decrease supplemental oxygen within parameters given by the physician. The DON stated the oxygen concentrator should be set on the amount ordered by the physician. During an interview on 03/14/2025 at 4:54 PM, the Administrator stated he expected staff to follow the facility policy related to physician orders for oxygen therapy.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 52219 Based on observation, interview, and facility document and policy review, the facility failed to provide food that accommodated resident allergies and preferences for 2 (Resident #257 and Resident #41) of 3 residents sampled for food. Findings included: A facility policy titled, Food Allergies, dated 2023, revealed, Policy: Residents with food allergies will be identified upon admission. The policy also indicated, Procedure: 1. Allergies will be noted in the medical record. 2. All allergies will be communicated in writing directly to the FNS [Food and Nutrition Services] Director by Nursing. 3. Appropriate food substitutions will be offered for foods the resident cannot eat. 4. Refer to [Vendor Name] Diet Manual for food allergy information. 5. Allergies will be noted on the tray card, the resident diet profile, and posted in the kitchen and nursing station, if necessary. A facility policy titled, Food Preferences, dated 2023, revealed, Policy: Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group. Condiments such as salt, pepper, and sugar are available at each meal unless contraindicated by the diet order. The policy also indicated, Procedure: Food preferences will be obtained as soon as possible through the initial resident screen. This screening must be completed within 7 days of admission by the FNS Director. Food preference can be obtained from the resident, family, or staff members. Updating of food preferences will be done as the resident's needs change and/or during the quarterly review. A facility policy titled, Food Allergies and Intolerances, revised August 2017, revealed, Residents with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergen(s). The policy revealed, Assessment and Interventions: 1. Residents are assessed for a history of food allergies and intolerances upon admission and as part of the comprehensive assessment. 2. All resident reported food allergies and intolerances are documented in the assessment notes and incorporated into the resident's care plan. Further review revealed, 5. Residents with food intolerances and allergies are offered appropriate substitutions for foods that they cannot eat. 1. An Admission Record revealed the facility admitted Resident #257 on 02/25/2025. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified protein-calorie malnutrition, gastro-esophageal reflux disease without esophagitis, type 2 diabetes mellitus without complications, and a personal history of other diseases of the digestive system. The Admission Record indicated Resident #257 was allergic to bell pepper, broccoli, cauliflower, and eggs. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2025, revealed Resident #257 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident required setup or clean-up assistance with eating and received a mechanically altered and therapeutic diet during the assessment lookback period. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #257's Care Plan Report included a focus statement dated 03/05/2025, that indicated the resident was at risk for impaired nutritional status as well as increased risk for malnutrition related to carbohydrate consistent diet (CCHO) diet restrictions, requests for a mechanical soft diet related to missing teeth, a recent hospitalization for a fracture, and obesity with a body mass index (BMI) greater than 30. The focus statement revealed the resident was allergic to eggs, bell peppers, broccoli, and cauliflower. Interventions directed staff to provide and serve the resident's diet as ordered (initiated 03/05/2025). Resident #257's Registered Dietitian Nutrition Assessment, dated 03/05/2025, indicated the resident had an allergy to eggs, bell peppers, broccoli, cauliflower. A document titled Good For Your Health Menus revealed the facility menus for the timeframe from 03/10/2025 through 03/16/2025. The menus revealed that for 03/10/2025 the lunch served to residents was tarragon chicken with oven roasted potatoes, green beans with red peppers, broccoli salad, and a tropical fruit mold. A Diet Type Report, dated 03/11/2025, revealed Resident #257 had the following food allergies: bell pepper, broccoli, cauliflower, and eggs. An undated document titled, Tray Check cart 2 Lunch, revealed Resident #257 had a food allergy to broccoli, cauliflower, bell peppers, and eggs. An observation on 03/10/2025 at 12:39 PM revealed Resident #257 in their room, seated in a wheelchair. Resident #257's lunch was delivered by a staff member and placed on the tray table in front of the resident. The lunch meal included a small bowl of broccoli salad. Resident #257 asked the staff member to remove the broccoli salad because the resident could not eat it. The staff member removed the broccoli salad, left the room, and did not offer an alternative. The resident's tray card was observed on their tray and showed that the resident was allergic to broccoli. During an interview on 03/12/2025 at 12:17 PM, Resident #257 stated that the meals they received included whatever the facility had on the menu and staff did not provide a substitute when a mistake with their meal was made. During an interview on 03/12/2025 at 1:36 PM, Dietary Aide #12 stated she looked at the tray check list on the wall in the kitchen for a list of resident allergies, preferences, and dislikes. She stated the allergies, preferences, and dislikes were also on the tray cards. She stated that when plating a meal, the dietary aide looked at the tray cards and let her know what was on the card for the meal to include preferences, dislikes, and allergies. Dietary Aide #12 stated they would give the resident an alternative if the meal went on the tray and there was an error. During an interview on 03/12/2025 at 1:54 PM, the Dietary Manager stated she printed the tray card, and the dietary staff were to check them. She stated the allergies, food preferences, and dislikes were on the tray card and on the Diet Type Report that was printed three times per week on Mondays, Wednesdays, and Fridays. She stated the dietary aides wrote on the tray card if there was an allergy or dislike even though it was already printed on the tray card. She stated staff were supposed to double check. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 3:49 PM, the Registered Dietician (RD) stated the original allergy lists were part of the medical record and were not able to be revised without a physician's order. The RD stated the Dietary Manager, and she would visit a new resident within the first couple of days and confirm a resident's likes and dislikes. The RD stated the dietary staff needed to double check the list and tray cards. The RD stated the staff member could have offered something different to Resident #257. On 03/13/2025 at 1:20 PM, the Director of Nursing (DON) stated staff needed to read the names and diet (on the tray cards) and if something was wrong with the meal, staff should take the meal back to the kitchen to get a proper meal for the resident. 2. An Admission Record revealed the facility admitted Resident #41 on 09/01/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified protein calorie malnutrition. The Admission Record indicated Resident #41 was allergic to mushrooms. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/03/2024, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident was independent with eating and received a therapeutic diet during the assessment lookback period. Resident #41's Care Plan Report included a focus statement initiated 09/04/2024, that indicated the resident had a nutritional problem or potential nutritional problem related to a carbohydrate consistent diet (CCHO) diet, no added salt diet restrictions, and the resident was very particular about foods. The focus statement revealed the resident had an allergy to mushrooms and that the resident stated they had an allergy to eggs. Interventions indicated that the registered dietician would evaluate and make diet change recommendations as needed (initiated 09/04/2024). Resident #41's Progress Notes revealed a Nutrition/Dietary Note dated 12/18/2024 at 3:15 PM, that indicated the resident had an allergy to mushrooms listed in their electronic medical record. The note revealed the resident reported being allergic to eggs and any food that contained sulfur. The note revealed the resident's extensive list of preferences was provided to the dietary department. Per the note, the resident continued to have complaints regarding food and continued to change their preferences. The note revealed the resident refused all vegetables. The note indicated the resident would continue to provide preferences as needed, remained self-directed with intake, and frequently changed requests based on allergies. Resident #41's Progress Notes revealed a Nutrition/Dietary Note dated 01/08/2025 at 10:39 AM, that indicated the resident was particular about foods, did not receive vegetables, was allergic to mushrooms, and stated that they had an allergy to eggs. The note indicated that the resident's preferences were noted and honored. A Diet Type Report, dated 03/11/2025, revealed Resident #41 had a food allergy to mushrooms. An undated document titled Tray Check cart 2 Lunch revealed for Resident #41 there were instructions for staff to check the resident's dislikes, and NO VEGETABLES. The document revealed the resident was allergic to eggs and mushrooms. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #41's tray card for lunch, dated 03/13/2025, revealed Resident #41 was allergic to mushrooms and eggs. The tray card indicated Resident #41's dislikes included bread, eggs, and No Vegetables. During an interview on 03/10/2025 at 11:58 AM, Resident #41 was in their room, seated in a wheelchair. Resident #41 stated a list was given to the facility staff of foods the resident was unable to eat which included eggs, broccoli, and Brussel sprouts. Resident #41 stated they were allergic to foods with sulfur in it. Resident #41 stated if they ate any of the foods, they listed they would be fire engine red and itch constantly. Resident #41 stated they were very particular about what they ate. A document titled Good For Your Health Menus revealed the facility menus for the timeframe from 03/10/2025 through 03/16/2025. The menus revealed that for 03/12/2025 the lunch served to residents was sweet and sour chicken, sesame noodles, stir fry vegetables, mandarin Asian salad, and a lemon snow bar. An observation on 03/12/2025 at 12:12 PM revealed Resident #41 was in their room in a wheelchair, and a lunch tray was delivered by Certified Nursing Assistant (CNA) #6. During an observation on 03/12/2025 at 12:13 PM, Resident #41's meal tray revealed the resident was served stir fry vegetables. During a concurrent interview Resident #41 stated they did not eat the stir fry vegetables. An observation of Resident #41's tray card on their tray revealed no vegetables was circled with black marker. During an interview on 03/12/2025 at 12:21 PM, CNA #6 stated she looked at the food on the tray and the tray card. She stated Resident #41 had vegetables on their tray and the resident should not. During an interview on 03/12/2025 at 1:36 PM, Dietary Aide #12 stated she looked at the tray check list on the wall in the kitchen for a list of resident allergies, preferences, and dislikes. She stated the allergies, preferences, and dislikes were also on the tray cards. She stated that when plating a meal, the dietary aide looked at the tray cards and let her know what was on the card for the meal to include preferences, dislikes, and allergies. Dietary Aide #12 stated they would give the resident an alternative if the meal went on the tray and there was an error. During an interview on 03/12/2025 at 1:54 PM, the Dietary Manager stated she printed the tray card, and the dietary staff were to check them. She stated the allergies, food preferences, and dislikes were on the tray card and on the Diet Type Report that was printed three times per week on Mondays, Wednesdays, and Fridays. She stated the dietary aides wrote on the tray card if there was an allergy or dislike even though it was already printed on the tray card. She stated staff were supposed to double check. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 3:49 PM, the Registered Dietician (RD) stated the original allergy lists were part of the medical record and were not able to be revised without a physician's order. The RD stated the Dietary Manager, and she would visit a new resident within the first couple of days and confirm a resident's likes and dislikes. The RD stated Resident #41's list was brought to the kitchen, and the staff must look at the list each time. Resident #41 should not receive vegetables. Resident #41 was allergic to sulfa antibiotics, so she put eggs as an allergy on the tray card as a precaution, and the resident stated being allergic to food items with sulfur in it. The RD stated the dietary staff needed to double check the list and tray cards. On 03/13/2025 at 1:20 PM, the Director of Nursing (DON) stated staff needed to read the names and diet (on the tray cards) and if something was wrong with the meal, staff should take the meal back to the kitchen to get a proper meal for the resident.

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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. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBPs) were provided for 2 (Resident #111 and Resident #24) of 7 residents reviewed for transmission based precautions and failed to ensure staff followed infection control practices observed during medication administration for 1 (Resident #46) of 6 residents during medication administration and 1 (Resident #111) of 1 resident during wound care. Findings included: 1. A facility policy titled, Enhanced Barrier Precautions, dated 08/2022, revealed Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-frug resistant organisms (MDROs) to residents. The policy revealed, 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. The policy revealed, 3. Exampled of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. [et cetera; and so forth]); and h. wound care (any skin opening requiring a dressing. Per the policy, 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. The policy revealed, 9. Staff are trained prior to caring for residents on EBPs. A facility policy titled, Handwashing/Hand Hygiene, revised 08/2019, revealed, This facility considers hand hygiene the primary means to prevent the spread of infections. The policy revealed, 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations: which included, b. before and after direct contact with residents; e. before and after handling invasive device (e.g. [exempli gratia, for example], urinary catheters, IV [intravenous] access sites); g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from contaminated body site to a clean body site during resident care; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves. The policy revealed, 8. Hand hygiene is the final step after removing and disposing or personal protective equipment. Per the policy, 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used: b. When anticipating contact with blood or body fluids; and c. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. An Admission Record revealed the facility admitted Resident #111 on 01/22/2025 and most recently on 03/04/2025. According to the Admission Record, Resident #111 had a medical history that included hemiplegia (total or nearly complete inability to use one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, generalized muscle weakness, need for assistance with personal care, bacteremia, severe sepsis with septic shock, a personal history of other infectious and parasitic diseases, and unspecified malignant neoplasm of the colon (colon cancer). (continued on next page)

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	055869	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East Orangeburg Avenue Modesto, CA 95350

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2025, revealed Resident #111 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #111 was dependent on staff for toileting hygiene and required substantial/maximal assistance from staff with showering/bathing, personal hygiene, and dressing of the upper body and lower body. The MDS indicated Resident #111 was dependent on staff for transferring to and from bed. Resident #111's Care Plan Report included a focus area initiated on 03/05/2025 that indicated the resident required tube feeding (gastrostomy tube) related to swallowing problems. Interventions informed staff that the resident was dependent on tube feeding and water flushes (initiated 03/05/2025). The Care Plan Report included a focus area initiated 03/05/2025, that indicated Resident #111 had an indwelling urinary catheter due to urinary retention. Interventions directed staff to position the catheter bag below the level of the bladder (initiated 03/05/2025). The Care Plan Report included a focus area initiated 03/05/2025, that indicated the resident had potential/actual impairment to their skin integrity related to a coccyx wound cleanse. Interventions directed staff to monitor/document location, size, and treatment of skin injury (initiated 03/05/2025). On 03/11/2025 at 11:35 AM, an observation was made of Licensed Vocational Nurse (LVN) #14 administering medications to Resident #111 by the resident's gastrostomy tube. LVN #14 entered the resident's room, checked placement of the gastrostomy tube, flushed the gastrostomy tube, and gave the medications via gastrostomy tube. LVN #14 wore gloves but had not donned a gown prior to entering the resident's room. LVN #14 was interviewed on 03/11/2025 at 11:50 AM. LVN #14 stated she had not heard the term enhanced barrier precaution and had not received education instructing her to wear a gown when caring for a resident with a feeding tube or urinary catheter. LVN #14 stated she was unaware she should have worn a gown when administering medications to Resident #111 via gastrostomy tube. On 03/11/2025 at 11:40 AM, Certified Nursing Assistant (CNA) #1 was observed moving Resident #111's urinary catheter drainage bag from the foot of the bed to the side of the bed on a lower rail. CNA #1 donned gloves before moving the urinary catheter drainage bag but had not donned a gown. During a concurrent interview, CNA #1 stated he was unaware of the term enhanced barrier precaution and had not been taught that a gown was needed when caring for a resident with an indwelling urinary catheter. During an observation on 03/12/2025 at 8:53 AM, the Director of Staff Development (DSD), who was also the wound care nurse, changed a wound dressing for Resident #111. Resident #111's room had an EBP sign on the doorframe. The DSD used hand sanitizer prior to donning gown and gloves. CNA #1 assisted the DSD to turn the resident onto their right side. The DSD removed her gloves and donned clean gloves without using hand sanitizer or washing her hands. The DSD removed Resident #111's wound dressings. An outline of wound drainage was seen on the dressings. After cleaning the wound, the DSD removed her gloves and donned new gloves without using hand sanitizer or washing her hands. The DSD applied skin preparation (a product used to help protect the area of skin around the wound and to help the dressing adhere better to the resident's skin). The DSD removed her gloves and before donning clean gloves she was stopped. During a concurrent interview, the DSD stated she knew she should have cleaned her hands before donning new gloves but had been nervous and forgot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/12/2025 at 8:53 AM, CNA #1 assisted the DSD with wound care for Resident #111. CNA #1 donned a gown and gloves prior to assisting the DSD with positioning of the resident. At 9:11 AM, CNA #1 began to provide Resident #111 with a bed bath without removing the gloves he used for assisting with wound care. CNA #1 washed Resident #111's face and upper body and provided catheter care for the resident without changing gloves. CNA #1 then washed the resident's buttocks and anal area. Without changing gloves, CNA #1 opened a container of moisture barrier and applied the moisture barrier to the resident's buttocks and anal area. CNA #1 did not change the gloves he was wearing. CNA #1 then applied a clean brief to Resident #111. CNA #1 touched the resident's pillow and bare arm and placed a clean gown on the resident. CNA #1 then emptied the resident's catheter drainage bag and placed the dirty linens and clothes in a bag. Wearing the same gloves, CNA #1 placed a blanket across Resident #111. CNA #1 removed his gown and gloves before leaving the room but failed to use hand sanitizer. CNA #1 went into the hall and requested assistance to reposition Resident #111, retrieved the dirty linen cart, and before entering the resident's room again donned a clean gown and gloves but did not use hand sanitizer or wash his hands. After repositioning Resident #111, CNA #1 removed their gown and gloves and, without using hand sanitizer, donned clean gloves to empty the resident's urinal after emptying the catheter drainage bag. CNA #1 then removed his gloves and used hand sanitizer. Without using gloves, CNA #1 emptied the dirty bath water, dried the wash basin with paper towels, and then used hand sanitizer. CNA #1 was interviewed on 03/12/2025 at 9:33 AM. CNA #1 stated he usually changed gloves between dirty and clean tasks but had not changed gloves during the resident's bath because he had been nervous. CNA #1 stated he had not used gloves to empty the bath water and stated he did not usually use gloves to empty dirty bath water. During an interview on 03/11/2025 at 11:55 AM, the Infection Preventionist (IP) stated she had read about EBP and knew staff should wear gowns and gloves when providing care for residents with gastrostomy tubes, indwelling urinary catheters, and wounds, but had not discussed what she had read with the Director of Nursing (DON). The IP confirmed the staff had not received any training on EBP and confirmed EBP signage had not been posted. The IP stated she was unsure if the facility had an EBP policy. The DON was interviewed on 03/11/2025 at 12:00 PM. The DON stated EBP should be used with any resident that had the potential to transmit body fluids to the staff. The DON stated these included residents that had urinary catheters, gastrostomy tubes, and wounds. The DON stated there had been no staff training on EBP. During an interview on 03/12/2025 at 9:58 AM, the DON stated that when gloves were removed the best practice was to use hand sanitizer before new gloves were donned, and gloves were expected to be changed between dirty and clean tasks. The DON stated she expected CNA #1 to remove their gloves after applying the moisture barrier to Resident #111's buttocks and before touching clean briefs or linens and expected the CNA to wear gloves when the dirty bath water was dumped. During an interview on 03/13/2025 at 1:27 PM, the Administrator stated he expected personal protective equipment (PPE) to be worn for residents that required EBP when care was provided. The Administrator stated he expected staff to wash or sanitize hands and change gloves between dirty and clean tasks and when involved in dirty tasks such as emptying bath water. The Administrator stated if nurses touched medications, he expected them to wear gloves to keep the medication from being absorbed through the skin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/14/2025 at 9:27 AM, Medical Doctor (MD) #5 stated that when a resident required EBP he expected staff to wear PPE during the provision of care to prevent the spread of germs. MD #5 stated he expected gloves to be changed between dirty and clean tasks and added that after touching the catheter, CNA #1 should have removed their gloves and donned clean gloves. MD #5 stated any body cavity was a dirty area and CNA #1 should have changed gloves after applying cream to the resident's buttocks. 2. A facility policy titled, Enhanced Barrier Precautions, dated 08/2022, revealed Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-frug resistant organisms (MDROs) to residents. The policy revealed, 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. The policy revealed, 3. Exampled of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. [et cetera; and so forth]); and h. wound care (any skin opening requiring a dressing. Per the policy, 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. The policy revealed, 9. Staff are trained prior to caring for residents on EBPs. An Admission Record revealed the facility admitted Resident #24 on 02/18/2025. According to the Admission Record, the resident had a medical history that included diagnoses of sepsis, need for assistance with personal care, disorder of the kidney and ureter, and dependence on renal dialysis. Resident #24's Care Plan Report, included a focus area initiated 01/17/2025, that indicated the resident needed dialysis related to renal failure. Interventions directed staff to check and change dressing daily at access site (initiated 01/17/2025). The Care Plan Report included a focus area initiated 02/18/2025, that indicated the resident had the potential impairment to skin integrity related to fragile skin. The focus area revealed the resident had an ulcer to their right toe and ischium. Interventions directed staff to provide treatment as ordered (initiated 03/10/2025). During an observation on 03/12/2025 at 8:14 AM, Certified Nursing Assistant (CNA) #20 entered Resident #24's room which had an enhanced barrier precaution (EBP) sign on the door. CNA #20 was observed assisting Resident #24 stand and pivot from the bed to the wheelchair. CNA #20 was holding the resident's arm with one hand and had her arm under the resident's other arm. CNA #20 wore no gloves and no gown when she placed the resident in the wheelchair during the transfer. When the transfer was completed, CNA #20 donned gloves but no gown and removed the linens from the resident's bed. CNA #20 was interviewed on 03/12/2025 at 8:38 AM. CNA #20 stated she had been taught if someone was on EBP she was supposed to wear personal protective equipment (PPE) when care was provided. CNA #20 stated the EBP sign on the door was for Resident #24. CNA #20 stated she had been told she did not have to wear a gown or gloves when a resident was transferred. CNA #20 stated she knew she should have worn a gown and gloves when removing linens, but she had forgotten to put a gown on to prevent from being exposed to germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/11/2025 at 11:55 AM, the Infection Preventionist (IP) stated she had read about EBP and knew staff should wear gowns and gloves when providing care for residents with gastrostomy tubes, indwelling urinary catheters, and wounds, but had not discussed what she had read with the Director of Nursing (DON). The IP confirmed the staff had not received any training on EBP and confirmed EBP signage had not been posted. The IP stated she was unsure if the facility had an EBP policy. The DON was interviewed on 03/11/2025 at 12:00 PM. The DON stated EBP should be used with any resident that had the potential to transmit body fluids to the staff. The DON stated these included residents that had urinary catheters, gastrostomy tubes, and wounds. The DON stated there had been no staff training on EBP. During an interview on 03/13/2025 at 1:27 PM, the Administrator stated he expected PPE to be worn for residents that required EBP when care was provided. During an interview on 03/14/2025 at 9:27 AM, Medical Doctor (MD) #5 stated that when a resident required EBP he expected staff to wear PPE during the provision of care to prevent the spread of germs. 3. A facility policy titled, Infection Control, revised 10/2028, revealed, This facility's infection control policies and practices are intended to facility maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. An observation was made on 03/12/2025 at 8:24 AM of Registered Nurse (RN) #9 preparing medications for Resident #46. During the preparation of medications, RN #9 punched losartan 25 milligrams (mg) 1/2 tablet out of the medication card and used his bare fingers to place the medication into a cup. RN #9 then removed a methadone 10 mg tablet out of the medication card and used his bare fingers to place the tablet into the medication cup. The medications were then crushed, mixed with applesauce, and given to the resident. During an interview on 03/12/2025 at 8:32 AM, RN #9 stated he had received no education indicating medications could not be touched with bare hands, but added he tried not to touch medications. During an interview on 03/12/2025 at 9:58 AM, the DON stated RN #9 was not expected to touch medication with their bare hands due to the risk of contamination.