STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055955	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Home for the Aged	6720 E. Kings Canyon Fresno, CA 93727

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608 Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for two of two sampled residents (Resident 2 and Resident 26) when Resident 2 and Resident 26's urinary catheter (tube inserted into the bladder through the urethra, to drain freely into a connected bag) bags were not placed in a dignity bag (a bag the catheter drainage bag into to shield the resident's urine from view) and were visible from the hall outside the resident's room. This failure violated Resident 2 and Resident 26's need for urinary catheterization to remain private to ensure their dignity and respect. Findings: During a review of Resident 2's Admission Record (AR), dated 03/27/24, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis which included Dementia (impaired thinking, remembering or reasoning), Type 2 Diabetes Mellitus (high levels of sugar in the blood), Anemia (lower than normal red blood cells), Neuromuscular Dysfunction (nerve and muscle weakness and pain), Hypertensive Heart Disease with Heart Failure (higher than normal blood pressure causing the heart not to function correctly), Dysphagia (swallowing difficulties), Benign Prostatic Hyperplasia without lower Urinary Tract Symptoms (a build up of prostatic tissue against the urethra making it difficult to urinate). During a review of Resident 2's Minimum Data Set (MDS), Section C Brief Interview for Mental Status (BIMS - assessment of cognitive status for memory and judgement [a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment and 99 indicates they are unable to complete the interview) score dated 6/22/2023, indicated Resident 2's BIMS score was 4 which indicated Resident 2 was severely cognitively impaired. During a review of Resident 26's Admission Record (AR), dated 01/25/2022, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis which included Multiple Sclerosis (long lasting disease of the central nervous system), Anemia, Major Depressive Disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems), Muscle Weakness, Neuromuscular Dysfunction of Bladder, Urinary Tract Infection. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 26's MDS Section C dated 02/07/24, indicated the BIMS score was 9 which indicated Resident 26 was moderately cognitively impaired. During the initial tour of the facility on 03/25/24 at 9:56 a.m., in Resident 2's room, Resident 2's urinary catheter drainage bag was observed to be on the floor next to the left side of Resident 26's bed without a dignity bag (a bag the catheter drainage bag is placed into to shield the resident's urine from view). The catheter bag was visible from the hall outside of the room and in view of visitors, staff, and other residents. During the initial tour of the facility on 03/25/24 at 9:57 a.m., in Resident 26's room, Resident 26's urinary catheter drainage bag was observed attached to the left side of his wheelchair without a dignity bag. The catheter bag was visible from the hall outside of the resident's room and in view of visitors, staff, and other residents. During a concurrent interview and record review on 03/25/24 at 04:22 p.m., with Licensed Vocational Nurse (LVN) 8, LVN 8 verified Resident 2 and 26's catheters were not in dignity bags. LVN 8 stated, it is the facility's policy that all catheter bags are to be placed in dignity bags. During a concurrent interview and record review on 03/27/24 at 11:12 a.m. with the Infection Preventionist (IP), IP Verified Resident 2 and 26's catheter was not in dignity bags. The IP stated, the urine catheter bags should always be in a dignity bag to protect the resident's dignity. IP stated, the facility's expectation of urinary catheter care is to follow the facility policy on urinary catheter care. During a concurrent interview and Record Review on 3/27/24 at 04:21 p.m. with the Director of Staff Development (DSD), the DSD verified Resident 2 and 26 catheters were not in dignity bags. The DSD stated the expectation of staff is to always place catheter bags into a dignity coverage bag to protect the dignity of the residents. During a concurrent interview and record review on 03/27/24 at 10:44 a.m. with the Director of Nursing (DON), the DON verified Resident 2 and 26's catheters were not in dignity bags. The DON stated, both catheter bags should have been placed in a dignity bag cover to respect the resident's dignity. During a review of the facility's Policy and Procedure (P&P), titled, Dignity dated 02/2021, the P&P indicated, . Each resident shall be cared for in a manner that promotes and enhances his or her sense of wellbeing, at a level of satisfaction. With life, and feelings of self-worth and self-esteem .helping the resident to keep urinary catheter bags covered .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48424 Based on observation, interview, and record review the facility failed to provide a comfortable homelike environment for three of 15 sampled residents (Residents 1, 29 and 81) when the air vents (an opening which allows air to pass out of or into a room) in Resident 1, 29, and 81's rooms were covered with black and brown stains and had dust in between the slits of the vent. This failure resulted in Residents 1, 29, and 81 not being provided a comfortable, homelike environment and had the potential to cause the residents to experience illness from breathing in dust from the air vents. Findings: During a concurrent observation and interview on 3/25/24 at 10:26 am with Resident 1 and 29 in their room, the air vent above their door was observed to have black and brown stain marks over the exterior. Resident 1 stated her air vent looked dirty to her and she could not recall when the air vent last looked clean. Resident 1 stated she would have never had the air vent in her own home in the same condition as the one in her current room. Resident 1 stated she would like to see the air vent cleaned. Resident 29 stated the air vent looked dirty and she would also like to see it improved. During a concurrent observation and interview on 3/25/24 at 10:27 a.m. with Certified Nursing Assistant (CNA) 10 in Resident 1 and 29's room, the air vent above the door looked to be stained with black and brown marks over the exterior. CNA 10 stated the air vent in Residents 1 and 29's room appeared dirty. CNA 10 stated the air vent did not appear homelike and she would not have them in the same condition in her house. CNA 10 stated the air vents should have been cleaned when the problem was noticed. During a concurrent observation and interview on 3/25/24 at 11:08 a.m. with Resident 81 in Resident 81's room, the air vent's exterior was covered in a layer of brown and gray dust and had a collection of dirt in between the spacing of the vent. Resident 81 stated it was not homelike and she would have preferred to have the vent in a clean condition. During a concurrent observation and interview on 3/25/24 at 11:09 a.m. with CNA 8 in Resident 81's room, the air vent's exterior was covered in a layer of brown and gray dust and had a collection of dirt in between the spacing of the vent. CNA 8 stated the air vent appeared dirty and she would not have it in the same condition in her home. CNA 8 stated the air vent may make Resident 81 feel uncomfortable to be in her room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/24 at 10:17 a.m. with the Infection Preventionist (IP), the IP stated all air vents should be in a clean condition. The IP stated a dirty air vent may have caused the residents to breath in dirty air. The IP stated maintaining clean air vents would have been important for residents with respiratory issues like pneumonia (lung infection that can cause illness), chronic obstructive pulmonary disease (lung disease which makes breathing difficult), and asthma (lung condition which makes breathing difficult and causes wheezing and coughing) because these types of residents would be vulnerable to respiratory illnesses (diseases of the lungs). The IP stated if vents had too much dust build up it could have led to restricted air ventilation which could lead to increased respiratory distress (breathing difficulty) in vulnerable residents. During an interview on 3/27/24 at 11:59 a.m. with the Director of Hospitality (DOH), the DOH stated housekeeping staff were responsible for cleaning vents as part of their regular height dusting (cleaning of tall hard to reach areas). The DOH stated the air vents should have been cleaned as needed or requested in order to keep fresh air coming into resident's' rooms and so residents don't breathe in dust and debris. During a concurrent observation and interview on 3/27/24 at 2:18 p.m. with the DOH in Resident 1 and 29's room, the air vent above their door was observed to have black and brown stain marks over the exterior. The DOH stated the vent looked dirty and it could have been cleaned by housekeeping. The DOH stated if dust or dirt are present on the air vent, it does not provide a homelike experience. The DOH stated having dirty unappealing vents could have made residents uncomfortable where they lived. The DOH stated if vents were too stained to be cleaned, then maintenance should have replaced them. During an interview on 3/27/24 at 4:32 p.m. with the Maintenance Lead (ML), the ML stated air vents should have been replaced when the facility was redoing the air conditioning system. The ML stated air vents that were not able to be cleaned should be repainted or replaced. The ML stated not replacing or repainting the air vents did not promote a homelike environment for the residents. The ML stated it was important to clean, repaint or replace unappealing vents so residents feel comfortable in their rooms and so they don't breathe in dust or contaminants (things that can make a person sick). During an interview an interview on 3/28/24 at 11:22 am with the Assistant Director of Nursing (ADON), the ADON stated having clean air vents in residents' rooms was important because people may question the cleaning services of the rooms. The ADON stated if dust and dirt are found in the air vents, it could cause allergic reactions in residents. During an interview on 3/28/24 at 2:33 p.m. with the Director of Nursing (DON), the DON stated having dirty unappealing air vents did not promote a homelike environment. The DON stated the vents should be clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's document titled, Housekeeping Department description, undated, the form indicated, . A clean and sanitary environment is conducive (helpful) to the physical and mental well-being of residents and staff. Effective environmental sanitation is required to lessen the hazards of exposure to contaminated air, dust, furnishings (decorations such as curtains and rugs), equipment, and other fomites (objects or materials which are likely to carry infection). Frequent cleaning of the building's interior will aid on physically removing some of the microorganisms (bacteria that can cause infection) which might cause these hazards .the Houskeeping Department will contribute to the infection control am by providing a clean and sanitary building, and will comply with all local, state and federal laws, standards, regulations, and guidelines . Act jointly with the Infection Control Commitee in making periodic inspections of the facility to establish and maintain consistently high infection control standards . During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated February 2021, the P&P indicated, . Residents are provided with a safe, clean, comfortable, and homelike environment . 1. Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean sanitary and orderly environment .

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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** 40641 Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for one of five sampled residents (Resident 65) when Resident 65's functional limitation in range of motion was inaccurately coded on the MDS assessment. This failure had the potential to result in Resident 65's care needs not met. Findings: During a review of Resident 65's Admission Record (document with resident demographic and medical diagnosis information), dated 3/28/24, indicated Resident 65 was admitted in the facility on 12/20/23, with diagnosis which included hemiplegia (severe or complete loss of strength and hemiparesis (mild loss of strength), muscle weakness and atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque [small, abnormal patch of tissue] in the inner lining of an artery). During a concurrent observation and interview on 3/25/24 at 10:53 a.m. with Resident 65 in room [ROOM NUMBER], Resident 65 was sitting in her wheelchair next to her bed. Resident 65 was observed with her left arm flexed and positioned on top of her lap. Resident 65 stated, . I had a stroke a few years ago and this is the result . Resident 65 stated she did not have the full mobility of her left arm like her right arm and needed help for everyday care. During an interview on 3/28/24, at 8:34 a.m. with Certified Nurse Assistant (CNA) 7, CNA 7 stated she was familiar with Resident 65's care. CNA 7 stated Resident 65 was weak on her left arm and needed assistance with her activities of daily living (ADL-skills required to care for self such as bathing, dressing, transfers, mobility and eating) care. During an interview on 3/28/24, at 8:47 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 65 has limited mobility on her left arm limiting her ability to be independent with her care. LVN 2 stated Resident 65 had always been weaker on one side since she was admitted to the facility. LVN 2 stated Resident 65 needed assistance with her ADL care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/28/24, at 11:43 a.m. with Minimum Data Set Registered Nurse (MDSRN), Resident 65's five (5) days assessment dated [DATE], section GG was reviewed. The MDSRN stated Resident 65 was coded as no impairment of upper extremity (shoulder, elbow, wrist, hand) on the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs). MDSRN stated she completed the assessment on Resident 65 and remembered Resident 65's left upper extremity did not have the same range of motion (ROM-extent or limit to which a body can be moved around a joint) as her right upper extremity. MDSRN stated on assessment Resident 65's right upper extremity helped raised her left upper extremity to reached/touched her head. MDSRN stated she made an error in her assessment of Resident 65. MDSRN stated Resident 65 should have been coded with impairment on one side of her upper extremity. MDSRN stated the facility did not have a policy on MDS, the facility follows the Long Term Care Facility Resident Assessment Instrument (RAI- core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) guideline. During an interview on 3/228/24, at 3:25 p.m. with the Director of Nursing (DON), the DON stated Resident 65 has limited mobility on her left upper extremity. The DON stated the MDSRN should have coded Resident 65 as having weakness on her upper extremity. The DON stated her expectation was to ensure staff are completing their assessments accurately. During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.18.11 Manual (RAI- core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) dated 10/23, indicated, .With resident seated on a chair, instruct them to reach with both hands and touch palms to back of head . touch each shoulder with the opposite hand . Code 1, impairment on one side: if resident has an upper- and/or lower-extremity impairment on one side that interferes with daily functioning .

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR-The State is required to ensure that every person entering a Medicaid certified Nursing Facility [NF] receives a Level I screening and if necessary a Level II evaluation to ensure that their NF residence is appropriate and to identify what specialized services they may need) was completed for one of five sampled residents (Resident 27) when Resident 27 was diagnosed with major depressive disorder (persistent feeling of sadness and loss of interest), dementia (loss of of cognitive functioning-thinking, remembering and reasoning) and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions) and was started on psychotropic medications (medications used to treat mental health disorders) on 12/2/19. This failure had the potential for Resident 27 to not receive the necessary and appropriate psychiatric (relating to mental illness) level of treatment and evaluation in the facility. Findings: During a concurrent observation and interview on 3/25/24, at 9:50 a.m. during the initial tour of the facility in room [ROOM NUMBER], Resident 27 was lying in bed with eyes open. Resident 27 stated she had been in the facility for more than eight years. Resident 27 stated she did not have any concerns. During a review of Resident 27's Admission Record (AR), dated 3/28/24, the AR indicated, Resident 27 was admitted to the facility on [DATE], with diagnoses which included depression (sadness), dementia (loss of of cognitive functioning-thinking, remembering and reasoning) and psychotic disorder. During a concurrent interview and record review on 3/28/24, at 10:28 a.m. with the admission coordinator (AC), the AC reviewed Resident 27's PASRR (PASRR-The State is required to ensure that every person entering a Medicaid certified Nursing Facility [NF] receives a Level I screening and if necessary a Level II evaluation to ensure that their NF residence is appropriate and to identify what specialized services they may need) assessment dated [DATE]. The AC stated she was aware Resident 27 has diagnosis of dementia and was currently on psychotropic medications but was not sure when medications were started. The AC stated she was not able to find a PASRR assessment completed after 11/8/19 to reflect Resident 27's diagnosis of dementia and use of psychotropic medications. The AC stated there should have been a PASRR assessment completed. The AC stated she was responsible in making sure PASRR assessment was completed for any significant changes in condition and hospitals are sending a copy of the completed assessments for new admission and re-admission. The AC stated the facility did not have a policy on PASRR and they follow current regulatory guidelines. During an interview on 3/28/24, at 3:10 p.m. with the Director of Nursing (DON), she stated, . I learned that when a resident was put on psychotropic medication, a new PASRR assessment should be completed to make sure resident who has mental condition be referred and received the proper treatment deserved The DON stated Resident 27 needed a new PASRR assessment when started on psychotropic medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for four of 22 sampled residents (Residents 49, 80, 37 and 4) when: 1. Residents 49 and 80 did not have an individualized care plan developed and implemented for the use of side rails. This failure had the potential for Residents 49 and 80 to be injured while using the side rails. 2. Resident 37 had an order of ipratropium bromide (medication used for breathing) via hand-held nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled through a connected mouthpiece or facemask) once a day for respiratory illness. This failure placed Resident 37 at a potential risk for not being educated on how to use a hand-held nebulizer for prescribed treatments. 3. Resident 37 was using low air loss mattress to prevent skin breakdown (when skin is deprived of blood flow the skin can become damaged and begin to breakdown). This failure placed Resident 37 at risk for pressure ulcers (damage to the skin caused by constant pressure on the area for a long time). 4. Facility failed to implement a person-centered care plan to meet Resident 4's medical needs when staff did not implement urinary catheter monitoring for Resident 4's indwelling urinary catheter (an indwelling urinary catheter - a thin tube placed in the bladder to drain urine into a bag). This failure had the potential to put Resident 4 at an increased risk of developing a urinary tract infection (a condition in which bacteria invade and grow in the urinary tract [any part of the urinary system]). Findings: 1.During a review of Resident 49's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/27/24, the AR indicated, Resident 49 was admitted from a rehabilitation hospital on 2/19/24 to the facility, with diagnoses that included Fracture of Left Femur (thigh bone), Alzheimer's Disease (loss of memory and ability to carry simple tasks), Urinary Tract Infection (bladder infection), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Muscle Weakness, Constipation, and History of Falling. During an observation on 3/25/24, at 11:02 a.m., in Resident 49's room, Resident 49 was awake and laying in bed, on her back, with quarter-length side rails up on both sides of the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 3/26/24, at 9:03 a.m., Resident 49's nursing Care Plan (CP) was reviewed. The ADON stated, Resident 49 had a risks and benefits form for side rail use and consent signed by family agreeing to the use of side rails on 2/19/24. The ADON reviewed Resident 49's care plans and stated, there was no care plan developed for the use of side rails. The ADON stated, the use of side rails should have been care planned to include interventions such as bed inspection, frequent visual checks and monitoring of side rails for continued use. The ADON stated, the care plan for side rails should have been developed when the consent was signed by Resident 49's responsible party (RP) and after obtaining a physician order (PO). During a review of Resident 80's AR, dated 3/28/24, the AR indicated, Resident 80 was admitted from an acute care hospital on 3/7/24 to the facility, with diagnoses which included Muscle Weakness, Unsteadiness on Feet, Lung Cancer, Protein Calorie Malnutrition (not consuming enough protein and calories), Bacteremia (presence of bacteria in the blood), and Methicillin-resistant Staphylococcus aureus (MRSA, a type of infection that is difficult to treat because of resistance to some antibiotics). During a concurrent observation and interview on 3/25/24, at 3:24 p.m., with Resident 80, in Resident 80's room, Resident 80 was sitting on the edge of her bed, with quarter-length side rails up on both sides of the bed. Resident 80 stated, I use the siderails to pull myself from lying to sitting position. I also use them to get up from my bed. During a concurrent interview and record review with the ADON, on 3/26/24, at 9:16 a.m., Resident 80's nursing CP was reviewed. The ADON stated, Resident 80 had a risks and benefits form for side rail use completed on 3/7/24 and the consent signed by the RP agreeing to the use of side rails on 3/7/24. The ADON reviewed Resident 80's care plans and stated, there was no care plan developed for the use of side rails. The ADON stated, the use of side rails should have been care planned to include interventions to prevent risks of entrapment, injury, and monitoring for continued use. The ADON stated, the care plan for side rails should have been developed when the consent was signed by Resident or RP and after obtaining a PO. During an interview with the Director of Nursing (DON), on 3/28/24, at 12:01 p.m., the DON stated, upon reviewing the risks and benefits form for side rail use and obtaining the consent from the RP, a physician order should be obtained from the Attending Physician and a care plan should be developed. The DON stated, the care plan drove resident care to ensure residents care was being met. The DON stated, the facility failed to follow the facility's P&P related to care planning process. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 2/2016, the P&P indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is development and implemented for each resident . g. incorporated identified problem areas; h. Incorporate risk factors associated with identified problems . During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, undated, the document indicated, . Provides direct resident care in accordance with the Nurse Practice Act, applicable State and Federal regulations and facility policies and procedures . Performs assessment on all changes of condition and develops appropriate care plans . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Home for the Aged	6720 E. Kings Canyon Fresno, CA 93727

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40641 2. During a concurrent observation and interview on 3/25/24, at 10:55 a.m. with Resident 37 in their room, Resident 37 was lying in bed awake and watching television. Resident was observed using oxygen via nasal cannula (device used to deliver supplemental oxygen). Observed at Resident 37's bedside table was a handheld nebulizer mouthpiece placed on top of the nebulizer machine (small machine that turns liquid medicine into a mist that can be easily inhaled through a connected mouthpiece or facemask). Resident 37 stated the nurse gives her medication using the mouthpiece for her breathing. During a review of Resident 37's Admission Record (AR-a document with resident demographic and medical diagnosis information), dated 3/28/24, the AR indicated, Resident 37 was admitted on [DATE] with diagnoses which included chronic respiratory failure, asthma (airways in the lungs become narrowed and swollen, making it difficulty to breath), and shortness of breath. During a concurrent interview and record review on 3/28/24, at 8:54 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 37's physician orders was reviewed. LVN 2 stated Resident 37 had an order for ipratropium bromide inhalation solution (medication used for breathing) medication dated 3/15/24. LVN 2 stated she did not find a care plan for Resident 37's use of ipratropium bromide inhalation medication. LVN 2 stated there should have been a care plan developed as soon as the medication was ordered and it was the responsibility of the nurse who received the order to initiate a care plan in order to educate Resident 37 on it's use. During a concurrent interview and record review on 3/28/24, at 2:43 p.m., with the Director of Nursing (DON), the DON stated Resident 37 did not have a care plan for the use of ipratropium medication. The DON stated Licensed Nurses should have developed a care plan for Resident 37's use of ipratropium medication. The DON stated the nurse receiving the order was responsible in developing the care plan at the time the order was received. The DON stated care plan should be individualized because it provided a guide for the nursing staff on how to care for the resident. 3. During a concurrent observation and interview on 3/25/24, at 10:55 a.m. with Resident 37 in room [ROOM NUMBER], Resident 37 was lying in bed awake and watching television. Resident was observed using oxygen via nasal cannula. Resident 37 observed with a low air loss mattress in her bed and head of bed was elevated. Resident 37 stated she was using the special mattress to prevent her from developing bed sores (also know as pressure ulcers-injury to skin and underlying tissue resulting from prolonged pressure on the skin) During a review of Resident 37's Admission Record (AR-a document with resident demographic and medical diagnosis information), dated 3/28/24, the AR indicated, Resident 37 was admitted on [DATE] with diagnoses which included muscle weakness and venous insufficiency (leg veins become damaged and struggle to send blood back to the heart). During a concurrent interview and record review on 3/28/24, at 8:56 a.m. with LVN 2, Resident 37's physician orders was reviewed. LVN 2 stated Resident 37's physician orders indicated low air loss mattress was ordered 7/13/23. LVN 2 stated she did not find a care plan for the use of low air loss mattress. LVN 2 stated there should have been a care plan developed for the use of low air loss mattress. LVN 2 stated care plan directs the plan of care of residents and licensed nurses are responsible in initiating a care plan when order was received. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24, at 1:56 p.m., with Registered Nurse (RN) 1, RN 1 stated care plan is needed for all medication orders and treatments. RN 1 stated use of low air loss mattress should be care planned and the licensed nurse who received the order should have initiated the care plan. RN 1 stated care plan is important because it was a way to monitor if interventions are effective or if needed revision. During a concurrent interview and record review on 3/28/24, at 2:48 p.m. with the DON, the DON reviewed Resident 37's care plan was reviewed and stated she did not find a care plan for the use of low air loss mattress. The DON stated, . It was ordered, then she needs a care plan and there is not a care plan in [Resident 37's] record . During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/16, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan . Incorporate identified problem areas . risk factors associated with identified problems .Reflect treatments goals, timetables, and objectives in measurable outcomes . 48739 4. During a review of Resident 4's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/27/24, the AR indicated Resident 4 was admitted on [DATE] with diagnoses of obstructive and reflux uropathy (a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys), retention of urine (a condition where the bladder does not empty completely or at all), type II diabetes mellitus (a disease that occurs when your blood sugar is too high) and congestive heart failure (a condition in which the heart doesn't pump blood as efficiently as it should). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/6/24, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 12 (a score of 0-7 indicated severe cognitive impairment, 8-12 indicated moderately impaired, 13-15 indicates cognitively intact), which indicated Resident 4 was moderately impaired. During a concurrent observation and interview on 3/25/24 at 11:17 a.m. with the Director of Nursing (DON) in Resident 4's room, Resident 4 was observed with her urinary catheter tubing touching the floor. The DON verifed the catheter tubing was on the floor. The DON stated the catheter tubing should not have been touching the floor. The DON stated the catheter tubing could have gotten dislodged. The DON stated if germs moved up the catheter, it could cause an infection in the resident. During an interview on 3/27/24 at 9:33 a.m. with CNA 8, CNA 8 stated Resident 4's urinary catheter tubing should not be on the floor. CNA 8 stated Resident 4's catheter tubing needed to be monitored. CNA 8 stated the tubing should be put in a bag without kinks and off the floor. CNA 8 stated the CNAs would put findings for resident monitoring in the resident's record in the computer, but mainly the findings were communicated with each other by talking to each other. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/27/24 at 2:41 p.m. with the Assistant Director of Nursing (ADON), Resident 4's Care Plan (CP), dated (undated) was reviewed. The CP indicated, . check foley catheter bag for kinks every 2 hours each shift . The ADON stated all staff should have made sure Resident 4's indwelling catheter tubing was off the ground. The ADON stated the catheter tubing on the ground could cause an infection in Resident 4. During a concurrent interview and record review on 3/28/24 at 10:22 with the Director of Staff Development (DSD), Resident 4's chart was reviewed for documentation of urinary catheter monitoring. The DSD stated she did not see any charting for urinary catheter checks in Resident 4's chart. The DSD stated if the resident's tubing was on the ground, there could be cross-contamination and infection control issues. The DSD stated the charge nurses at each station would monitor staff by visually checking to see if resident monitoring was being done. During a concurrent interview and record review on 3/28/24 at 10:30 a.m. with LVN 2, Resident 4's CP, dated (undated) was reviewed. The CP indicated . check foley catheter bag for kinks every 2 hours each shift . LVN 2 stated she did not know there was a monitoring order for catheter checks. LVN 2 stated she did not see a physician (MD) order for every two-hour monitoring for Resident 4's catheter. LVN 2 stated there should have been a monitoring order put in. LVN 2 stated the order was what flagged the nurse to perform resident monitoring. LVN 2 stated an order would occur in the Treatment Administration Record (TAR) and the Medication Administration Record (MAR). LVN 2 stated charting for resident monitoring is in the MAR or TAR. Resident 4's TAR, dated 3/28/24 was reviewed. The TAR indicated no monitoring of Resident 4's urinary catheter was documented. LVN 2 stated if there was no order put in, monitoring would not be in the MAR or TAR. During a concurrent interview and record review on 3/28/24 at 11:11 a.m. with the ADON, Resident 4's CP, dated (undated) was reviewed. The CP indicated, . check foley catheter bag for kinks every 2 hours each shift . Resident 4's Order Summary Report, dated 3/27/24 was reviewed. The Order Summary Report indicated no catheter monitoring orders for Resident 4. Resident 4's TAR dated 3/28/24 was reviewed. The ADON stated no orders were documented for catheter checks on Resident 4's urinary catheter tubing. The ADON stated staff would need a resident monitoring order from the MD to put the order in the resident's CP. The ADON stated staff would not be monitoring the resident without an order. The ADON stated nurses would need a monitoring order to flag them to have this task performed, otherwise the nurses would not have anything to alert them to monitor the resident. The ADON stated her expectation was if staff saw a situation like this, they would notify the MD for an order for monitoring the resident. The ADON stated she would expect staff to make a progress note regarding why the order was put in the resident's CP. During a concurrent interview and record review on 3/28/24 at 2:33 p.m. with the Minimum Data Set Registered Nurse (MDSRN), Resident 4's CP, dated (undated) was reviewed. The CP indicated, . check foley catheter bag for kinks every 2 hours each shift . The MDS stated nurses and MDS would enter interventions in the resident's CP. The MDSRN stated there was no area to document urinary catheter monitoring. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, indicated, . the comprehensive, person-centered care plan will: . describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being . aid in preventing or reducing decline in the resident's functional status and/or functional levels . reflect currently recognized standards of practice for problem areas and conditions . no single discipline can manage an approach in isolation . the resident's physician (or primary healthcare provider) is integral to this process . the interdisciplinary team (IDT) must review and update the care plan: . at least quarterly, in conjunction with the required quarterly MDS assessment .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to meet professional standards of practice for four of 12 sampled residents (Residents 25, 52, 55 and 66) when: 1. Registered Nurse (RN) 1 signed the electronic Medication Administration Record (eMAR- legal record of drug administration to a patient at a facility by a health care professional) prior to administering Resident 25's medications. This failure resulted in inaccurate charting and placed Resident 25 at a risk to not receive the medications ordered. 2. RN 1 did not follow the medication administration direction when she applied a lidocaine patch (medication patch applied on top of the skin for relief of pain) to Resident 25's left upper arm. This failure had the potential to put Resident 25 at risk for skin irritation. 3. LVN 4 did not follow medication administration direction when she administered Resident 55's medication without food. This failure had the potential to put Resident 55 at risk for stomach upset which could result in serious health condition. 4. Resident 52's oxygen flow rate was set to 3L (liters-a unit of measurement) instead of the ordered 4L. This failure resulted in Resident 52 not receiving the correct amount of oxygen as ordered which could have resulted in shortness of breath and respiratory distress (difficulty breathing). 5. Resident 52's humidifier (a device used to increase the mositure in level in the air with a room or enclosed space) bottle was not changed for six days. This failure had the potential to cause health risks from bacteria growing in the stagnant water (water that is left sitting for long periods of time) and inadequate humidification of the oxygen being delivered. 6. Resident 66's humidifier (a machine that makes the air in a place less dry) bottle was not being changed every three days. This had the potential for causing dry mucosal membranes (the moist, inner lining of some organs and body cavities) resulting in nosebleeds and/or pain. Findings: 1. During a concurrent observation, interview and record review on [DATE], at 7:40 a.m. in Station 2 hallway, RN 1 was observed preparing Resident 25's medications and clicked (checked as given) each medication in the electronic Medication Administration Record (eMAR- legal record of drug administration to a patient at a facility by a health care professional) as she popped each medications in a small medication cup and clicked saved after she popped all of Resident 25's medications. RN 1 administered the medications to Resident 25. RN 1 stated she had always clicked in the eMAR after she popped each medication from the bubble pack to make sure she has all the medications and clicked saved prior to administering the medications. RN 1 stated she was not sure why she documented the medication as administered prior to administering medications to Resident 25. RN 1 stated she should not have documented prior to administering medications to Resident 25 because it was not a good nursing practice. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 25's Admission Record [document with resident demographic and medical disgnosis information], dated [DATE], the admission record indicated, Resident 25 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure), muscle weakness and chronic pain. During an interview on [DATE], at 2:55 p.m. with the DON, she stated the practice had always been to administer medication to residents then document. The DON stated licensed nurses should never document medication was administered prior to administering the medication to a resident.The DON stated the licensed nurse should also make sure resident takes the medication then document the medicine as given. During a review of facility's poilicy and procedure (P&P) titled, Medication Administration General Guidelines, dated ,d+[DATE], the P&P indicated, . 20. The resident is always observed after administration to ensure that the dose was completely ingested . The individual who adinisters the medication dose, records the administration on the residents MAR immediately following the medication being given . During a review of the professional reference titled, Nursing 2022 Drug Handbook dated 2022, indicated, The eight 'rights' of medication administration .The right documentation: Completely and accurately document in the patient's medical record the drug administered; the monitoring of the patient, including the patient's response; and other nursing interventions . 2. During a concurrent observation, interview and record review on [DATE], at 7:40 a.m. in Station 2 hallway, RN 1 was observed preparing Resident 25's medications. RN 1 went inside Resident 25 with the lidocaine patch (medication patch applied on top of the skin for relief of pain). RN 1 was observed pulling up Resident 25's left sleeve and applied the lidocaine patch. RN 1, she stated she administered Resident 25's lidocaine patch without cleaning the site. RN 1 stated she read the lidocaine medication direction which indicated to clean the site and wait to dry then apply the patch. RN 1 stated she should have cleaned the site, waited for the skin to dry then applied the patch. RN 1 stated not cleaning the skin could affect the absorption of the medication. During a review of Resident 25's Admission Record, dated [DATE], the admission record indicated, Resident 25 was admitted to the facility on [DATE], with diagnoses which included hypertension, muscle weakness and chronic pain. During a review of Resident 25's Medication Review Report, dated [DATE], the Medication Review Report, indicated, . Lidocaine External Patch 4 [four] % [percent] Apply to left upper arm . Order Date [DATE] . During an interview on [DATE], at 2:50 p.m. with the DON, she stated licensed nurse should follow the instruction/direction in the medication box. The DON stated the nurse should have cleaned the skin and waited for the skin to dry before she applied the patch. The DON stated, . Always follow the intsruction/direction. During a professional reference review retrieved from (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	https://www.webmd.com/drugs/2/drug-,d+[DATE]/lidocaine-hcl-topical/lidocaine-patch-topical/details If you are using the over-the-counter product to self-treat, read and follow all directions on the product package before using this medication. If you have any questions, consult your pharmacist. If your doctor has prescribed this medication, use it as directed. This product should only be applied to normal intact skin. Do not apply to skin that is broken or irritated. The dosage is based on your medical condition and response to treatment. Remove the protective liner and apply the patch to the skin area that is most painful. Apply the prescribed number of patches as directed by your doctor, usually once a day. Depending on your product, the patch may be left on the skin for up to 8 or 12 hours. Follow the instructions carefully . 3. During a concurrent observation and interview on [DATE], at 8:03 a.m. in Station 3 (three) hallway outside of Rom 307, LVN 4 prepared Resident 55's medications which included Potassium Chloride (used to treat low potassium level) oral tablet to be given with breakfast. LVN 4 administered medication to Resident 55 with water and not with breakfast as indicated in the medication direction. LVN 4 stated she should have made sure Resident 55 was eating her breakfast when she administered the medication. LVN 4 stated the medication could cause upset stomach causing discomfort and affects the absorption of the medication when the direction was not followed to give medication with breakfast. During a review of Resident 55s Admission Record, dated [DATE], the admission record indicated, Resident 55 was admitted to the facility on [DATE], with diagnoses which included hypokalemia (low levels of potassium), hypertension (high blood pressure) and muscle weakness. During a review of Resident 55's Medication Review Report, dated [DATE], the Medication Review Report, indicated, . Potassium Chloride ER Oral tablet Extended Release 20 MEQ [milliequivalent-unit of measurement] . (Administer with Breakfast at 0700 with 4 [four] oz [ounces-unit of measurement] of water) . Order Date [DATE] . During a review of facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated ,d+[DATE], the P&P indicated, . Medications are administered as prescribed in accordance with manufactures's specifications, good nursing principles and practices and only be person legally authorized to do so . 3. Medication administration timing parameters include the following: .Medications to be given with meals are to be scheduled for administration at the resident's meal time . 48430 4. During a concurrent observation and interview on [DATE] at 10:11 a.m. in Resident 52's room with Restorative Nursing Assistant (RNA) 1, Resident 52 was observed sleeping. Resident 52 was connected to an Oxygen Concentrator (a medical device used to deliver oxygen to those who require it). The Oxygen Concentrator had a setting set to deliver 3L (liters-a unit of measurement) of Oxygen to Resident 52. RNA 1 stated, Resident 52 was receiving 3L of oxygen as indicated by oxygen regulator settings. During a concurrent interview and record review on [DATE] at 10:20 a.m. with Registered Nurse (RN 3), Resident 52's Orders Summary (OS), dated, [DATE] was reviewed. The OS indicated, Oxygen at 4L/min [L/min-liters per minute] via nasal canula every shift for Shortness of Breath. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 10:25 a.m. with RN 3 in Resident 52's room, RN stated, the machine was set to deliver 3L of oxygen. RN stated, she needed to be on 4L. RN stated, 3L is not sufficient for the resident's oxygen needs. During a interview on [DATE] at 9:39 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, 3L is not sufficient for Resident 52 according to the Medical Doctor's (MD) orders. LVN 1 stated, by not having 4L being delivered to the resident, a drop in oxygen saturations could happen, and the resident's shortness of breath can worsen leading to respiratory distress (trouble breathing). During an interview on [DATE] at 8:55 a.m. with the Director of Nurses (DON), the DON stated, nurses should always observe the settings on the machines to make sure the doctor's orders are being followed. During an interview on [DATE] at 9:07 a.m. with the DON, the DON stated, there was potential for the resident not getting enough oxygen. The DON stated, not getting enough oxygen can cause respiratory distress. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated [DATE], the P&P indicated, Adjust oxygen delivery so .the proper flow of oxygen is being administered. During a review of the facility's P&P titled, Oxygen Administration, dated [DATE], the P&P indicated, after completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: .the rate of oxygen flow . During a review of the facility's P&P titled, Medication and Treatment orders, dated [DATE], the P&P indicated, Orders for medications and treatments will be .safe and effective . During a review of Nursing 2024 The Peer-Reviewed Journal of Clinical Excellence (N2024), Who has the authority to give RNs an order?, dated [DATE], the N2024 indicated, .you [nurses] have a legal duty to carry out a physician's .orders. 5. During a concurrent observation and interview on [DATE] at 10:25 a.m. with RN 3 in their room, RN 3 stated, the humidifier bottle was dated ,d+[DATE] and was the water inside was almost empty. The RN 3 stated, the bottle is due to be changed and should have been changed every three days. The RN 3 stated, it is important to have the humidifier bottle changed every three days to maintain efficacy of humidification of oxygen being delivered. The RN 3 states, if the bottle isn't changed, bacteria can grow inside the bottle. During a concurrent interview and record review on [DATE] at 9:30 a.m. with LVN 1 Resident 52's Order Summary (OS) dated [DATE] was reviewed. The OS indicated, Change Humidifier Bottle every night shift every 3 day(s). The LVN 1 stated, all licensed nurses are responsible for changing the bottle. The LVN 1 stated, if the liquid runs out .the oxygen may not be properly humidified, the patient may develop dry nose, and bacteria can grow with an expired bottle. During an interview on [DATE] at 8:51 a.m. with the DON, the DON stated, humidifier bottles should be changed every 3 days. The DON stated, if the bottle was dated ,d+[DATE], it should have been changed on [DATE]. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 8:55 a.m. with the DON, Resident 52's Medication Administration Record (MAR), dated [DATE] was reviewed. The DON stated, the MAR indicated, on ,d+[DATE] an LVN initialed to indicate the humidifier bottle was changed. The DON stated, it is not OK to sign that you did something that wasn't done. The DON stated, if the humidifier bottle hasn't been changed, the water could become stagnant and or run out. The DON stated, this can cause dry mucous membranes resulting in bleeding from the nose, discomfort, sores, and pain. During a review of the facility's P&P titled, Oxygen Administration, dated [DATE], the P&P indicated, Be sure there is water in the humidifying jar and the water level is high enough that the water bubbles as oxygen flows through .periodically re-check water level in humidifying jar. During a review of the facility's P&P titled, Medication and Treatment orders, dated [DATE], the P&P indicated, Orders for medications and treatments will be consistent with principles of safe and effective . During a review of Nursing 2024 The Peer-Reviewed Journal of Clinical Excellence (N2024), Who has the authority to give RNs an order?, dated [DATE], the N2024 indicated, .you [nurses] have a legal duty to carry out a physician's .orders. During a record review of the Professional Standard (PS) titled, USAID-Reaching Impact, Saturation, and Epidemic Control (RISE) Standard Operating Procedure Operation and Maintenance of Oxygen Concentrator, https://media.path.org/documents/SOP_on_Oxygen_Concentrator_08032022-_USAID_RISE.pdf, undated, the PS indicated, The humidifer bottle is typically meant as a single use item .The water in the bottle must be changed regularly in order to prevent contamination. - 48424 6. During a review of Resident 66's Admission Record (AR) (document with resident demographic and medical diagnosis information), dated [DATE], the AR indicated Resident 66 had been admitted to the facility on [DATE]. Resident 66 had the diagnosis of Chronic obstructive pulmonary disease (disease which makes it hard to breath due to closing of the airways) upon admission. During a concurrent observation and interview on [DATE] at 10:13 a.m. with Licensed Vocational Nurse (LVN) 6 in Resident 66's room, Resident 66's nasal cannula (tube that delivers oxygen to the nose) tubing did not have a labeled with the nurse's initials or the date it was opened. LVN 6 stated the nasal cannula tubing should have been labeled with the date it was open and nurse initials. LVN 6 stated it was important to label tubing, so it gets changed out regularly. LVN 6 stated the tubing may have been contaminated if it was not changed. During a concurrent interview and record review on [DATE] at 4:46 p.m. with LVN 7, Resident 66's Order Summary, dated [DATE] was reviewed. The order summary indicated, . change oxygen tubing every night shift every [Sunday] (date and initial new tubing). LVN 7 stated the nasal cannula tubing should have been changed every Sunday and labeled with the date and nurses initials. LVN 7 stated it was important to label the tubing to prevent any contamination by throwing away expired tubing. LVN 7 stated if the tubing was not labeled it could have led to it being used past the ordered date which could have led to contamination of the tubing or an infection in the resident. (continued on next page)

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	055955	A. Building B. Wing	03/28/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:39 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated oxygen tubing was supposed to be labeled with the date opened. CNA 9 stated if oxygen tubing was not labeled it may have been mixed up and used on a different resident. CNA 9 stated unlabeled tubing could have led to an infection if it was not replaced when it should have been. During an interview on [DATE] at 11:22 a.m. with the Assistant Director of Nursing (ADON), the ADON stated it was not the facilities standard to have the oxygen tubing without the date labeled. The ADON stated it was important to label the oxygen tubing, so staff members know when it was last replaced. The ADON stated the doctors order was not followed when the tubing was not labeled with the date. During an interview on [DATE] at 2:13 p.m. with the Infection Preventionist (IP), IP stated the oxygen tubing should have been labeled. The IP stated the unlabeled tubing could have led to an infection because the tubing could have been a portal of entry (Opening where the pathogen[bacteria that may cause diseases] may enter). The IP stated the doctor's order was not followed if the oxygen tubing was not labeled with the date. During an interview on [DATE] at 2:33 p.m. with the Director of Nursing (DON), the DON stated the oxygen tubing was supposed to be labeled with the date so it could have been replaced within seven days. The DON stated the staff should have labeled the tubing with the date first used. The DON stated labeling the tubing was important because tubing used beyond seven days could have led to bacterial growth within it. The DON stated the doctors order was not followed. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated [DATE], indicated, .Preparation 1. Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the residents care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44899 Based on interview and record review, the facility failed to provide sufficient staff with the appropriate competencies and skill sets to provide nursing services to ensure residents receive services to maintain their highest practicable physical, mental, and psychosocial well-being when one of four nursing staff (Infection Preventionist-IP) did not receive a competency skills check after being hired. This failure had the potential to place residents' at risk of being exposed to the spread of infections. Findings: During a concurrent interview and record review on 3/26/24, at 10:44 a.m., with the Director of Nursing (DON) and the Director of Staff Development (DSD), the facility document titled, Licensed Nurse Competency, undated was reviewed. The DON stated, the IP completed her employment application on 11/30/23 and was hired and started her orientation on 12/18/23. The DON stated, the IP was responsible for the facility's infection prevention and control program and reports to the DON. The DON stated, she does not recall initiating and validating the IP's nurse competency. The DSD stated, the DON was responsible in validating and completing the IP's nurse competency after being hired. The DON stated, without the nurse competency completed, the facility does not have a proof that the IP can provide appropriate nursing care to facility residents. During an interview on 3/26/23, at 12:30 p.m., with the IP, the IP stated, she submitted her employment application on 11/30/23 and was initially hired on 12/18/23. The IP stated, she spent the first day of orientation with the Human Resources staff and the DSD and went over the different areas of the new hire packet. The IP stated, I don't recall having my nurse competency checked by the DON or DSD. I don't remember signing a document related to nurse competency. During a review of the facility's policy and procedure (P&P) titled, Orientation Program for Newly Hired Employees, Transfers, Volunteers, dated 5/2019, the P&P indicated, . All newly hired personnel/volunteers/transfers must attend orientation within seven (7) days of hire . c. An introduction to resident care procedures, which includes, but is not limited to . (1) a review of the facility's most common Nursing Service Policies . (3) a review of the facility's infection control practices . Our orientation program is an in-depth review of our facility's [policy and procedures]. A checklist is used to record materials reviewed . During a review of the facility's document titled, Infection Preventionist Job Description, undated, the document indicated, . The Infection Preventionist is responsible for the facility's infection prevention and control program (IPCP), which is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . Maintains current knowledge of federal, state, and local regulations . Performs any other duties as assigned by the supervisor .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40641 Based on observation, interview and record review, the facility failed to provide pharmaceutical services which ensured the administration of medications to meet residents needs for one of seven sampled residents (Resident 25) when Resident 25's metoprolol (medication used to treat high blood pressure) was not available for administration for 1 day (3/27/24). This failure had the potential for Resident 25's blood pressure to be uncontrolled and lead to serious medical condition such as a stroke (a loss of blood flow to part of the brain, which damages brain tissue). Findings: During a concurrent medication pass observation and interview on 3/27/24 at 7:15 a.m., at Station 2, Registered Nurse (RN) 1 was preparing Resident 25's medications after checking blood pressure which was 150/85 (a normal blood pressure for adults is a systolic measurement of less than 120 milimeters of mercury (mmHg unit of measurement) and a diastolic reading under 80 mmHg) and pulse of 85. RN 1 did not administer Resident 25's metoprolol medication. RN 1 stated the medication was not available to give to Resident 25. RN 1 stated Resident 25's B/P was at 150/85 and could go higher and pulse rate was 85. RN 1 stated she would call the physician to notify them that Resident 25's metoprolol medication was not available to administer. During a review of Resident 25's Admission Record [document with resident demographic and medical diagnosis information], dated 3/28/24, the admission record indicated, Resident 25 was admitted in the facility on 2/21/24, with diagnoses which included hypertension (pressure in the blood vessels are too high), heart failure (when the heart muscle can't pump enough blood to meet the body's needs) and muscle weakness. During a review of Resident 25's Progress Notes, dated 3/27/24, the Progress Notes indicated, . 03/27/2024 08:32 . [metoprolol brand name] Tablet . Med not available. Called Medical Doctor (MD) . Call Pharmacy for medication . During an interview on 3/28/24, at 9:15 a.m. with Licensed Vocational Nurse (LVN) 2, she stated the facility practice when medication was not available was for administration to call the MD and follow up with the pharmacy. LVN 2 stated licensed nurses are responsible in making sure medications are available to administer to residents. LVN 2 stated, .We do not want our residents to miss their medication because we did not have it available . During an interview on 3/28/24, at 2:10 p.m. with RN 1, she stated she had not received report from the previous nurse regarding medication for Resident 25 not being available for administration and did know if it was followed up with pharmacy. RN 1 stated she was not sure if the medication was administered the previous days. RN 1 stated Resident 25 is taking the medication to regulate her pulse and if not administered Resident 25's pulse could even go higher which could lead to more serious medical condition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24, at 2:55 p.m. with the Director of Nursing (DON), she stated the licensed nurses are responsible in making sure they are ordering residents' medications from the pharmacy and available for administration. The DON stated the licensed nurse who administered the last dose should have followed up with the pharmacy, Resident 25's missed medication was for her high blood pressure and pulse if not given it could lead to more serious health conditions. During a review of facility's policy and procedure (P&P), titled, Medication Shortages, dated 2007, the P&P indicated, . The facility nurse must make every effort to ensure that a medication ordered for the resident is available to meet their needs . Nursing staff . Notify the attending physician of the situation . During a review of the facility's P&P, titled, Non Controlled Medication Orders, dated 2007, the P&P indicated, . 4. The prescriber shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not available .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 40641 Based on observation, interview, and record review, the facility failed to ensure the facility medication error rate did not exceed five percent or greater when: 1. Registered Nurse (RN) 1 did not administer metoprolol (medication used to treat high blood pressure and pulse). This failure resulted in Resident 25 not receiving her blood pressure medication as prescribed by the physician and had the potential for Resident 25 to have elevated or low blood pressure and pulse and serious medical condition. 2. Licensed Vocational Nurse (LVN) 4 did not follow direction on the medication label to administer with breakfast when she administered Resident 55's potassium chloride (medication used to treat hypokalemia [low potassium level]). This failure had the potential for Resident 55 to not receive the therapeutic effect of the medication which could lead to high or low potassium level and result in serious medical condition. These medication errors resulted in a calculated medication error of 7.69 percent. Findings: 1. During a concurrent medication pass observation and interview on 3/27/24, at 7:40 a.m. in Station 2, Registered Nurse (RN) 1 was passing medication. RN 1 stated she already checked Resident 25's blood pressure and pulse which were noted as blood pressure of 150/85 and pulse of 85. RN 1 prepared Resident 25's medications and administered nine of ten medications scheduled for Resident 25. RN 1 stated she did not administer metoprolol to Resident 25 because it was not available. RN 1 stated she should have given the medication to Resident 55 as ordered since Resident 25's blood pressure was elevated at 150/85 and pulse was 85. RN 1 stated Resident 25's blood pressure and pulse could go higher and cause more serious health condition since the medication was not administered. During a review of Resident 25's Admission Record [document with resident demographic and medical diagnosis information], dated 3/27/24, the admission record indicated, Resident 25 was admitted in the facility on 2/21/24, with diagnoses which included hypertension (pressure in the blood vessels are too high) heart failure (condition in which the heart muscle can't pump enough blood to meet the dy's needs) and muscle weakness. During a review of Resident 25's Medication Review Report, dated, 3/27/24, the Medication Review Report, indicated, . [metoprolol] Oral Tablet Extended Release 24 hour 25 MG [milligram-unit of measurement] Give one [1] tablet by mouth one time a day related to ESSENTIAL . HYPERTENSION . Hold if systolic blood pressure [SBP-indicates how much pressure blood is exerting against the artery walls when the heart contracts] < (less) 100 or if heart rate [HR] <60 . Order Date: 2/23/24 . During an interview on 3/28/24, at 9:40 a.m. with Licensed Vocational Nurse (LVN) 2, she stated licensed nurses are responsible in making sure medications are available to administer to residents. LVN 2 stated she did not want residents to not have medications administered as ordered because the medication was not available. LVN 2 stated not administering medications as ordered could lead to more serious health issues. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24, at 3:50 p.m. with the Director of Nursing (DON), she stated licensed nurses are responsible in making sure medications are available to administer to residents as ordered. The DON stated it was the licensed nurses responsibility to follow up with the physician for alternate medication and follow up with pharmacy for medication refills. The DON stated Resident 25's blood pressure and pulse could go higher and could lead to serious health condition because her medication was not available to be administered as ordered. During a review of the facility's policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, dated, 2/23, indicated, . A medication error is defined as the preparation or administering of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples of medication errors include: a. omission - a drug is ordered but not administered . Failure to follow manufacturer's instructions and/or accepted professional standards . 2. During a concurrent medication pass observation, interview and record on 3/27/24, at 8:03 a.m. at Station 3, with Licensed Vocational Nurse (LVN) 4, LVN 4 prepared Resident 55's medications and administered four out of five scheduled medications for Resident 55. LVN 4 stated she administered potassium (brand name) to Resident 55 without breakfast. LVN 4 stated Resident 55's breakfast tray was on top of the bedside table and Resident 55 was lying in bed with eyes closed. LVN 4 stated she should have given Resident 55's medication with breakfast as ordered. LVN 4 stated Resident 55 may develop upset stomach and affect the effectiveness of the medication when given on empty stomach. During a concurrent observation and interview on 3/25/24, at 10:07 a.m., Resident 55 was lying in bed and appeared tearful. Resident 55 stated she had been in the facility for a long time and felt terrible but did not able to explain further. Observed breakfast tray at bedside covered and food was untouched. During a review of Resident 55's Admission Record, dated 3/27/24, the admission record indicated, Resident 55 was admitted in the facility on 4/25/23, with diagnoses which included hypertensive heart disease with heart failure (condition in which the heart muscle can't pump enough blood to meet the body's needs), hypokalemia (low levels of potassium) and muscle weakness. During a review of Resident 55's Medication Review Report, dated, 3/27/24, the Medication Review Report, indicated, . [brand name] Oral Tablet Extended Release 20 MEQ [milliequivalent-unit of measurement] . Give one [1] tablet by mouth one time a day related to HYPOKALEMIA . (Administer with Breakfast at 0700 with four [4] oz [ounces] of water) . order date 06/26/2023 . During an interview on 3/28/24, at 2:05 p.m. with RN 1, she stated medications with direction to give with breakfast or food had to be followed. RN 1 stated Resident 55 should have been actively eating when medication was administered to prevent upset stomach like nausea, vomiting or diarrhea. RN 1 stated some medications are irritating to the stomach linings which could lead to more serious health conditions. During an interview on 3/28/24, at 2:15 p.m., with the DON, she stated medications should be given as directed. The DON stated when a medication direction is to give with breakfast, the resident should be actively eating when administering the medication in order for the resident to have some food in her stomach. The DON stated medications like potassium could make a resident nauseous and stomach discomfort which could cause a lot of harm. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Medication Error Reporting and Adverse Drug Reaction Prevention and Detection, dated, 09/10, the P&P indicated, . 1. Medication error/variance shall be defined as any preventable event that may cause or lead to inappropriate medication use or resident harm . Such events may be related to professional practice . procedures . including . administration . During a professional reference review retrieved from https://www.drugs. com/tips/potassium-chloride-patient-tips#:~:text=Take%20potassium%20chloride%20tablets%20with, are%20also%20high%20in%20potassium. Take potassium chloride tablets with food or just after a meal to reduce the risk of stomach irritation. Follow with a full glass of water. Some foods (such as squash, spinach, cabbage, lentils, kidney beans, orange juice, bananas, tomatoes, zucchini, or cucumber) are also high in potassium. Ask your doctor if there is a limit to how much of these foods you can eat. Some salt substitutes or low-salt dietary products also contain potassium - be careful how much of these you eat. Do not crush, break, chew, or suck extended-release potassium chloride tablets as doing this may cause too much potassium chloride to be released at once, irritating your throat and stomach. Tablets are designed to release potassium slowly over time. Sometimes you may notice the remnants of a potassium chloride tablet in your stool.

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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** 40641 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles when two of two improper medication storage and labeling occured for: 1. Resident 5's hydromorphone (medication used to treat pain), hydrocodone-acetaminophen (a narcotic medication used to treat pain) and lorazepam (medication used to treat anxiety) were found repacked in smaller plastic bags with no labels and placed back in the plastic medication container from the pharmacy. These failures had the potential for Resident 5 to not receive the right medication which could lead to more serious medical conditions and had the potential for drug diversion (abuse of prescription drugs or their use for purposes ot intended by the prescriber). 2. Medication cart three had two boxes of omeperazole (medication used to treat heartburn) without received dates (a date when the medication had been opened) and did not have expiration dates on the boxes. This failure had the potential for residents to receive expired medications resulting in less efficacy. Findings: 1. During a concurrent observation and interview on 3/27/23, at 9:23 a.m. in Station 3, medication cart (cart 4). The medication cart contained a bottle of brand name of hydromorphone tablets were placed in three small plastic bags (used to crushed pills). The medication cart also contained a bottle of hydrocodone (a narcotic medication used to treat pain) tablets that were placed in three small plastic bags. Licensed Vocational Nurse (LVN) 4 stated Resident 5 was a hospice patient and hospice used a different pharmacy from the facility. LVN 4 stated since she started working in the facility, the loose narcotics had always been placed in smaller plastic bags for faster counting. LVN 4 stated she was not sure if the Director of Nursing (DON) or Assistant Director of Nursing (ADON) was aware of the practice of licensed nurses repacking narcotics in smaller plastic bags. During a review of Resident 5's clinical record titled, Admission Record [AR-document containing resident ddemographic and medical diagnosis information], dated 3/28/24, the AR indicated, Resident 5 was admitted to the facility on [DATE] with diagnoses which included . heart failure [heart doesn't pump enough blood for the body's need], palliative care [care focused on providing pain relief and other serious illness] and chronic pain . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Order Summary Report, dated 3/28/24, the Order Summary Report indicated, . [hydromorphone] Oral tablet two [2] MG [(Hydromorphone HCl) (hydrochloride] [milligram-unit of measurement] Give 0.5 tablet by mouth every four [4] hours as needed for pain 4-6 or dyspnea [difficulty breathing] . HYDROcodone-Acetaminophen Oral tablet 5-325 MG . Give one (1) tablet by mouth every six (6) hours related to OTHER CHRONIC PAIN . LORazepam Oral Tablet 0.5 MG (Lorazepam) . During an interview on 3/28/24, at 9:05 a.m., with LVN 2, she stated narcotics are labeled when delivered from pharmacy. LVN 2 stated, . It is a practice here to bag the narcotics in [set of 10 tablets] to make the counting process faster . LVN 2 stated she was not sure if it was a good practice placing the narcotics in smaller plastic bags then put back in the original container from the pharmacy because the plastic bags did not contain any labels. LVN 2 stated she was not sure if it was allowed to repack or transfer narcotics to smaller plastic bags because she was told by another nurse that they can to make counting of narcotics easy and faster. LVN 2 stated she now realized there was a higher chance of infection control and drug diversion (when medication is taken for use by someone other than whom it was prescribed). During an interview on 3/28/24, at 2:01p.m., with Registered Nurse (RN) 1, she stated, . Narcotics are never to be repacked, you have to leave the narcotics the way it was sent or delivered from the pharmacy . RN 1 stated narcotics can not be placed in small plastic bags for easy and faster counting. RN 1 stated licensed nurses can not repack and label narcotics, only pharmacist can. RN 1 stated she did not know why other nursing stations are repacking narcotics by transferring the tablets in smaller plastic bags. RN 1 stated it was not a good nursing practice. During an interview on 3/28/24, at 3:15 p.m., with the Director of Nursing (DON), she stated she was not aware the licensed nurses in other nursing stations were repackaging narcotics. The DON stated only the pharmacist has the right to repacked narcotics. The DON stated repacking narcotics is not approved practice, it could lead to a lot of other issues. During a review of facility's policy and procedure (P&P) titled, Medications and Medication Labels, dated 5/16, the P&P indicated, . 6. Medication labels are not altered . Contents are not transferred from one container to another . Only the pharmacy may place a label on the medication container . 41608 2. During a concurrent observation and interview on 3/27/24 at 10:10 am with LVN 1, in Station 2, inside cart 3, two boxes of omeprazole were in the third drawer of cart 3. The edge of the boxes with the expiration date had been removed. LVN 1 stated, she could not find an expiration date or a received date (a date when the medication had been opened) on either of the boxes. LVN 1 stated without an expiration date on the medication, Residents could potentially receive expired medication. LVN 1 stated expired medication could be less effective or have undesired side effects (unwanted, undesired effects). During a concurrent observation and interview on 3/27/24 at 10:30 a.m., in Medication room [ROOM NUMBER], with Director of Nurses, (DON), the DON confirmed the two boxes of omeprazole did not have received dates or expiration dates on them. The DON stated all medication in the medication carts are required to have expiration dates to prevent residents from receiving expired medications. (continued on next page)

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California Home for the Aged	6720 E. Kings Canyon Fresno, CA 93727

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Medication Packaging dated 10/2007, indicated . a. All unit dose medications contain a lot number, expiration date, product name .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28773 49949 Based on observations, interviews and record review, the facility failed to provide residents with a well-balanced diet to meet their nutritional needs for: 1.Three of five sampled residents (Resident 44, Resident 74 and Resident 83) when the Residents had a physician order for a supplement that was discontinued, and the Residents continued to receive the supplement. 2.Two of the five sampled residents (Resident 75 and Resident 30) when the Residents did not have a physician order for a chopped diet. This failure resulted in Resident 44, Resident 74 and Resident 83 receiving a discontinued supplement and had the potential to result in Resident 75's and Resident 30's nutritional needs not being met. Findings: 1. During a concurrent observation and interview on 3/25/24 at12:00 p.m., with Cook 3 and the Food Service Worker (FSW) 1, in the kitchen during the lunch meal service (a process when food is put into a tray) Resident 74 was missing a juice nutrition supplement (a nutritional supplement designed to support essential nutrients) eight ounces (oz). The surveyor asked FSW 1 if Resident 74 should have a juice nutrition supplement on her food tray. FSW 1 asked, What was a Breeze. Cook 3 indicated, there were no Breeze on the food tray for Resident 74. During a concurrent interview and record review on 3/26/24 at 4:42 p.m., with the Dietary Service Supervisor (DSS), Resident 74's Tray Ticket [a ticket which includes: name, room, diet, date, adaptive equipment, allergies, specific food and beverages items, likes and dislikes and notes] dated Tuesday March 26, 2024, was reviewed. The tray ticket indicated, on March 26, 2024, Resident 74 had supplements for Breeze 8 oz. The Surveyor and DSS reviewed the Ticket Tray for Resident 74. The DSS indicated, the Breeze was discontinued. The DSS stated, there were no communication slips (a paper form used to communicate to the kitchen of changes in diet) for Resident 74's. During a review of Resident 44's Tray ticket dated Wednesday March 27, 2024, the Tray ticket indicated, Resident 44's has supplement Honey Boost (a nutritional drink with protein and nutrients with honey consistency) 8 oz. During a review of Resident 44's .SNF-Progress Notes New (PNG) dated on 3/13/24 the PNG indicated the Registered Dietitian (RD) stated, Resident has boost nutritional supplement of equal or higher caloric value (8oz) TID with meals. Resident does not care for the nectar thickened fluids. Resident more receptive to drinking house shake. Rec house shake (4oz) TID with meals and d/c boost nutritional supplement of equal or higher caloric value (8oz) TID with meals--monitor on consumption of supplement. Will continue to monitor resident. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 44's SNF-Order Audit Report ([NAME]) dated March 27, 2024, the [NAME] indicated, Order Summary .Boost/Nutritional Supplement of =/> caloric value with meals for Supplement (give 8 0z. (237 ml) by mouth was discontinued on 3/18/2024 at 3:49 p.m. During a review of Resident 83's Tray Ticket dated Wednesday March 27, 2024, the Ticket Tray indicated Resident 83 orders were for supplement Magic Cup (a ice-cream like supplement with added calories and protein for Resident experiencing weight loss) 4 oz. During a review of Resident 83's SNF-Order Audit Report ([NAME]) dated [DATE], the [NAME] indicated, Order Summary: Magic cup two times a day for (give 4 oz (120 ml) with lunch and dinner at 1200 &1700 was discontinue 3/26/2024 @ 6:54 p.m. During an interview on 3/27/24 at 11:49 a.m. with the DSS, the DSS stated there was no diet communication slip to notify the kitchen of Resident 83's discontinues of the Magic cup. During an interview on 3/27/24 at 12:14 p.m., with the Director of Nursing (DON), the DON stated, the nurse should communicate the changes in diet order to the kitchen. The DON stated, the nurse could notify the kitchen of a discontinue or diet change to the kitchen by phone, in person or communication slip. During an interview on 3/27/24 at 12:37 with Resident 83, Resident 83 stated, I have asked them to stop giving magic cup a week ago. I put in the order for Sherbert cup yesterday. Resident 83 stated, I am not fond of it [magic cup] and they are good at letting me fix it [changing the supplement to something she likes]. During a concurrent interview and record review on 3/27/24 at 3:19 PM with the Assistant Director of Nursing (ADON), Resident 83's [NAME] dated [DATE], was reviewed. The [NAME] indicated Order Summary: Magic cup two times a day for (give 4 oz (120 ml) with lunch and dinner at 1200 &1700 was discontinued 3/26/2024 at 6:54 p.m. The DON indicated, the order was discontinued on 3/26/24. The ADON was asked the communication process between nurses and the kitchen staff. The ADON stated, I believe we have a communication log. The ADON indicated she was not sure and wanted to verify with the DON. The ADON went to the DON's office. The ADON confirmed with the DON and the ADON indicated, the nurses should communicate with the kitchen staff using the communication log. The ADON also indicated, the nurses can call or walk to the kitchen services to notify staff about the changes in the diet. The ADON indicated there was no communication slip sent to the kitchen about the discontinue Magic cup order for Resident 83. The ADON stated it was not acceptable to not communicate with the kitchen staff about changes in diet order for Resident 83. The ADON indicated lack of communication between the nurse and kitchen can lead to possible weight loss for Resident 83. During a review of the facility's (P&P) titled, Food and Service Policy & Procedures [NAME] dated 2018, the P&P indicated, Nutrition Care .Diet orders for New Admission, diet changes, NPO, or hold meals .the facility will serve diets as ordered by the physician and in accordance with the approved diet manual .the nursing department is responsible for initiating the admission diet order . all diet orders and changes must be ordered on a Diet Communication Form (Page 93) and delivered to the Department of Food and Nutrition Services prior to the next meals . 2. During a record review of Resident 30's Tray Ticket dated Wednesday March 27, 2024, the Tray Ticket indicated, Resident 30's diet orders were for CCHO chopped meat, regular portion. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 30's Order Details (OD) dated 2/19/2024, the OD indicated, Order Summary: CHHO diet, regular texture, regular (thin) consistency. No chopped meat was written in the OD. During a record review of Resident 75's Tray Ticket dated Wednesday March 27, 2024, the Tray Ticket indicated, Resident 75 diet orders were Regular chopped meat, regular portion. During a record review of Resident 75's Order Detailed (OD) dated 2/13/2024, the OD indicated, Order Summary: regular diet, regular texture, regular (thin) consistency. No chopped meat was written in the OD. During an interview on 3/27/24 at12:14 p.m., with the DON, the DON stated Resident 30 's diet order was CCHO regular texture and regular liquids. The DON stated, Resident 75's diet orders were regular diet and regular texture and thin consistency (regular thin fluids). During an interview on 3/27/24 starting at 2:24 p.m. with the RD and DSS, the RD stated diets or therapeutic diets should have a physician's order. During a record review of the facility's policy and procedure titled, Food Service Policy and Procedure (P&P) dated 2018, the P&P indicated, Menus .all menus will provide adequate nutrients to meet the special needs of the residents/patients, including special dietary modifications .Menus are planned to meet the nutritional needs of the residents/patients in accordance with the physician's diet order, the approved diet manual, federal/state regulations and in accordance with the most current edition of Dietary Reference intakes (DRI) from the Food and Nutrition Board of Institute of Medicine

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observations interviews and record review, the facility failed to ensure two of the seven sample residents (Resident 13 and Resident 21) small portion diet were not followed according to their alternate menu for lunch on March 25, 2024. The failure had the potential result to not meet the resident's caloric intake and contribute to weight loss, further compromising the medical status. Finding: During an observation on 3/25/24 at 12:00 p.m., in the kitchen during the lunch meal service, Cook 1 was observed using a #16 scoop (1/4 cup) of Spanish rice on Resident 13's and Resident 21's lunch tray. Review of the lunch tray ticket for Resident 13 and Resident 21 showed, they were on a small portion diet. During a concurrent interview and record review of the lunch menu on 3/25/24 at 12:33 p.m. after the lunch meal service was completed, with Cook 1 and Dietary Service Supervisor (DSS), the Daily Spreadsheet dated March 25, 2024, was reviewed. The Daily Spread sheet indicated Spanish rice small portion scoop size was #12 scoop (1/3 cup). Cook 1 stated scoop size #16 was used to serve Spanish rice for small portion. Cook 1 stated scoop size #16 was for the small portions diet. Cook 1 was asked by the surveyor to look at the lunch Daily Spreadsheet (menu) and identify the scoop size on the menu. Cook 1 did not respond. The DSS asked the surveyor team to clarify the question. The DSS confirmed the Spanish rice was supposed to be scoop sized #12 and not scoop size #16. During a record review of Resident 21 California Armenian Home-SNF Order Audit Report ([NAME]) dated 4/20/23 at 5:41 p.m. the [NAME] indicated, Resident 21 Order Summary for regular diet, regular texture, regular thin consistency and small portions. During a record review of Resident 13 California Armenian Home-SNF Order Audit Report dated 12/4/20 at 4:19 p.m. the [NAME] indicated, Resident 13 Order Summary for regular diet, regular texture, regular thin consistency and small portions. During an interview on 3/27/24 at 2:45 p.m. with the Registered Dietitian (RD), the RD was asked about her expectation for the kitchen staff for scoop sized. The RD stated the expectation is the correct scoop size should be followed for each resident based on the Daily Spreadsheet (menu). The RD she was notified of the resident getting scoop size #16 instead of scoop size #12. The RD stated the Daily Spreadsheet was not followed. The RD stated the portion size can potentially cause further weight loss for residents if not given the correct amount. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Food Service Policy &Procedures [NAME] dated 2018 the P&P indicated, Food preparation .portion control assures correct quantities are served to resident/patients to meet the nutritional specification as determined by the menu .resident/patient satisfaction is highest when expectation about amount of food received . The procedure stated scoops are sized according to the number of scoops need to equal one quart. The smaller the number, the larger the size. 28773

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28773 49949 Based on observation, interview and record review, the facility failed to ensure the food was prepared in accordance with professional standard for food service safety when one of two sampled kitchen staff (Cook 2) did not have a beard restraint while preparing food. This failure had the potential for Cook 2's hair to fall into the food and caused contamination. Findings: During a concurrent observation on 3/26/24 at 9:10 a.m. with the Dietary Service Supervisor (DSS), in the kitchen during food preparation, Cook 2 was observed slicing and measuring roast beef. Cook 2 was observed with a surgical mask that covered his mouth and nose only. It was observed that he had facial hair on the sides of his face that was without a beard restraint to cover his facial hair and beard. During an observation on 3/26/24 at 9:36 a.m. in the kitchen during food preparation, Cook 2 was observed putting roast beef into a food processor and chopped it. Cook 2 was observed putting roast beef with the juice from the roast beef into the food processor and blending it. Cook 2 was observed without no beard restraint to cover his facial hair and beard. During an interview on 3/27/24 at 2:25 p.m. with the Registered Dietitian (RD), the RD stated kitchen staffs were expected to wear a snood (a hairnet or fabric bag worn over the hair at the back). The RD stated beard restraint should be used in the kitchen. During an interview on 3/27/24 at 2:35 p.m. with the DSS, the DSS stated Cook 2 was not wearing his snood during food preparation. During a review of the facility's policy and procedure (P&P) titled, Food Service Policy and Procedures [NAME] dated 2018, the P&P indicated, Sanitation and Infection Control .a hair net and/or head covering which, completely cover all hair, should be worn during meal preparation and service . Beards and/or mustaches should be covered during meal preparation and service .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 48430 Based on interview, and record review, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards when: 1. One of four residents (Resident 52) medical record did not reflect when change of the humidifier bottle (medical devices filled with water that increase the humidity in the oxygen being delivered) and amount of oxygen administered was not accurately documented. This failure placed Resident 52 at risk of the humidifier bottle not being changed timely, the water becoming stagnant (stale or foul), oxygen would not be humidified leading to dry, cracked and bleeding mucosal membranes (the moist outer layer that lines various cavities in the body) and receiving the incorrect amount of oxygen. 2. Four of eight sampled residents (Residents 29, 77, 81and 83) Physician Orders for Life-Sustaining Treatment (POLST - a medical order signed by both the patient and medical provider that specifies the types of medical treatment a patient wishes to receive toward the end of life) were incomplete. This failure had the potential for Resident 29, 77, 81 and 83's decisions regarding treatment options and end of life wishes to not be honored. Findings: 1. During a concurrent observation and interview on [DATE] at 10:25 a.m. with Registered Nurse (RN) 3 in Resident 52's room, the humidifier bottle was observed to have a date label of ,d+[DATE]. The RN 3 stated, it was last changed at that date and needed to be changed every 3 days. The RN stated, it should have been changed on ,d+[DATE]. During a concurrent interview and record review on [DATE] at 9:30 a.m. with Licensed Vocational Nurse (LVN) 1 Resident 52's Order Summary (OS) dated [DATE] was reviewed. The OS indicated, Change Humidifier Bottle every night shift every 3 day(s). The LVN 1 stated, all licensed nurses are responsible for changing the bottle. The LVN 1 stated, if the liquid runs out .the oxygen may not be properly humidified, the patient may develop dry nose, and bacteria can grow with an expired bottle. During a concurrent interview and record review on [DATE] at 9:57 a.m. with LVN 1 Resident 52's Medical Administration Record (MAR), dated [DATE] was reviewed. The MAR indicated, the humidifier bottle was changed on Fri 22 signed by SJL. The LVN 1 stated, because the bottle was still dated ,d+[DATE], it did not reflect the MAR documentation that it was changed on ,d+[DATE]. The LVN 1 stated, the bottle was not changed on ,d+[DATE]. During an interview on [DATE] at 8:51 a.m. with the Director of Nurses (DON), the DON stated, humidifier bottles should be changed every 3 days. The DON stated, if the bottle was dated ,d+[DATE], it should have been changed on ,d+[DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 8:55 a.m. with the DON, Resident 52's MAR, dated [DATE] was reviewed. The DON stated, the MAR indicated, on ,d+[DATE] an LVN initialed to indicate the humidifier bottle was changed. The DON stated, it is not OK to sign that you did something that wasn't done. The DON stated, if the humidifier bottle hasn't been changed, the water could become stagnant and or run out. The DON stated, this can cause dry mucous membranes resulting in bleeding from the nose, discomfort, sores, and pain. During a concurrent interview and record review on [DATE] at 9:15 a.m. with the DON, Resident 52's MAR, dated [DATE] was reviewed. The DON stated, no they [MAR documentation of change of the humidifier bottle signed ,d+[DATE]] are not accurate, it does not appear to be accurate. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated [DATE], the P&P indicated, Documentation in the medical record will be .accurate. 48739 2. During a review of Resident 29's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 29 was admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), atherosclerotic heart disease (when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body become thick and stiff), chronic systolic heart failure (when the heart is weak, and the left side can't contract [squeeze] normally when the heart beats), cardiomegaly (enlargement of the heart), anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), muscle weakness and shortness of breath. During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS Section C indicated Resident 29 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE]) score of 15 (a score of ,d+[DATE] indicates severe cognitive impairment, ,d+[DATE] indicates moderately impaired, ,d+[DATE] indicates cognitively intact). Resident 29's BIMS score of 15 indicated Resident 29 was cognitively intact. During an interview on [DATE] at 11:04 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated a residents POLST should be filled out with the doctor's name and contact information. CNA 9 stated if the phone number was not written on the POLST, someone reading the POLST may not be able to get in contact with the doctor in case of an emergency. CNA 9 stated everything on the POLST should be filled out since it was a doctor's order. During a concurrent interview and record review on [DATE] at 9:21 a.m. with Registered Nurse (RN) 3, Residents 29's POLST, dated [DATE] was reviewed. The POLST indicated no physician phone number was present on Resident 29's POLST order. RN 3 stated the POLST was not fully completed. RN 3 stated the phone number should have been filled out by the physician. RN 3 stated a POLST was sent with residents whenever they were transferred out of the facility. RN 3 stated having the phone number was important to have in order to call the doctor in case of an emergency. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 11:22 a.m. with the Assistant Director of Nursing (ADON), Residents 29's POLST, dated [DATE] was reviewed. The POLST indicated no physician phone number was present on Resident 29's POLST order. The ADON stated the POLST let people know if someone should receive cardiopulmonary resuscitation (CPR-lifesaving procedure done when someone's heart stops beating). The ADON stated the POLST was sent out with the resident if they were going to the hospital or when being discharged . The ADON stated she would have questioned the validity of a POLST if she saw the signature was missing. During a review of Resident 77's AR, dated [DATE], the AR indicated Resident 77 was admitted on [DATE] with diagnoses of heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), end stage renal disease (a condition where the kidneys can no longer function on their own and dialysis [a process of removing excess water, and waste products from the blood] or kidney transplant is required to survive), and chronic atrial fibrillation (an irregular and often very rapid heart rhythm lasting more than a week). During a review of Resident 77's MDS, dated [DATE], the MDS section C indicated Resident 77 had a BIMS score of 15, which indicated Resident 77 was cognitively intact. During a concurrent interview and record review on [DATE] at 9:51 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 77's POLST, dated [DATE] was reviewed. The POLST indicated, the Physician/Nurse Practitioner (NP)/Physician's Assistant (PA) Phone number fields were not completed and the Physician/PA License number, NP Certification number were not completed. LVN 6 stated Resident 77's POLST was incomplete. LVN 6 stated the physician phone number and physician license number were missing. LVN 6 stated the physician phone number and license number should be completed. LVN 6 stated Resident 77's POLST was null and void. LVN 6 stated staff would not get in touch with the physician right away and that could delay treatment. During a concurrent interview and record review on [DATE] at 11:23 a.m. with the Director of Nursing (DON), Resident 77's POLST, dated [DATE] was reviewed. The POLST indicated, the Physician/Nurse Practitioner (NP)/Physician's Assistant (PA) Phone number fields were not completed and the Physician/PA License number, NP Certification number were not completed. The DON stated the POLST told the nurse and staff members what the wishes were of the resident or responsible party (RP). The DON stated the POLST indicated if Cardiopulmonary Resuscitation (CPR - an emergency life-saving procedure that is done when someone's breathing, or heartbeat has stopped. CPR combines rescue breathing and chest compressions), nutrition or certain measures were in place, such as comfort measures. The DON stated the POLST was sent with the resident if they were transported out of the facility. The DON stated without the physician phone number and license number, the POLST was not completed. The DON stated if the POLST was not completed staff would have to do CPR on the resident, which could violate the wishes of the resident or family member if that is not what they wanted. The DON stated her expectation was for the POLST to be completed. (continued on next page)

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	055955	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Home for the Aged	6720 E. Kings Canyon Fresno, CA 93727

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:45 a.m. with the Admission Coordinator (AC), the AC stated the POLST let us know what the wishes were for the resident in the event of an acute emergency. The AC stated the POLST would go with the resident if they were transported out of the facility. The AC stated if the POLST did not have the physician phone number or license number, staff could still use it. The AC stated she did not believe the physician's phone number and license number were required for the POLST to be a valid document. The AC refused to validate if the POLST was incomplete without the Physician/NP/PA phone number, Physician/PA License number, NP Certification number, or additional contact fields completed. During a review of Resident 81's AR, dated [DATE] , the AR indicated Resident 81 was admitted on [DATE] with diagnoses of diffuse large B-cell lymphoma (blood cancer that affects the white blood cells), Major depressive disorder (disease that causes sadness), anemia (disease that occurs when the body doesn't have enough red blood cells to carry oxygen) and tumor lysis syndrome (condition In which cancer cells go into the bloodstream). During a review of Resident 81's MDS, dated [DATE], the MDS section C indicated Resident 81 had a BIMS score of 15, which indicated Resident 81 was cognitively intact. During a concurrent interview and record review on [DATE] at 9:21 a.m. with RN 3, Residents 81's POLST, dated [DATE] was reviewed. The POLST indicated no physician phone number was present on Resident 81's POLST order. RN 3 stated Resident 81's POLST was not fully completed. RN 3 stated the phone number should have been filled out by the physician to have a complete form. RN 3 stated having the phone number was important in order to call the doctor in case of an emergency. During a concurrent interview and record review on [DATE] at 11:22 a.m. with the assistant director of nursing (ADON), Residents 81's POLST, dated [DATE] was reviewed. The POLST indicated, no physician phone number was present on Resident 81's POLST order. The ADON stated a POLST lets people know if someone should receive CPR or not. The ADON stated she would have questioned the validity of a POLST if she saw the signature missing. The ADON refused to validate if Resident 81's POLST was incomplete. During a review of Resident 83's AR, dated [DATE], the AR indicated Resident 83 was admitted on [DATE] with diagnoses of multiple fractures of pelvis (a break of the ring of bones that connect your spine to the hips), fracture of sacrum (a break of the large triangular bone at the bottom of the spine), and multiple fractures of ribs (several breaks in the rib bones). During a review of Resident 83's MDS, dated [DATE], the MDS section C indicated Resident 83 had a BIMS score of 15, which indicated Resident 83 was cognitively intact. During an interview on [DATE] at 11:02 a.m. with Resident 83, Resident 83 stated she would want her significant other and daughter-in-law notified if she were sent out to another facility. During a concurrent interview and record review on [DATE] at 9:51 with LVN 6, Resident 83's POLST was reviewed. LVN 6 stated the Additional Contact field was not completed. LVN 6 stated no additional contact information was entered. LVN 6 stated the information should be entered. LVN 6 stated having additional contact information would be helpful to notify the person listed as an additional contact if the resident was sent out of the facility. LVN 6 stated Resident 83's family would want to be notified. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:45 a.m. with the AC, the AC stated the POLST let us know what the wishes were for the resident in the event of an acute emergency. The AC stated the POLST would go with the resident if they were sent out of the facility. The AC stated the family information is on the admit sheet. The AC stated the facility would communicate with the family who was next in line if the resident was sent out of the facility. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated , d+[DATE], indicated, . documentation in the medical record will be objective (not opinionated or speculative), complete and accurate .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608 Based on observation, interview, and record review, the facility failed to implement safe infection control measures for two of three sampled residents (Resident 2 and Resident 4) when: Resident 2's urinary catheter bag (a tube that is inserted into the bladder, allowing the urine to drain freely into an attached bag), and Resident 4's urinary tubing was observed lying on the floor. This failure had the potential to spread harmful bacteria (microorganisms that can be found on surfaces and in the body), infections to both Resident 2 and Resident 4. Findings: During a review of Resident 4's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/27/24, the AR indicated Resident 4 was admitted on [DATE] with diagnoses of obstructive and reflux uropathy (a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys), retention of urine (a condition where the bladder does not empty completely or at all), type II diabetes mellitus (a disease that occurs when your blood sugar is too high) and congestive heart failure (a condition in which the heart doesn't pump blood as efficiently as it should). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/6/24, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 12 (a score of 0-7 indicates severe cognitive impairment, 8-12 indicates moderately impaired, 13-15 indicates cognitively intact), which indicated Resident 4 was moderately impaired. During a concurrent observation and interview on 3/25/24 at 11:17 a.m. with the Director of Nursing (DON) in Resident 4's room, Resident 4 was observed with her urinary catheter tubing touching the floor. The DON verified the catheter tubing was on the floor. The DON stated the catheter tubing should not be touching the floor. The DON stated the catheter tubing could get dislodged. The DON stated if germs move up the catheter, it could cause infection in the resident. During an interview on 3/27/24 at 9:33 a.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated the catheter tubing should not be on the floor. CNA 8 stated if the catheter was on the floor it was contaminated. CNA 8 stated the resident could catch an infection. CNA 8 stated the tubing should be stored in a privacy bag for cover and so it would not be on the floor. (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 3/27/24 at 9:51 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated the catheter tubing should not be dragging on the floor. LVN 6 stated the catheter should be covered with a protected cover. LVN 6 stated if the resident is in a wheelchair, the catheter should be on the side of the wheelchair, the catheter tubing should not drag on the ground. LVN 6 stated it is an infection control issue for the resident and everyone else. LVN 6 stated if the catheter wasn't cleaned properly, it could get urine on ground. LVN 6 stated if there were germs on the ground, they could travel back up to the resident through the catheter tubing and the resident could get an infection. During a review of Resident 2's Admission Record (AR), dated 03/27/24, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis which included Dementia (impaired thinking, remembering or reasoning), Type 2 Diabetes Mellitus (high levels of sugar in the blood), Anemia (lower than normal red blood cells), Neuromuscular Dysfunction (nerve and muscle weakness and pain), Hypertensive Heart Disease with Heart Failure (higher than normal blood pressure causing the heart not to function correctly), Dysphagia (swallowing difficulties), Benign Prostatic Hyperplasia without lower Urinary Tract Symptoms (a buildup of prostatic tissue against the urethra making it difficult to urinate). During a review of Resident 2's MDS Section C dated 06/22/24, Resident 2's BIMS score was 4 which indicated severe cognitive impairment. During the initial tour of the facility on 03/25/24 at 9:57 a.m., in Resident 2's room, Resident 2's urinary catheter drainage bag was observed lying on the floor next to the left side of Resident 2's. During a concurrent interview and record review on 03/25/24 at 04:22 p.m., with LVN 8, LVN 8 verified the catheter bag was on the floor. LVN 8 stated the Catheter bag should not be on the floor. LVN 8 stated the bacteria from the floor could have gone up the catheter tubing into the resident. During a concurrent interview and record review on 03/27/24 at 11:12 a.m. with the Infection Preventionist (IP), IP verified that the catheter bag was on the floor. IP stated, urine catheter bags should never be on the floor, it put the resident at risk for infection. The IP stated the facility's policy on urinary catheter care was not followed. During a concurrent interview and record review on 03/27/24 at 4:21p.m. with the Director of Staff Services (DSD), DSD verified the catheter bag was on the floor. The DSD stated, Resident 2's catheter bag should never have touched the floor. DSD stated the urinary catheter bag should not have contact with the floor it could have spread infection from the floor up the catheter tubing and into the resident. The DSD stated the catheter on the floor is not the expected practice for catheter care. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated 8/2022, indicated, . the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections . be sure the catheter tubing and drainage bag are kept off the floor . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Policies and Practices - Infection Control, dated 10/2018, indicated, . the objectives of our infection control policies and practices are to: prevent, detect, investigate, and control infections in the facility . 48739

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40641 Based on observation and interview, the facility failed to provide a safe, functional, and comfortable environment for residents, staff and the public when one of three medication rooms (Station 5) was observed with only one of four fluorescent lights was working. This failure had the potential for distribution of the wrong medications for residents and for staff to trip and fall. Findings: During a concurrent observation, interview and record review on 3/26/24, at 3:50 p.m. in Station 5 medication room with Licensed Vocational Nurse (LVN) 5, the medication room was observed to be dark when we entered the room, there were four fluorescent lights in the ceiling and only one of the four fluorescent lights was working. LVN 5 stated she did not usually worked in Station 5 and was not aware if the lights had already been reported to maintenance department. LVN 5 stated all four fluorescent lights should all be working to be better to see medication labels better. LVN 5 stated, . it could cause tripping and fall . During an interview on 3/26/24, at 5:02 p.m. with Registered Nurse (RN) 2, in Nursing Station 5, RN 2 stated she had only been working in the facility for two months. RN 2 stated, .It's been like that since I started working two months ago . RN 2 stated she had noticed the lights when she was training with another nurse and was told it was broken. RN 2 stated she did not remember putting in a request to get the lights fixed nor did she knew if the other nurse submitted a work order for the maintenance. RN 2 stated the medication room was dark and a a nurse can not really see or read medication labels, there is also possibility to cause a trip and fall. RN 2 stated it was not an ideal situation and the expectation was for the lights to be fully functional. During a concurrent observation and interview on 3/26/24, at 5:30 p.m. with the Maintenance Facility Director (MFD) in Station 5's medication room, MFD was observed looking up at the fluorescent lights and stated he was not aware of the issue with the lights prior today (3/26/24) at 5:20 p.m. The MFD stated the lights in the station 5's medication room was not acceptable, it was not a safe working environment. The MFD stated, . All the lights should have been working properly . The MFD stated it was safety issues which could lead to trip and fall and nurses may not be able to read the medication label properly which could lead to medication error. The MFD stated the nursing staff should have let maintenance know by putting the request in system named TELS (is a building management platform designed for Senior Living with integrated Asset Management, Life Safety, and Maintenance solutions). (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24, at 2:25 p.m. with the administrator (ADM), she stated the MFD took care of the lights on 3/26/24. The ADM stated she did not think the lack of enough light in the medication room would cause immediate health and safety hazard but just minor delay. The ADM stated the licensed nurses have an alternate means of lighting to appropriately to see the medication labels, the nurses could always use their cell phone lights and flash lights to read the medication labels or step outside into the nursing station where there was appropriate lights. The ADM stated, if the nurses had problems with the lights they should have put in work order in TELS report so maintenance can take care of it. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated, . The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike environment . includes . comfortable (minimum glare) yet adequate (suitable to the task) lighting . Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment . During a review of the facility's document, titled, Facility Assessment Tool, updated 10/24/23, the Facility Assessment Tool indicated, . Facility maintains routine service logs for most types of equipments and performs routine inspections . Facility Maintenance Lead ensures that all basic physical plant systems are maintained and operational at all times and works with professional contractors for repairs, upgrades as needed .

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 44899 Based on interview and record review, the facility failed to follow the policy and procedure titled In-service Training to ensure Licensed Nurses (LNs), Certified Nursing Assistants (CNAs) and ancillary (additional) support staff received and demonstrated competency to prevent and recognize resident abuse and the necessary skills and techniques necessary to care for residents with Dementia [a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning] when: 1. 36 of 67 CNAs had not attended and completed the 2023 annual mandatory in-service training for Dementia Module 1 titled Caring for Persons with Dementia. 2. 47 of 67 CNAs had not attended and completed the 2023 annual mandatory in-service training for Dementia Module 4 titled More than Words. 3. 22 of 120 facility staff had not attended and completed the 2023 annual mandatory in-service training for Fall Prevention. 4. 50 of 120 facility staff had not attended and completed the 2023 annual mandatory in-service training for Abuse Prevention. These failures had the potential to place residents at risk for care not provided in a safe and competent manner. Findings: During a concurrent interview and record review on 3/26/24, at 4:14 p.m., with the Director of Staff Development (DSD), the in-service training for Dementia Module 1, titled Caring for Persons with Dementia, dated 1/11/23 and 1/23/23 was reviewed. The DSD stated, they have 67 CNAs providing direct care to facility residents. The document indicated 36 of 67 CNAs had not attended the mandatory training. The DSD stated, Dementia modules, including Module 1, were mandatory trainings for CNAs and should be completed annually. During a concurrent interview and record review on 3/26/24, at 4:19 p.m., with the DSD, the in-service training for Dementia Module 4, titled More Than Words, dated 9/26/23 and 9/28/23 was reviewed. The document indicated 47 of 67 CNAs had not attended the mandatory training. The DSD stated, Dementia modules, including Module 4, were mandatory trainings for CNAs and should be completed annually. During a concurrent interview and record review on 3/26/24 at 4:27 p.m. with (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the DSD, the in-service training for Fall Prevention dated 9/28/23 and 9/29/23 was reviewed. The DSD stated, they have 120 employees providing direct and indirect care to facility residents. The document indicated 22 of 120 facility staff had not attended the mandatory training. The DSD stated, the in-service training for Fall Prevention was mandatory training for all staff. The DSD stated, without the training, staff would not have the proper knowledge on preventing residents from falling. During a concurrent interview and record review on 3/26/24 at 4:35 p.m. with the DSD, the in-service training for Abuse Prevention dated 5/5/23, 5/25/23 and 5/31/23 was reviewed. The document indicated 50 of 120 facility staff had not attended the mandatory training. The DSD stated, the in-service training for Abuse Prevention was mandatory training for all staff. The DSD stated, without the training, staff would not have the proper knowledge on preventing resident abuse. During a concurrent interview and record review on 3/28/24 at 11:47 a.m. with the Director of Nursing (DON), the 2023 In-service Training Calendar was reviewed. The DON stated, the trainings for Abuse Prevention, Fall Prevention, and Dementia Module 1 and Module 4 were mandatory trainings and should be completed annually. The DON stated, in-service training should be attended by LNs, CNAs, and support staff to provide proper care to facility residents. During a review of the facility's Resident matrix [listing of residents by medical conditions] dated 3/25/24, indicated there were 27 of 87 residents diagnosed with Alzheimer's disease (an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) or Dementia. During a review of the facility's policy and procedure (P&P) titled, Staff Development Program, undated, the P&P indicated, . All employees receive, at time of hire and periodically thereafter, in-service training relative to resident rights and our facility's abuse prevention program policies and procedures . Annual in-service training programs include educational sessions on such topics as: a. Understanding the resident's abusive actions . d. Recognizing signs and symptoms of abuse . f. dealing with aggressive or catastrophic resident behavior/reactions . During a review of the facility's P&P titled, Preventing Resident Abuse, undated, the P&P indicated, . Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training program, systems . 2. Our abuse prevention/intervention program includes . c. In-service training programs designed to teach staff how to better understand the resident's abusive actions . The professional reference document titled Center for Clinical Standards and Quality/Survey & Certification Group, dated 9/14/12, indicated The Affordable Care Act: Section 6121 requires the Centers for Medicare & Medicaid Services (CMS) to ensure that nurse aides receive regular training on caring for residents with dementia and on preventing abuse. CMS created this training program to address the requirement for annual nurse aides training on these important topics. During a review of the facility's document titled, Certified Nurse Aide Job Description, undated, the document indicated, . Provides for resident's personal hygiene, give bedpans, urinals, baths, backrubs . Provides comfort needs of residents . Follows all policies, procedures and regulations governing the facility . Attend all required In-service Training sessions . (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's document titled, Director of Staff Development Job Description, undated, the document indicated, . Functions as an education instructor in the development and implementation of policies and procedures. Provides on-going In-service Education as required by regulation and facility needs . Develops In-service education calendar for all mandatory in-service meetings per regulations . During a professional reference review retrieved from https://www.nursinghomeabuse.org/articles/nursing-home-abuse-training/ titled, Abuse and Neglect Training in Nursing Homes, dated 3/31/21, the professional reference indicated, .Nursing home abuse and neglect is unfortunately still a problem in nursing homes across the country. Nursing homes can significantly reduce the incidence of abuse and neglect in their facilities by investing in training and prevention. Nursing home facilities that do offer training have shown to have fewer cases of abuse and neglect .