STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055886	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Care Center	1161 Cirby Way Roseville, CA 95661

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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 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** 45770 Based on observation, interview, and record review the facility failed to follow its own policy for medication self-administration for one of 36 sampled residents (Resident 422) when the facility did not obtain a physician's order for Resident 422 to self-administer medications. This failure had the potential to result in an unsafe medication self-administration. Findings: A review of Resident 422's Admission Record indicated she was admitted [DATE] with diagnoses including the presence of intraocular lens to both eyes. During a concurrent observation and interview on 5/6/24 at 8:40 a.m. inside Resident 422's room, observed Resident 422 instill own eye drops after Licensed Nurse 16 (LN 16) handed her the vial of a single use eye drop. Resident 422 was not instructed to do hand hygiene before administration and stated she wanted to reuse the used vial. A review of Resident 422's Order Summary Report, dated 4/26/24, indicated an order for cyclosporine emulsion 0.05% (eye drop medication for dry eyes due to inflammation) one drop to both eyes twice a day for dry eyes. There was no documented order for medication self-administration. In a concurrent interview and record review on 5/7/24 at 9 a.m. with LN 16, a Physician Order was reviewed for Resident 422. LN 16 acknowledged Resident 422 administered her own eye drops without a doctor's order and proper assessment. In an interview on 5/9/24 at 10:10 a.m. with the Director of Nursing (DON), the DON stated Resident 422 should have been assessed if she's capable to administer her own medication safely and a doctor's order should have been obtained before she was allowed to administer her own medications. A review of the facility's Policy and Procedure (P&P) titled Administering Medications revised 4/23, stipulated, Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Planning Team, has determined that they have the decision-making capacity to do so safely.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48694 Based on observation, interview, and record review, the facility failed to ensure the protection of residents' personal information for census of 179, when tray tickets were thrown into the trash and outside dumpsters. This failure had the potential to place resident personal information at risk for misuse. Findings: During a concurrent observation and interview on 5/6/24 at 8:47 a.m. with Dietary Aide 1 (DA 1) and Assistant Dietary Services Supervisor (ADSS) in the kitchen, the DA 1 was observed stripping the breakfast trays. The DA 1 was throwing the meal tickets into the regular trash along with food scraps. The meal tickets contained the resident's name, resident's ID (medical record number), room number, diet order, food allergies, food preferences, and special instructions. The ADSS stated this was their process for disposing of the meal tickets . During an interview on 5/6/24 at 8:55 a.m. with the Dietary Services Supervisor (DSS) in the kitchen, the DSS stated there was no other method of disposing of meal tickets. During an interview on 5/8/24 at 3:04 p.m., with the Director of Nursing (DON), the DON stated for privacy and confidentiality concerns, all meal tickets should be shredded after recording the intake information. During a review of the facility's policy and procedure (P&P) titled, Confidentiality of Information and Personal Privacy, dated September 2023, the P&P indicated, .The facility will safeguard the personal privacy and confidentiality of all residents personal and medical records .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 45770 Based on interview and record review the facility failed to ensure a Significant Change of Status Assessment (SCSA) was completed within 14 days after discharging from Hospice Care (end of life care) for one of 36 sampled residents (Resident 97). This failure decreased the facility's potential of providing appropriate care and services to Resident 97 based on his current status. Findings: A review of Resident 97's Admission Record indicated he was admitted in 2/24 with diagnoses including bladder cancer. A review of Resident 97's Order Summary Report, dated 4/10/24, indicated Resident 97 was admitted to Hospice Care due to bladder cancer. A review of Resident 97's Minimum Data Set (MDS, an assessment tool) dated 4/14/24, indicated an SCSA was initiated and completed due to admission to Hospice Care and a change in cognition. A review of a document titled, Revocation of the Election of Hospice Care, dated 4/15/24, indicated Resident 97's family decided to discontinue his enrollment from Hospice Care. A review of Resident 97's MDS assessments indicated no SCSA had been initiated 14 days or sooner after discharge from Hospice Care on 4/15/24. In an interview on 5/8/24 at 11 a.m. with the MDS Coordinator (MDSC), the MDSC confirmed Resident 97 was discharged from Hospice Care per family request and an SCSA should have been generated. In an interview on 5/8/24 at 2:35 p.m. with the MDS Consultant (MDS Con) the MDS Con stated an SCSA should have been developed and completed for Resident 97 when his family elected to discontinue Hospice Care. The MDS Con stated as a general rule, an SCSA should be done whenever a resident is admitted or discharged from Hospice Care to reflect their current status. A review of the facility's Policy and Procedure (P&P) titled, Resident Assessments revised 10/23, indicated The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44971 Based on observation, interview, and record review, the facility failed to accurately assess three of 36 sampled residents (Resident 101, Resident 88, and Resident 143), when: 1. Resident 101's Minimum Data Set (MDS; an assessment tool) indicated restorative nursing program (RNA; a program to maintain a person's highest level of physical, mental, and psychosocial function) was not performed; 2. Resident 88's MDS assessment did not reflect continuous oxygen use; and, 3. Resident 143's MDS wound assessment was coded inaccurately. These failures decreased the facility's potential to identify residents' care needs accurately. Findings: 1. A review of Resident 101's Admission Record, indicated Resident 101 was admitted to the facility in May 2022 with diagnoses including lumbar (lower back) region spondylosis (age-related wear and tear of the spinal disks), muscle weakness and abnormalities of gait and mobility. A review of Resident 101's MDS, dated [DATE], indicated RNA program was not performed in the last seven calendar days for Resident 101. A review of Resident 101's Nursing-RNA Weekly Summary, dated 11/23/23, indicated Resident 101 was seen twice by RNA in the last week and was provided with active range of motion (ROM) exercises for bilateral upper and lower extremities. The RNA Weekly Summary further indicated gentle stretches were provided to Resident 101 prior to active ROM to bilateral lower extremities using omnicycle (advanced therapeutic exercise system) for 15 minutes. A review of Resident 101's Order Listing Report, dated 5/9/24, indicated Resident 101 started on 9/7/23 to receive RNA program exercises twice a week for her bilateral upper and lower extremities. A review of Resident 101's Care Plan, dated 9/5/23, indicated Resident 101 required RNA for bilateral upper and lower extremities. During an interview on 5/9/24 at 9:18 a.m. with MDS Coordinator (MDSC), MDSC confirmed Resident 101's MDS was inaccurate and stated Resident 101 received RNA and MDS data should have been accurate because it could have impacted Resident 101's plan of care. During an interview on 5/9/24 at 9:43 a.m. with Director of Nursing (DON), DON confirmed Resident 101's MDS was inaccurate and stated an inaccurate MDS might impact the plan of care. A review of the facility's policy titled, Resident Assessments, dated 10/23, indicated Persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45770 2. A review of Resident 88's Admission Record indicated she was admitted in March 2024 with diagnoses including chronic respiratory failure (a long-term condition that inhibits the body from exchanging oxygen and carbon dioxide effectively) and infection of a dehisced wound to the back of the neck. During an observation and interview on 5/6/24 at 9:31 a.m., Resident 88 was seen in bed using oxygen. According to Resident 88, she used oxygen all the time. A review of an Order Summary Report for 5/24 indicated Resident 88 had an order for the continuous use of oxygen 2 liters per minute via nasal cannula due to shortness of breath. In a concurrent interview and record review on 5/8/24 at 11 a.m. with the MDS Coordinator (MDSC), MDSC acknowledged the MDS assessment completed for Resident 88 on 3/28/24 was inaccurate, and that Resident 88's use of oxygen should have been coded accordingly. 3. A review of an Admission Record for Resident 143 indicated he was originally admitted first week of 3/24 with diagnoses including difficulty in walking and muscle weakness. A review of Resident 143's Order Summary Report for 5/24 indicated he was admitted with a stage 3 pressure ulcer (PU) to the coccyx (full thickness wound to the tailbone) and an unstageable wound to the mid back. A review of the MDS Discharge assessment dated [DATE] indicated Resident 143 was sent to the general acute care hospital for further evaluation. A review of both MDS Admission Assessment (AA) dated 3/5/24 and Discharge Assessment (DA) on 3/16/24 for Resident 143 it indicated a discrepancy on how the PUs were coded. The AA indicated only one stage 3 PU present on admission. The DA indicated there were two stage 3 PUs present on admission. In an interview on 3/8/24 at 11 a.m. with the MDSC, she stated Resident 143's MDS wound assessments on admission (3/5/24) and discharge (3/16/24) were not coded accurately, there should have been only one stage 3 PU present on admission not two. In an interview on 5/9/24 at 10:10 a.m. with the DON, the DON stated she expects all the staff members who are assigned in assessing the residents should be thorough, should complete the assessments properly and on time to make sure the residents are receiving the care they needed. A review of the facility's Policy and Procedure (P&P) titled Resident Assessments revised 10/23, indicated, The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments .Assessments are completed by staff members who are knowledgeable about the resident's needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39489 Based on observation, interview, and record review, the facility failed to provide services according to professional standards of quality for four of 36 sampled residents (Resident 223, Resident 43, Resident 88, and Resident 525), when: 1. Resident 223 was not monitored after an unwitnessed fall as indicated in the physician's order; 2. Resident 43's diet order was not followed as indicated in physician's order; 3. Resident 88's intravenous (IV, delivered into a vein by injection or through a catheter) antibiotic order was not administered on time; and, 4. Resident 525's Oxycodone (a medication to treat pain) order was not followed as indicated in physician's order. These failures decreased the facility's potential to safely implement the physician's orders. Findings: 1. A review of Resident 223's Clinical Record indicated Resident 223 was admitted to the facility in April 2024 with diagnoses that included unspecified fracture of facial bones, muscle weakness, nontraumatic subarachnoid hemorrhage (bleeding within the brain) and history of falling. During a review of Resident 223's Minimum Data Set (MDS; an assessment tool), dated 4/25/24, Cognitive Patterns Section C, indicated a score of eleven of fifteen, meaning moderate mental impairment. A review of Resident 223's Progress Notes, dated 5/5/24, indicated, @ [at] 0615 am Resident has unwitnessed fall ., patient complain [sic] he was trying to go to toilet. A review of Resident 223's Progress Notes, dated 5/5/24, indicated the on-call doctor ordered to evaluate and monitor Resident 223 for 72 hours after the fall as follows: Every 15 minutes for 4 times; every 30 minutes for 4 times; every hour for 4 times; every 4 hours for 2 days. A review of Resident 223's NAF (Neurological Assessment Flowsheet) tool, initiated on 5/5/24, showed nurses monitored Resident 223 every 15 minutes for 4 times; every 30 minutes for 2 times; every hour for 2 times; every 2 hours for 2 times; every 4 hours for 4 times and every 8 hours for 6 times. During a concurrent observation and interview on 5/8/24 at 10 a.m., with LN 14, LN 14 stated, We must perform 72 hours assessment after head injury using the NAF tool and monitor the resident especially when they suffered from unwitnessed falls, and yes, we should follow the physician's order. During a concurrent observation and interview on 5/8/24 at 10:25 a.m., with LN 9, LN 9 confirmed Resident 223 had an unwitnessed fall on 5/5/24 during night shift, the NAF sheet was completed, and the medical record staff had collected the sheet. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/8/24 at 10:30 a.m., with the Medical Record Assistant (MRA), the MRA acknowledged she collected Resident 223's NAF sheet and was about to scan and file it in the resident's EHR. During an observation and interview on 5/8/24 at 12:15 p.m., with the Director of Nursing (DON) at her office, the DON confirmed and acknowledged that based on the physician's order documented in the progress note dated 5/5/24 at 3:02 p.m., the frequency and duration done in the NAF sheet showed the nurses did not follow the physician's order. The DON further stated the nurses should have informed the physician about the ongoing NAF and started a new set of assessment based on the physician's order. During a review of the facility's policy and procedure (P&P) titled, Physician Orders, dated October 2022, indicated, . The license staff shall carry out physician/nurse practitioner's order as prescribed . 44971 2. A review of Resident 43's Admission Record, indicated she was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing). A review of Resident 43's Minimum Data Set (MDS; an assessment tool), dated 3/16/24, indicated Brief Interview of Mental Status (BIMS) score was 12 of 15 with some memory problems. During a concurrent observation and interview on 5/6/24 at 12:38 p.m. with Activities Director (AD) in the facility's dining room, Resident 43 was eating her lunch and drinking from a cup using a straw. Resident 43's meal tray ticket placed on the dining table indicated Adaptive Equipment: No Straws. AD confirmed Resident 43 was drinking using a straw and her meal tray ticket indicated Adaptive Equipment: No Straws. During a concurrent observation and interview on 5/7/24 at 12:17 p.m. with Resident 43 in the facility's dining room, Resident 43 was eating her lunch and drinking from a cup using a straw. Resident 43 stated she was drinking hot tea. During an observation on 5/7/24 at 11 a.m. in Resident 43's room, water pitcher was placed at bedside with a straw. During an interview on 5/8/24 at 10:15 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 43 had been drinking water from her pitcher using a straw since she had been taking care of her for a while. A review of Resident 43's Order Listing Report, dated 5/8/24, indicated Resident 43 should have no straw with her regular diet and thin liquids. A review of Resident 43's Annual Nutritional Risk Assessment, dated 12/30/23, indicated Resident 43's diet order was regular with thin liquids consistency and no straw. A review of Resident 43's Nutrition Care Plan, dated 9/25/23, indicated diet as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 9:55 a.m. with Speech Therapist (ST), ST stated she did not know why Resident 43 had a physician order indicating not to provide her with a straw. ST further stated Resident 43's order and care plan were not followed before she formally assessed Resident 43. During an interview on 5/8/24 at 11:11 a.m. with DON, DON stated Resident 43's physician order and care plan were not followed which could have potentially increased Resident 43's risk for aspiration. A review of the facility's policy titled, Physician Orders, dated 10/23, indicated The licensed staff shall carry out physician .orders as prescribed. 47563 4. A record review of Resident 525's admission record indicated Resident 525 was admitted in early May 2024 for aftercare following right hip replacement surgery. A review of Resident 525's OSR for active orders as of 5/9/2024, indicated Resident 525 was prescribed, [Oxycodone] Oral Tablet 5 MG [milligram a unit of measure] .Give 3 tablet by mouth every 4 hours as needed for severe pain . start date 5/2/2024 . An interview on 5/8/24 at 4:07 p.m., LN 12 stated when giving a resident a controlled drug (drugs that can cause physical and mental dependence), nurses are expected to document the time and how many tablets/pills given to the resident on the controlled drug record form as well as document in the resident's electronic health record (EHR). LN 12 added the EHR will indicate the accurate time when the controlled drug was administered to the resident. During a concurrent interview and record review on 5/9/24 at 8:34 a.m. with LN 13 and the DON, Resident 525's EHR and progress notes, dated 5/5/24, were reviewed. LN 13 confirmed Resident 525's EHR indicated 3 pills of Oxycodone 5mg had been given at 3:17 a.m. and again at 5:36 a.m. LN 13 stated the order for Oxycodone indicated it should be given at least four hours apart and that the record indicated it had been given about two and a half hours apart. LN 13 added she would have expected to see a progress note indicating the doctor was contacted and approved the drug to be administered earlier than the four hours. LN 13 reviewed Resident 525's progress notes and stated there was no progress note indicating a reason for Resident 525 to be administered Oxycodone early. The DON confirmed Resident 525 had been administered Oxycodone before at least four hours had elapsed. The DON added the nurse who administered the Oxycodone was not following doctor's orders, was not handling controlled drugs per the facility's policy, and put Resident 525 at an increased risk for respiratory depression (when breathing slows). A review of the facility's P&P titled, controlled Medication, reviewed September 2023, indicated, .when a controlled medication is administered, the licensed nurse administering the medication enters the following information on the accountability record and the medication administration record (MAR): 1) date and time of administration 2) amount administered 3) the signature of the nurse administering the dose, completed after the medication is administered . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Physician Orders revised October 2023, indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner/physician assistant order . medication and treatments shall be administered only upon the order of a person duly licensed and authorized to prescribe such medications and treatments . 45770 3. A review of Resident 88's Admission Record indicated she was admitted in 3/24 with diagnoses including infection of a dehisced wound (reopened wound) to the back of the neck. On 5/7/24 at 9:40 a.m. inside Resident 88's room, Licensed Nurse 2 (LN 2) was observed administering Resident 88's intravenous antibiotic (IV antibiotic). LN 2 stated the IV antibiotic was ordered to be given every eight hours around the clock for Resident 88's wound at the back of the neck. A review of Resident 88's Order Summary Report, dated 5/3/24, indicated an order for Meropenem (intravenous medication used to treat complicated skin infections) 1 gram (gm, unit of measurement) to be given intravenously every 8 hours for infection until 5/10/24. A review of a May 2024 Medication Administration Record (MAR) for Resident 88 indicated Meropenem 1 gram IV should be given every 8 hours, at 12 midnight, 8 a.m., and 4 p.m. In an interview on 5/7/24 at 10 a.m. with LN 2, LN 2 acknowledged that she administered the IV antibiotic late. In an interview on 5/9/24 at 11 a.m. with the Director of Nursing (DON), the DON agreed that LN 2 was late administering Resident 88's IV antibiotic. It should have been given an hour before or an hour after its scheduled time of administration. A review of the facility's P&P titled Administering Medications revised 4/23, stipulated Medications are administered in a safe and timely manner as prescribed .Medications are administered within one (1) hour before and (1) hour after the prescribed time, unless otherwise specified.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on observation, interview, and record review the facility failed to provide proper care and services to one of 36 sampled residents (Resident 420) when Resident 420's order for enteral feeding (a method of providing nutrient directly to the stomach or small bowel using a tube) did not include the kind of feeding formula to be infused, its duration, and the mechanism of administration. This failure had the potential to cause an error during administration of the feeding. Findings: A review of an Admission Record for Resident 420 indicated he was admitted [DATE] with diagnoses including cancer of the tonsils and the presence of a feeding tube. On 5/6/24 at 11 a.m. during an observation inside Resident 420's room, a half-filled bottle of enteral feeding formula was hanging by the side of the bed, which indicated the formula was hung on 5/5/24 at 3:32 p.m. A review of Resident 420's Order Summary Report (OSR) for 5/2/24 indicated an incomplete order for an enteral feeding; the order did not include the following components an enteral feeding order should have: what kind of formula to use, when to start and end the feeding, the duration of the feeding, how much caloric value the resident should have, and the manner of administration. In a concurrent interview and record review on 5/6/24 at 11 a.m. the OSR was reviewed with Licensed Nurse 16 (LN 16). LN 16 confirmed Resident 420 had a feeding tube placed recently and an order to start enteral feeding was just initiated. LN 16 agreed that the enteral feeding order for Resident 420 was incomplete and inaccurate and further stated the order should have been modified so that the LNs would be able to know the right kind of formula to give, when to start the feeding, and how many liters per hour should be infused. In an interview on 5/9/24 at 11 a.m. with the Director of Nursing (DON), the DON stated the order developed for Resident 420's enteral feeding was incomplete. The nursing staff should have transcribed and followed the doctor's order accordingly. A review of the facility's Policy and Procedure titled Enteral Feedings reviewed 9/23, indicated Check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID and room number; b. Type of formula; c. Route of delivery; d. Access site; e. Method (pump, gravity, syringe): and Rate of administration (ml/hour).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48874 Based on observation, interview, and record review the facility failed to adequately maintain pharmacy services for 3 out of a census of 185 when: 1. An injectable Emergency medication box with a fill date of 2/29/24 was found to be opened and unsealed without proper documentation and not replaced within 72 hours; 2. An Emergency medication E-kit (a box with a supply of medications that may be used for residents when pharmacy services are not available) in the refrigerator was accessed and used without proper documentation when one used lorazepam (a medication used to treat mood disorders) injectable medication was not documented; 3. Prescription medication for 3 residents (Resident 97, Resident 114, and Resident 7) were not available at the time of administration; and, 4. A dose of lacosamide (a medication given for seizures) was given and not signed on out by the LN (Licensed Nurse). This failure had the potential to cause inaccurate accountability of controlled medications, unauthorized individuals' access to controlled medications and worsening of the resident's clinical condition. 1. In a concurrent observation and interview in Station B2 medication room on 5/6/24 at 2:24 p.m. with LN 4, there was an E-kit #057 that had been opened with a filled date of 2/29/24. This E-kit included several injectable (medications given using a needle and syringe), nasal, and oral suspension (a medication containing solid particles of active ingredients dispersed in liquid) medications. LN 4 acknowledged that the E-kit had a date of 2/29/24. LN 4 stated the E-kit should have been replaced. In an interview with the DON (Director of Nursing) on 5/7/24 at 2:10 p.m., the DON stated her expectation is the LNs (Licensed Nurses) sign out a medication on the E-kit log at the time they take the medication. She stated the LN did not follow the process. She acknowledged that the pharmacy was not contacted to replace the E-kit. In a review of facility policy tilted, Emergency Kits dated May 2023, it indicated, As soon as possible, the nurse records the medication use and if exchanging kits, opened kits exchanged within 72 hours of opening. 2. In an observation of Station B2 medication room on 5/6/24 at 2:35 p.m. with LN 4, There was an E- kit #081. The E-kit had been opened. In a review of the Emergency Kit Log, it showed a lorazepam vial was signed out on 5/6/24 at 12:50 pm. There was one vial of Lorazepam that was missing and no emergency kit log slip record documenting who took out the medication. LN 4 acknowledged that one Lorazepam vial was missing and should have been recorded in the medication log. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 5/6/24 at 3:05 p.m. with LN 4, four other medication rooms throughout the facility were checked for the missing log slip from E-kit #081. The log slip was not located. In an interview on 5/6/24 at 3:09 p.m. with LN 10, LN 10 stated that the medical record department would have a record of the missing of slip from E-kit #081. In an interview on 5/8/24 at 3:07 p.m. with the medical records director, she stated that she not find a record of the missing log slip from E-kit #081. She stated that if is is not there, it didn't exist, and the nurses did not fill one out. In an interview on 5/7/24 at 2:10 p.m. with the DON, she stated she thought that LN 4 took the Lorazepam from for Resident 103-that was having a seizure (a condition where the brain sends message to the body resulting in involuntary movements) and got an order to give another dose if she was still having a seizure. In a record review of Resident's 103 E-MAR (electronic medication administration record) dated 5/6/24 indicated that Resident 103 was given Lorazepam 0.5 ml at 12:56 pm. In an interview on 5/7/24 at 2:20 p.m. with the DON, the DON stated her expectation that the LN notify the pharmacy and sign the medication out when LN takes it. The DON stated there needs to be accurate record of E-kit medications. In a review of facility's policy titled, Emergency Kits, revised May 2023, it indicated, As soon as possible, the nurse records medication use. 3. In a concurrent observation and interview of medication pass on 5/6/24 at 8:16 a.m. with LN 1, LN stated he had all his medications needed for his medication pass today. In an interview on 5/6/24 at 8:26 a.m. with LN 1, LN stated he did not have the following medications for his morning medication pass the following residents: Resident 97-phenazopyridine, Resident 114-rivaroxaban and Resident 7- escitalopram. During a review of Resident 97's admission record, the review indicated that Resident 97 was admitted in the winter of 2024 with multiple diagnoses including multiple neoplasm of the bladder (bladder cancer), infection and inflammation (swelling) reaction due to nephrostomy catheter (a tube inserted into the kidney to help drain urine) and cystitis (swelling of the bladder) unspecified without hematuria (blood in the urine). During a review of Resident 97 physician orders, dated 4/10/24, indicated that phenazopyridine (a medication used to relive pain with urination) 100 mg (unit of measurement) tablets, 1 tablet was to give every eight hours for dysuria (pain with urination). An order summary review dated 5/7/23, indicated Resident 97 was prescribed Phenazopyridine HCL oral tablet 100 mg-to be given by mouth every 8 hours for dysuria on 2/2/14. In an interview with LN 1 on 5/6/24 at 8:30 a.m., LN stated the medication was not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 114's order summary report dated 5/7/24, the review indicated that Resident 114 was admitted to the facility in the winter of 2023 with multiple diagnoses including: Other pulmonary embolism without acute cor pulmonale (heart condition) and hypertension (high blood pressure). During a review of Resident 114's order summary report dated 5/7/24, the review indicated that Resident 114 was prescribed: rivaroxaban (a medication used to treat and prevent blood clots) oral tablet 10 mg- 1 tablet was to be given by mouth one time a day for A-fibrillation (abnormal heartbeat). A review of an order summary dated 5/7/24 indicated Resident 114 was prescribed rivaroxaban oral tablet 10 mg-give 1 tablet by mouth one time a day for a-fib (abnormal heartbeat). In an interview with LN 1 on 5/6/24 at 8:30 a.m., LN stated the medication was not given. During a review of Resident 7's order summary report dated 5/7/24, the review indicated that Resident 7 was admitted to the facility in the spring of 2016 with several diagnoses including: Major depressive disorder, single episode, unspecified (an illness causing long term sadness) on 6/23/23. During a review of Resident 7's order summary report dated 5/7/24, the review indicated that Resident 7 was prescribed escitalopram (a medication used to treat problems with mood) tablet 10 mg-one tablet was to be given by mouth one time a day related to major depressive disorder as manifested by verbalization of sadness on 10/12/22. A review of Resident 7's order summary review dated 5/7/24, indicated Resident 7 was prescribed escitalopram 10 mg tablet-give one time a day related to depressive disorder manifested by verbalization of sadness. During an interview with the Director of Nursing (DON) on 5/9/24 at 7:58 a.m., the DON stated that is a medication is not available the LN should call the pharmacy. If the pharmacy can't provide the medication, the LN should call the doctor and get an alternative order if possible. DON stated they would need to investigate to see why the mediation was not delivered. A review of the facility's policy titled, Administering Medications revised April 2023, indicated, Medications are to be administered in accordance with prescriber orders, including any required time frame. 4. In an observation of medication cart, A-1 with LN 5 on 5/7/24 at 10:09 a.m., LN 5 took a dose of lacosamide out for a resident but did not record it in the controlled medication binder. In an interview with LN 5 on 5/27/24 at 10:15 am, LN 5 stated that she gave the dose of the medication at 9:05 am and should have signed it out in the binder. During an interview with the Director of Nursing (DON) on 5/7/24 at 2:26 p.m., the DON stated her expectation is that the LN should have logged the medication on the Narcotic Sheet before giving the medication. she further stated a failure to do so could result in an incorrect count.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40867 Based on observation, interview and record review, the facility did not ensure the medication error rate was less than 5% when a medication was not available for one resident, an extended release medication was crushed, and a chewable aspirin was given and not the delayed release medication. This failure resulted in 3 errors out of 28 opportunities during an observation of medication administration, which resulted in an error rate of 10.71 % for the faclility. Findings: During a medication pass observation on 5/6/24 at 8:26 a.m., with LN 1 (Licensed Nurse), LN 1 was observed preparing Resident's morning medicaions which did not include Phenazopyridine. In an interview with LN 1 on 5/6/24 at 8:30 am, LN 1 stated that the morning dose of phenazopyridine (medication used to treat pain experienced during urination) was not available to be administered with Resident 97's other medications. A review of Resident 97's physician orders, dated 4/10/24, indicated that phenazopyridine 100 mg tablets (mg = milligram, a unit of measure), 1 tablet was to be given every eight hours for dysuria (pain with urination). During an interview with the Director of Nursing (DON), on 5/9/24 at 7:58 a.m., the DON stated that if a medication is not available the LN should call the pharmacy. If the pharmacy can't provide the medication, the LN should call the doctor and get an alternative order if possible. DON further stated they would need to investigate to see why the mediation was not delivered. During a review of the facility's policy titled, Administering Medications revised April 2023, indicated, Medications are to be administered in accordance with prescriber orders, including any required time frame. During a medication pass observation on 5/6/24 at 8:46 am, LN 2 was observed crushing several medications for Resident 620, including a bupropion XL (an antidepressant medication) 300 mg tablet. In an interview LN 2 on 5/6/24 at 8:50 am, LN 2 acknowledged she crushed the medication, and stated she should not have crushed it since it was extended release (a medication that is released into the body over a specific duration gradually). She stated crushed extended-release medications can affect GI (relating to stomach) issues. She verified that the pharmacy placed an axillary label that stated Do not Crush on the medication package. During a review of Residents 620's physician's orders, dated 4/24/24, bupropion XL 300 mg tablet indicated to give 1 tablet by mouth daily for depression manifested by verbalization of sadness. The order stated may crush medications unless contraindicated. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON in 5/9/24 at 2:10 pm she stated that she did have an issue with the crushing of bupropion. Her expectation is that the LN follow the doctor's orders for administering medications. During a review of the facility policy titled, Administering Medications, revised April 2023, indicated, Medications shall only be crushed when it is appropriate and safe to do so. During a medication pass observation on 5/6/24 at 9:45 am. LN 3 was observed to administer Chewable Aspirin (a medication used for maintenance of cardiovascular issues by decreasing the blood's ability to clot) 81 mg to Resident 621. In a concurrent interview and record review with LN 3 on 5/6/24 at 12:11 pm, LN 3 stated that there are two different aspirin bottles, one for chewable aspirin which has an orange label, and one for delayed release (delayed release; the medication is coated to prevent absorption in the stomach which can cause ulcerations) which has a green label. LN 3 confirmed that she gave the chewable aspirin instead of the delayed release. She verified the physician order which showed the delayed release tablet was ordered. A review of Resident 621's physician orders, dated 5/5/24, indicated that Aspirin 81 mg Delayed Release, 1 tablet was to be given daily for DVT (deep vein thrombosis; blood clots) prophylaxis (prevention). During an interview with the DON, on 5/9/24 at 7:57 a.m., she stated that her expectation is that LNs follow the 6-7 rights for medication administration (right patient, right medication, right dose, right route, right time and right documentation). There may be a reason the physician prescribed the delayed release medication such as the resident may have GI (gastrointestinal, referring to system that digests food) issues. During a review of the facility's policy titled, Administering Medications revised April 2023, indicated, The individual administering medication checks the label to verify the right resident, right medication, right dosage, right time and right method before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48874 Based on observation, interview, and record review the facility failed to ensure medications were properly stored and labeled, when: 1. A partially used Multi dose inhaler was found without an open date label in a medication cart; 2. Two partially used glucose test strips containers without an open date label were found in two medication carts; 3. An intravenous IV antibiotic bag was found on one of the medication carts in the narcotic binder, accessible to residents and unauthorized individuals; 4. A medication cart was left unlocked with one of the drawers open, with four medication blister packs on top accessible to residents and unauthorized individuals; 5. The medication refrigerator was left unlocked with an unlocked medications box inside for controlled medications; and, 6. Five loose pills were found in three medication carts. This failure had the potential for residents to receive medications with unsafe or reduced potency from being used past their discard date or improper storage, and misuse of medications from not being securely stored in the medication carts. Findings: 1. During a concurrent observation and interview of medication cart B2-1 with Licensed Nurse (LN) 7 on 5/7/24 at 10:40 a.m., a box with fluticasone,-umeclidin, and -vilanter (combination of three medications used to help a person with lung problems to improve their breathing) was opened and not dated with an open date. LN 7 verified that it had no open date and stated it should be dated. In an interview on 5/9/24 at 1:50 p.m. with the DON (Director of Nursing), the DON stated that if an inhaler is opened it should be dated. The DON stated that the inhalers are only good for a certain amount of time, and if it is not dated the LN may be using a medication that is not effective. 2. During a medication pass observation with LN 2 on 5/6/24 at 8:46 a.m., a container of glucometer test strips (a device used to measure blood sugar) was opened and being used for Resident 620 and had no open date. LN 2 stated she did not date them because she opened a new container of test strips each day. LN 2 stated they should have an open date to know when they expire. During a concurrent observation and interview of medication cart A1-1 with LN 5 on 5/7/24 at 10:09 a.m., a container of glucometer test strips was opened and showed no open date. LN 5 stated they should have had an expiration date because they should be used within 6 months of opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of product specific instructions, it stated that are test strips are effective 6 months after the date they are opened. In an interview on 5/7/24 at 2 p.m. with the DON, she stated her expectation was that LNs put on open date on the container of glucometer test strips when they are opened. 3. During a medication pass observation on 5/6/24 at 9:18 a.m. with LN 2 on medication cart C3-1, a bag of ceftriaxone (a medication used for infections) IV (medication given in a vein) was observed to be stored inside of the narcotic binder on the medication cart. LN 2 stated she took it from the refrigerator at 7 a.m. and was warming it up. She acknowledged that she should not have left it in the binder and that someone could have taken it. In a review of the ceftriaxone label on 5/6/24 at 9:20 a.m., it indicated the medication should be refrigerated. In an interview on 5/7/24 at 1:58 p.m. with the DON, she stated that the LN should not have left the medication unattended in the binder. She acknowledged that someone could have taken it. She further stated it was not a proper way to warm the medication. Review of the facility policy titled, Storage of Medications dated September 2023, indicated During administration of medication .No medications are kept on the top of the cart. 4. In a concurrent observation and interview on 5/6/24 at 8:16 a.m., a medication cart was observed outside of room [ROOM NUMBER]. The cart was unattended with four blister packs of medication and a medication drawer left open. In an interview with LN 1, LN 1 stated that he should not have left the medication drawer open with four blister packs on the cart. In an interview with the DON on 5/7/24 at 1:45 p.m., the DON stated that the LN should not have left the medications on the medication cart with the drawer unlocked. The DON stated the LN should have put the medications away and locked the cart because a resident or someone else could have taken the medications. Review of facility's policy titled, Storage of Medications dated September 2023, indicated unlocked medication carts are not to be left unattended. 5. In a concurrent observation and interview of medication room A1 with LN 4 on 5/6/24 at 2:22 p.m., a black box in a refrigerator in the medication room was observed. The black box and the refrigerator were not locked. The black box contained eleven syringes for one resident and two other syringes for two other residents. LN 4 verified that the refrigerator and the black box should both have been locked. In an interview with the DON on 5/7/24 at 2:27 p.m., she stated that the black box and refrigerator should be locked, and an LN is assigned the key for each shift. She acknowledged that her concern was that it may be easier for an unauthorized staff member to access narcotics. Review of the facility policy titled, Storage of Medications dated September 2023, indicated, drugs and biologicals used in the facility are stored in locked compartments/areas, and medications requiring refrigeration, including vaccines, are stored in a refrigerator locked at the nurse's station. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. In a concurrent observation and interview of medication cart A1-1 with LN 5 on 5/7/24 at 10:09 a.m., two loose pills were observed at the back of the bottom drawer. LN 5 acknowledged that LNs could pick up a loose pill by mistake and confirmed that loose pills should not be on the cart. In a concurrent observation and interview of medication cart B2-1 with LN 6 on 5/7/24 at 10:40 a.m., a loose pill was observed at the back of the second drawer. LN 6 confirmed that loose pills should be placed in the drug buster (a solution used to destroy medications). In a concurrent observation and interview of medication cart D4-2 with LN 9 on 5/7/24 at 11:31 a.m., loose pills were found in the cart. One whole and several half tablets were found that were different pills. She stated if she found loose pills, she would have put them in the drug buster. In an interview with the DON on 5/7/24 at 2:04 a.m., she stated that there should be no loose pills on the medication carts. She stated the medications carts are cleaned monthly by housekeeping and it was the responsibility of the LN to remove any loose medications before the carts are cleaned. She stated that any of these pills should be disposed of in the drug buster. Review of the facility policy titled, Storage of Medications' dated September 2023, indicated, Discontinued, outdated, or deteriorated drugs or biologicals are placed in appropriate bins for destruction.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48694 Based on observation, interview, and record review, the facility failed to conserve the nutritive value and flavor of pureed foods for 17 out of 179 residents (Resident 1, Resident 2, Resident 17, Resident 26, Resident 30, Resident 37, Resident 52, Resident 56, Resident 69, Resident 74, Resident 86, Resident 133, Resident 470, Resident 570, Resident 571, Resident 572, and Resident 573) when the recipes were not followed. This failure had the potential for malnutrition, weight loss, slow wound recovery, and vulnerability to diseases. Findings: During a concurrent observation and interview on 5/7/24 at 9:45 a.m. with the [NAME] in the kitchen, the [NAME] was observed preparing the pureed foods for the lunch, including pasta and meat balls. No recipe or measuring tools were seen on the counter as the [NAME] set food items into the blender. During the preparation of pureeing the pasta, the cook added an unmeasured amount of pasta and pasta water to the blender before mixing. During the preparation of pureeing the meatballs, the cook added an unmeasured amount of meat and the cooking juices plus an unmeasured amount of salt and spices to the blender before mixing. During an interview on 5/7/24 at 2:30 p.m. with the Dietary Services Supervisor (DSS), the DSS agreed that [NAME] did not measure the food portions and did not use measuring tools to add liquids, salt, and spices to the food items. During an interview on 5/8/24 at 2:05 p.m. with the Registered Dietitian (RD), the RD stated the recipes should be followed when preparing pureed foods to maintain the nutritive value of food. During a review of facility's undated recipe titled Recipe: Pureed Starch (Rice, Pasta, Potatoes) from Healthcare Menus Direct, indicated, .Measure out the total number of portions (based on the portion size indicated on the cook's spreadsheet) needed for puree diets. Puree . to paste consistency before adding any liquid. Gradually add warm milk .recommended amounts . starting with smaller amount and adding in more as needed to the desired consistency . A review of Facility's undated recipe titled Recipe: Pureed Meats from Healthcare Menus Direct indicated, . Complete regular recipe . Measure out the total number of portions (based on the portion size indicated on the cook's spreadsheet) . Puree . to paste consistency before adding any liquid. Gradually add warm liquid (low sodium broth or gravy) . recommended amounts . starting with smaller amount and adding in more as needed to achieve the desired consistency .

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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. 48694 Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for a total of 179 residents who received facility prepared foods when: 1. Milk and eggs were stored only 1.5 above floor level; 2. Opened food items were not sealed in the dry storage area; 3. Food products were not labeled to ensure food safety; 4. Kitchen floors contained build-up of black grime, broken tile, and walls with chipped paint; 5. Unsafe kitchenware stored and available for use; 6. Emergency food was not monitored to ensure safety; and, 7. Resident refrigerator log in C3 showed two days of recordings above safe food storage range without corrective actions. These failures had the potential to lead to contamination and/or food borne illness. Findings: 1. During a concurrent observation and interview on 5/6/24 during the initial kitchen tour at 8:15 a.m., the walk-in refrigerator contained a ledge consisting of two stacked wooden slats sitting approximately 1.5 above the floor, running along the length of the wall. This ledge stored two boxes of milk cartons and a box of eggs. During a concurrent interview, the Dietary Services Supervisor (DSS) stated she was not sure of the required height for food storage above the floor. During an interview with the Registered Dietitian (RD) on 5/8/24 at 1:00 p.m., she stated that the height required depended on the food type. A review of the facility-provided policy titled Storage of Food and Supplies (Healthcare Menus Direct, 2023) indicated that food was to be stored 6 off the floor and on clean surfaces in a manner that protects it from contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During concurrent observation and interview on 5/6/24 at 9:05 a.m. in the dry food storage room, multiple food items were found exposed to the air. This included an opened bag of cake mix stored in a plastic bag that was not shut; an opened box of vanilla wafers with an inner bag of wafers that were left exposed to the air; and a dietetic instant vanilla pudding mix pouch that was stored in a plastic storage bag, which was not zipped closed. The DSS stated these three items should be tightly closed to prevent contamination and proceeded to discard. A review of the facility-provided policy titled Storage of Food and Supplies (Healthcare Menus Direct, 2023) indicated that, Loose cookies and crackers should be placed in containers or bins . Dry bulk foods should be stored in seamless metal or plastic containers with tight covers . if using plastic bags for dry bulk food storage, food grade bags must be used . Bins/containers are to be labeled, covered and dated . 3. During concurrent observation and interview on 5/6/24 at 9:05 a.m., it was noted that the opened vanilla wafers box and dietetic instant vanilla pudding were unlabeled. The DSS concurred that these items lacked the needed label to ensure safety. The spice rack in the cook's station contained a bottle of ground ginger with 3/22 written on it. The DSS stated that it should have been 3/22/24, which she wrote on the ginger bottle. She further explained that spices and seasonings were considered fresh for one year after opening. During an interview on 5/8/24 at 4:00 p.m., the Assistant Dietary Services Supervisor (ADSS) stated that the labels should include a month, day, and year so that staff would be able to identify when food products were no longer safe. A review of facility provided policy titled Labeling and Dating of Foods, (Healthcare Menus Direct, 2023) indicated that .Newly opened food items will need to be closed and labeled with an open date . A review of the facility provided policy titled Storage of Food and Supplies (Healthcare Menus Direct, 2023) indicated that .All food will be dated - month, day, year . 4. During a concurrent observation and interview on 5/6/24 at 9:05 a.m., the flooring in the dry goods storage room displayed black grime, smudges and streaks surrounding beneath the metal food storage shelves. Several tiles by the exterior door were cracked, and the walls had areas of chipped beige and green paint. During an interview on 5/6/24 at 9:10 a.m. interview with the DSS and ADSS, the DSS stated the Maintenance team is responsible for cleaning the dry goods storage room. During an interview on 5/6/24 at 9:20 a.m. with the Maintenance Supervisor (MS), he stated the housekeeping team would oversee cleaning of the floors. During an interview on 5/7/24 at 10:25 a.m. with the Supervisor for Housekeeping, Laundry, Janitorial (SHLJ), he stated his staff would strip and wax only the office space within dry good storage area. (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 with the RD on 5/8/24 at 1 p.m., she indicated that she had noted the dirty floors during her monthly audits and had reported her findings to the dietary supervisor and administrator. During an interview with the DSS and ADSS on 5/8/24 at 4:32 p.m., they both acknowledged that uncleaned floors could lead to contamination of food. When asked when the floors in the dry storage room had last undergone a deep cleaning, neither was aware when it had happened. The DSS stated it has been a minute. During an interview with the Food Services Efficiency Consultant on 5/8/24 at 5:00 p.m., he stated the company is in the process of formulating a deep cleaning policy. He further explained that he was in the process of trying to find a company to paint the kitchen. A review of facility provided policy titled General Cleaning of Food & Nutrition Services Department (Healthcare Menus Direct, 2023) indicated that Floors must be mopped at least once per day. A review of facility provided policy titled Storage of Food and Supplies (Healthcare Menus Direct, 2023) indicated The storeroom should be . clean at all times . All shelves and storage racks should be in accordance with state and federal regulations to . promote easy and regular cleaning . Routine cleaning . procedures should be developed and followed . Review of the US Department of Agriculture Food Code, 2022 indicated in section 6-501.11 that Physical facilities shall be maintained in good repair. Section 6-501.12 further indicated that (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of food is exposed such as after closing. 5. During a concurrent observation and interview on 5/6/24 at 9:47 a.m. with the DSS in the kitchen, two non-stick cooking pans with worn out interior cooking surfaces (more than one third of the cooking surface), were found stored wet. The DSS stated the kitchen utensils should not be stored wet. During a concurrent observation and interview on 5/6/24 at 9:56 a.m. with DSS in the cook's area of the kitchen, one green cutting board was found stored with three deep cuts on its surface. Both pans and cutting board were available for use. The DSS stated she was not aware of the damaged pans and cutting board. Upon asking when equipment should be replaced, the DSS took both the pans and the cutting board and stated now. A review of the facility's undated policy and procedure (P&P) titled, Dish Washing (Healthcare Menus Direct, LLC. 20123), the P&P indicated, . Dishes are to be air dried in racks before stacking and storing . The US Department of Agriculture Food Code, 2022, section 4-901.11, subtitle Equipment and Utensils, Air-Drying Required indicated, Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled, Sanitation (Healthcare Menus Direct, LLC., 2023), the P&P indicated, . All utensils . and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions . cracks and chipped areas . Review of the US Department of Agriculture Food Code, 2022, section 4-501.12, subtitle Cutting Surfaces, indicated, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. 6. A concurrent observation and interview on 5/6/24 at 9:37 a.m. with the DSS, the emergency food storage room was observed. There was not a thermometer for monitoring room temperature, nor air conditioning or other temperature control. The DSS stated she did not know that the emergency food storage needed temperature monitoring. During an interview on 5/8/24 at 2:05 p.m. with the Registered Dietitian (RD), the RD stated food was to be stored in cool place. She was not aware of that the emergency food storage room lacked a thermometer and a temperature log. A review of the facility's policy and procedure (P&P) titled, Storage of Food and Supplies (Healthcare Menus Direct, LLC., 2023), the P&P indicated, The storeroom should be well-lighted, well ventilated, cool, dry, and clean at all times. Thermometers should be placed in all storage areas and checked frequently. Recommended temperature is 50-85-degree Fahrenheit . 7. During a concurrent observation and interview on 5/6/24 at 3:12 p.m. with Licensed Nurse (LN) 11 in Station C-3, the residents' food refrigerator was observed with food packages labeled from 5/3/24 to 5/5/24. On the side of refrigerator, a temperature log showed recorded temperatures for May 2024. Two days (5/5/24 and 5/6/24) had entries of 42-degrees Fahrenheit (a unit of measurement) out of six days. LN 11 stated Residents' food (from home or outside) was stored for three days in this refrigerator. During an interview on 5/7/24 at 8:45 a.m. with the Director of Nursing (DON), the DON stated food could be stored for three days and refrigerator temperature should be maintained as required for food safety. The DON also stated when the refrigerator was found out of range, the food should have been monitored for safe temperature. If it was high, the food should be discarded. If the food temperature was within the safe range, it should be transferred to another refrigerator until the C-3 refrigerator temperature was back into the correct range. She expected this information would be included on the log where the elevated temperatures were found. The Temperature Log titled, Roseville Care Center Refrigerator Temperature Log dated May 2024, indicated, Temperature must be within 36-41 degree.

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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. 39489 Based on observation, interview and record review the facility failed to protect the residents' protected health information (PHI, such as individuals' health, treatment and payment information) visible and accessible to the public when the Kiosk/computer located between resident's room and storage room was left unattended and the computer screen showed information for the census of 179 residents. This failure had the potential for the public to access unauthorized residents' PHI and cause a breach of confidentiality. Findings: During a concurrent observation and interview on 5/6/24 at 2:35 p.m., with Licensed Nurse 15 (LN 15), LN 15 confirmed the Kiosk/computer screen was turned on, left unattended and showing the resident's PHI. LN 15 stated, residents' information should be protected at all times to prevent unauthorized accessed to their personal information which can be used to other peoples' advantage. LN 15 further stated, We should adhere to the Health Insurance Portability and Accountability Act (HIPAA, federal regulatory standards defining the lawful use protected health information to protect our residents. During an interview on 5/6/24 at 2:40 p.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 acknowledged she was using the Kiosk/computer and had to leave to attend to another resident. CNA 2 confirmed the Kiosk/computer was left turned on and unattended with the resident's PHI displayed on the screen. She further stated, I should not have left it unattended to avoid other people from looking into it. A review of the facility's policy and procedure titled, Confidentiality of Information and Personal Privacy, dated October 2021, indicated . The facility will safeguard the personal privacy and confidentiality of all resident ad personal and medical records .

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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. 45770 Based on observation, interview, and record review the facility failed to maintain an effective infection control program when: 1. Certified Nurse Assistant 3 (CNA 3) did not wear the proper Personal Protective Equipment (PPE) while giving care to Resident 12 who was on Enhanced Barrier Precautions (EBP) and did not perform hand hygiene in between tasks of providing care and collecting garbage; and, 2. Licensed Nurse 2 (LN 2) did not disinfect the glucometer (a device used to measure blood sugar) according to manufacturer's recommendation during a medication pass observation. These failures increased the risk of spreading infection at the facility. Findings: A review of Resident 12's Admission Record indicated she was originally admitted to the facility in November 2021 with diagnoses including type 2 diabetes (adult-onset diabetes characterized by high blood sugar and insulin resistance) with chronic foot ulcer. A review of an Order Summary Report dated 1/22/24 indicated Resident 12 was on Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multi-drug resistant organisms) due to history of Methicillin Resistant Staphylococcus Aureus (MRSA, an infection that is difficult to treat because of resistance to some antibiotics) in her wound. During an observation on 5/6/24 at 9:25 a.m. inside Resident 12's room, CNA 3 was observed not wearing a gown while giving care to Resident 12. In an interview on 5/6/24 at 9:40 a.m. with Resident 12, she stated only a few of the staff wears a gown when giving care to her, and the CNA 3 who assisted her for morning care was not wearing one. During an observation on 5/6/24 at 10:15 a.m. inside Resident 12's room CNA 3 did not perform hand hygiene in between tasks of assisting Resident 12 and collecting garbage. CNA 3 stated there was no need to sanitize her hands because she was wearing gloves and changed it two times while handling the garbage. CNA 3 also acknowledged she was not aware that she should have used a gown while giving care to Resident 12. In an interview on 5/9/24 at 11 a.m. with the Director of Nursing (DON), the DON confirmed all the staff received trainings in infection control and prevention practices and should be able to properly follow it to prevent the spread of infection in the facility. A review of the facility's Policy and Procedure (P&P) titled Infection Prevention and Control Program revised 10/18 it stipulated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Multidrug-Resistant Organisms, Infection Precaution & Enhanced Standard Precautions revised 8/19 it indicated Enhanced Barrier Precaution (EBP) will be integrated in the care of residents with chronic wounds or indwelling medical devices during high contact resident care activities . EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities . 48874 2. In a concurrent observation and interview during a medication pass on 5/6/24 at 8:46 a.m. on with LN 2, LN 2 used the glucometer on Resident 620. LN 2 stated the resident wanted her blood sugar re-checked and cleaned the glucometer (a device used to measure blood sugar). LN 2 cleaned the glucometer with an alcohol preparation pad. LN 2 stated she just wiped it down and did not do it for any certain amount of time. A record review of Resident 620's Admission record, dated 5/6/24, indicated Resident 620 was admitted in April 2024 with several diagnoses including Type 2 Diabetes Mellitus (problems with controlling blood sugar). In an interview on 5/7/24 at 2:06 p.m. with the Director of Nursing (DON), the DON stated that when cleaning the glucometer after use the facility follows manufacture instructions. It needs to wipe down with a bleach wipe with a dwell time of 3 minutes. She stated the LN 2 should have followed this process. In an interview on 5/9/24 at 10:34 a.m. with the Infection Preventionist (IP), the IP stated that the LN 2 should put a barrier down and used a bleach wipe because there is a risk of spread of blood borne pathogens if it is not cleaned properly. In a review of facility policy tilted, Obtaining a Finger Glucose level dated October 2023, it indicated, clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. In a review of an untitlted document titled, Even Care Glucometer User's Guide, it indicated, to disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. The following products have been approved for cleaning and disinfecting the Even Care G3 meter: cleaning wipes or bleach wipes.