STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	5901 Lemon Hill Ave Sacramento, CA 95824

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on observation, interview, and record review, the facility failed to ensure that a safe, clean, comfortable and homelike environment was provided for seven of 18 sampled residents (Resident 9, Resident 18, Resident 153, Resident 253, Resident 254, Resident 255, and Resident 256), when a cabinet and closet drawers were in disrepair, with chipped paint, and the walls were empty and bare inside the residents' rooms. This failure had the potential to result in the residents not attaining their highest practicable level of well-being. Findings: Resident 9 was admitted in late 2011 and readmitted in early 2022 with diagnoses which included stroke and weakness. During a review of Resident 9's Minimum Data Set (MDS, an assessment tool), dated 6/19/24, the MDS indicated Resident 9 had mild memory impairment and required extensive assistance with activities of daily living (ADLs). During a concurrent observation and interview on 7/9/24 at 8:35 a.m. in Resident 9's room, the cabinet drawers and closet doors were noted to be in disrepair, and the walls with chipped and had stained paint. Resident 9 was up in the wheelchair, awake and alert and verbally responsive and stated, Those cabinet drawers and doors don't close properly and they have been like that for a long time. The paint is wearing off. I don't know why they are not fixing them. It is very annoying. Resident 18 was admitted to the facility in early 2024 with diagnoses which included chronic lung disease and pneumonia (lung infection). During a concurrent observation and interview on 7/8/24 at 9:24 a.m. in Resident 18's room, the cabinet drawers were noted to be in disrepair and there was chipped and stained paint on the walls. The Administrative Assistant/Clerk (AA/C) verified the finding and stated, It is not homelike. It is not good for the residents. Resident 153 was admitted to the facility in late 2023 with diagnoses which included stroke, difficulty walking, muscle weakness, difficulty swallowing, and expressive language disorder. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/8/24 at 9:41 a.m. in Resident 153's room, Resident 153 was found asleep. The immediate environment and the walls were bare and no belongings were found in the bedside area except a urinal on top of the nightstand. During a concurrent observation and interview on 7/8/24 at 9:49 a.m. with Certified Nursing Assistant 5 (CNA 5) in Resident 153's room, CNA 5 verified the walls were empty and bare and stated, The room is not homelike. There are no pictures, like something from home, to provide dignity. During a concurrent observation and interview on 7/8/24 at 9:51 a.m. with CNA 6 in Resident 153's room, Resident 153's closet drawers did not close properly, with parts of the drawers unevenly protruding outward. Additionally the paint was noted to be chipped and stained. CNA 6 verified the findings and stated, The drawers are not safe. The residents in this room are ambulatory (out of bed and mobile) and may trip and can cause accidents and injuries to the residents. During a concurrent observation and interview on 7/8/24 at 9:54 a.m. with the Director of Nursing (DON) in Resident 153's room, the DON verified the cabinet drawers were in disrepair and the walls were bare and stated, The drawers here are not closing properly and somebody can trip and can cause some accident . Whenever we have an admission, we try to ask them, like what kind of preferences do they have, and if they don't have anything, we are going to, like pay for something (sic) to put something in the room. During a concurrent observation and interview on 7/8/24 at 10:07 a.m. with CNA 7, when asked about the cabinet drawers in Resident 153's room, CNA 7 stated, The drawers are not closing too well. It has been like that for a while. CNA 7 tried to close the drawers and stated, No. It's like sinking and not closing properly. I just don't like it if somebody can trip and fall. The residents here are walking and that's little unsafe for me. We don't want anybody to get hurt. During an interview on 7/8/24 at 10:09 a.m. with the Maintenance Supervisor (MS), when asked about the cabinet drawers and the chipped paint on the wall, the MS stated, So many of that (sic) because it's like a lot of things needs to be fixed .I think the broken drawers are not safe for the ambulatory residents .I mean, when you trip on those you can fall. 48175 Resident 253 was admitted to the facility in mid-2024 with diagnoses which included need for assistance with personal care. During an observation on 7/8/24 at 8:30 a.m., Resident 253 was lying in bed with an empty bedside table and nightstand, and the walls around the bed were bare. There were no personal belongings in Resident 253's immediate environment. During a review of Resident 253's MDS, dated [DATE], the MDS indicated Resident 253 had moderate memory impairment and required extensive assistance with ADLs. Resident 254 was admitted to the facility in mid-2024 with diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities), and need for assistance with personal care. (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 Resident 254's MDS, dated [DATE], the MDS indicated Resident 254 had severe memory impairment and required extensive assistance with ADLs. During an observation on 7/8/24 at 8:45 a.m., Resident 254 was lying in bed, the bedside table and nightstand were empty, and the walls around the bed were bare. There were no personal belongings in the immediate environment. Resident 255 was admitted to the facility in mid-2024 with diagnoses that included encephalopathy (damage or disease that affects the brain), and need for assistance with personal care. During a review of Resident 255's MDS dated [DATE], the MDS indicated Resident 255 had severe memory impairment and required extensive assistance with ADLs. During an observation on 7/8/24 at 8:45 a.m. Resident 255 was lying in bed, the bedside table and nightstand were empty, and the walls around the bed were bare. There were no personal belongings in the immediate environment. Resident 256 was admitted to the facility in mid-2024 with diagnoses that included major depressive disorder and need for assistance with personal care. During a review of Resident 256's MDS, dated [DATE], the MDS indicated Resident 256 required extensive assistance with ADLs. During a concurrent observation and interview on 7/8/24 at 8:45 a.m., Resident 256 was lying in bed, awake, alert, and verbally responsive. Resident 256's bedside table and nightstand were empty, and the walls around the bed were bare. There were no personal belongings in the immediate environment. Resident 256 stated, It would be nice to have some images on the wall. During an interview on 7/8/24 at 11:50 a.m. with CNA 1, CNA 1 confirmed Residents 253, 254, 255, and 256's rooms had bare walls without any personal belongings. CNA 1 stated, I have been here since December [2023], and I have not seen any personal items belonging to the residents. I mentioned the bare walls to the activity department and asked if any pictures could be placed on the walls or something to brighten the rooms. So far, nothing has been done. During a concurrent observation and interview on 7/8/24 at 11:55 a.m. with Licensed Nurse 4 (LN 4), LN 4 confirmed Residents 253, 254, 255, and 256's rooms had bare walls and contained no personal belongings. During an interview on 7/9/24 at 7:54 a.m. with Resident 253 regarding having some personal items in the surrounding environment, Resident 253 stated, I would like pictures of my family. I have two daughters and three granddaughters. During an interview on 7/9/24 at 9:30 a.m. with the Activity Director (AD), the AD confirmed Residents 253, 254, 255, and 256's walls were bare. (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 policy and procedure (P&P) titled, Safe and Homelike Environment, dated 3/23, the P&P indicated, The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting. a. The facility will allow residents to use their personal belongings, including furnishings and clothing (as space permits) to assist in creating and maintaining a homelike environment .the social service designee, or another designated staff member, will encourage residents and their families to bring in personal belongings (within space constraints) to personalize residents' rooms .the facility will honor and document a resident's choice not to personalize his/her room . During a review of the facility's P&P titled, Resident Rights, dated 3/23, the P&P indicated, The resident has a right to a safe, clean, comfortable and homelike environment .

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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. 38528 Based on interview and record review, the facility failed to develop and implement comprehensive, documented care plans for four of 18 sampled residents (Resident 18, Resident 15, Resident 204, and Resident 19), when: 1. Resident 18 had no documented care plan for the isolation precautions; 2. Resident 15 had no documented care plan for skin integrity; 3. Resident 204 had no documented care plan for the use of dentures; and 4. Resident 19 had no documented care plan for medication combined with other medications. These failures had the potential to put the residents at risk for unmet needs and as well as the potential to negatively impact their highest practicable level of well-being. Findings: 1. Resident 18 was admitted to the facility in early 2024 with diagnoses which included chronic lung disease and pneumonia (lung infection). During a review of Resident 18's Minimum Data Set (MDS, an assessment tool), dated 4/21/24, the MDS indicated Resident 18 had no memory impairment and required extensive assistance with activities of daily living (bathing, dressing, toileting). During a review of Resident 18's Nursing Care Plans (NCP), the medical record indicated there was no documented evidence a care plan was developed and implemented for contact/droplet isolation precautions. During a review of Resident 18's Baseline Care Plan (BCP), dated 4/16/24, the BCP indicated, Special Treatment: Contact/droplet isolation. During a review of Resident 18's Physician's Orders (PO), dated 4/17/24, the PO indicated, Contact/Droplet Precautions d/t [due to] MRSA [methicillin resistant staphylococcus aureus, an infectious bacteria]/nares [nostrils] & ESBL [extended spectrum beta-lactamase, enzyme produce by infectious bacteria causing resistance to antibiotics]/urine - (staff to wear gown and gloves when providing care to resident). During an observation on 7/8/24 at 9:11 a.m. outside Resident 18's room, the room door was closed with signs posted which indicated, Contact Precautions, and other guidelines to follow before entering room. There was no sign posted for Droplet Precautions. (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 observation and interview on 7/8/24 at 9:12 a.m. in Resident 18's room, Certified Nursing Assistant 6 (CNA 6) opened the room door while not wearing a face mask, indicated the room was on isolation precautions, and stated, [Resident 18] has ESBL in urine and MRSA in nostrils .Not all of them in this room are on isolation. The one on isolation is just [Resident 18]. During a concurrent observation and interview on 7/8/24 at 9:18 a.m. in Resident 18's room, Resident 18 was in bed, awake, alert and verbally responsive. Resident 18 had an oxygen (O2) tubing connected to an O2 concentrator, and stated, It's not good here .They have not done a chest x-ray I requested. I have been having difficulty breathing. During a concurrent observation and interview on 7/9/24 at 8:45 a.m. with Licensed Nurse 2 (LN 2), LN 2 stated, [Resident 18] is on droplet precautions. The LN verified there was no sign for droplet precautions, and stated, [Resident 18] has MRSA nares and ESBL urine. So, when I go in there, I usually wear face masks because of the droplet . During an interview on 7/9/24 at 11:38 a.m. with LN 4, LN 4 stated, [Resident 18] has ESBL in urine and MRSA in the nostrils. LN 4 verified the listed diagnoses did not indicate ESBL and MRSA but the physician's order indicated what type of isolation precautions, and stated, There should be diagnosis. The order indicates contact and droplet precautions. During an interview on 7/9/24 at 11:40 a.m. with LN 4, LN 4 verified the physician's order for contact/droplet precautions was dated 4/17/34, and stated, It has been three months. There should have been a diagnosis. There should have been a posted sign about the droplet precautions .I'm not sure if [staff] know about the droplet precautions. The LN confirmed there was no posted sign for droplet precautions on the Resident 18's door, and stated, I am not sure if [staff] know about the droplet precautions. The roommates are not on isolation .I think it's not safe for the other residents. During an interview on 7/9/24 at 11:41 a.m. with LN 4, when asked if the isolation precautions were in the nursing care plan, LN 4 verified there was no care plan created in the Resident 18's electronic medical record, and stated, The isolation precautions should be documented in the care plan. I don't find any care plan for the isolation [precautions]. I tried to find it but I can't find [the isolation care plan]. During an interview on 7/9/24 at 11:42 a.m. with the Director of Nursing (DON) at the nurse's station, the DON verified and confirmed there was no posted sign for droplet precautions in Resident 18's room door, and stated, When the [Resident 18] came from the hospital, she was admitted with the droplet infection. During an interview on 7/11/24 at 11:40 a.m. with the Director of Nursing (DON), the DON stated, The nurses need to develop and implement a care plan for any problem the residents have and the care plan needs to be revised and updated and documented. 42255 2. Resident 15 was admitted in mid-2023 with diagnoses which included diabetes (uncontrolled blood sugar), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), dependence on renal dialysis, acute kidney failure (a disorder of the urinary tract that occurs when urine cannot filter the waste from the blood). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 15's clinical record did not include the following documents: a care plan with interventions for a skin assessment, repositioning, monitoring, offloading, heel protectors and/or hygiene/shower. During a concurrent observation and interview on 7/9/24 at 12:10 p.m., with Administrative Assistant/Clerk (AA/C), the AA/C agreed with the observation that Resident 15's right heel which had a slight odor and an open wound the size of a half dollar. Additionally, the wound bed had a dark black hard crust in the center, with flakes of dry skin surrounding the outside. The AA/C stated, This is not right, I'll have to check to see what going on, it should at least be offloaded. During a concurrent interview and record review on 7/9/24 at 12:20 p.m. with LN 5, LN 5 stated, I just saw that wound and received orders for treatment. Every day I check the left foot but not the right. LN 5 confirmed that there was no care plan with interventions for Resident 15's right heel, and stated, I don't have one [care plan] for skin protection . During an interview on 7/10/24 at 9:16 a.m. with the DON, the DON stated, There should be an available care plan for the risk of the development of PU/PI [pressure ulcer/pressure injury] . There should always be care plans in place to assist the staff in the care of resident. 46995 3. Resident 204 was admitted to the facility in mid-2024 with diagnoses which included adult failure-to-thrive (weight loss, decreased appetite, and physical inactivity), need for assistance with personal care, and Alzheimer's disease (progressive memory loss). During a review of Resident 204's NCP, the medical record indicated there was no documented evidence a care plan was developed and implemented for Resident 204's use of dentures. During an observation on 7/9/24 at 12:33 p.m. of Resident 204's lunch tray, Resident 204 was served a whole piece of chicken and zucchini. He was not wearing any dentures. During an interview on 7/9/24 at 12:47 p.m. with CNA 7, CNA 7 was asked why Resident 204 was not wearing dentures. CNA 7 stated, I did not know he had dentures, I should have checked before his meal. During a concurrent observation and interview on 7/10/24 at 9:53 a.m. with CNA 8 of Resident 204, CNA 8 agreed that Resident 204 was lying in bed without dentures. CNA 8 was asked if Resident 204 wore dentures while eating, and stated, I don't know. I did not know he had dentures . During an interview on 7/10/24 at 9:59 a.m. with the DON, the DON was asked how a CNA would know if a resident needed dentures. The DON stated he would expect CNAs to look at [medical record] before providing care. During an interview on 7/10/24 at 12:49 p.m. with the Infection Preventionist/Director of Staff Development (IP/DSD), the IP/DSD was asked if the use of dentures were to be care planned. The IP/DSD stated, Yes. The IP/DSD confirmed there were no care plan in place for Resident 204's dentures. When asked why the care plans were important, the DSD stated, It is important so staff can give care. 48860 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 19 was admitted to the facility in late 2022 with diagnoses which included heart failure, diabetes mellitus (condition in which the body has trouble controlling blood sugar), chronic kidney disease (impaired kidney function), pain in leg, neuralgia (severe, sharp, and often shock-like nerve pain) and neuritis (nerve inflammation). During a review of Resident 19's Medication Review Report (MRR), the MRR indicated, .Norco Tablet 5-325 MG (milligrams, a unit of measurement) (Hydrocodone-Acetaminophen, narcotic pain reliever) Give 1 tablet by mouth every 6 hours as needed for mod [moderate] to severe pain ., Amitriptyline HCL Tablet 25 MG Give 1 tablet by mouth at bedtime for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet) .and Gabapentin Oral Capsule 100 MG (Gabapentin, for nerve pain) Give 1 capsule by mouth two times a day for neuropathic pain. During a review of the Resident 19's Care Plan History there were no care plans indicated for gabapentin administration and monitoring. During a review of Residents 19's Physician's Progress Notes/Psychological Evaluation, dated 5/30/24, the progress notes indicated, .No specific psychiatric diagnoses. Continue Amitriptyline for Neuropathy. During a review of Residents 19's Medical Doctor Notes [MDN] dated 6/24/24, the MDN indicated, . Physician's Response: 1. Continue Amitriptyline as written, 2. Add Gabapentin 100 MG 1 tablet BID [Twice a day]. During a review of Resident 19's Medication Administration Review (MAR) for June to July 2024, the MAR indicated Resident 19 received Gabapentin 100 MG in the morning and evening since 6/27/24 and Amitriptyline HCL 25 MG during bedtime since 6/1/24. During a concurrent interview and record review on 7/10/24 at 11:50 a.m. with LN 2, LN 2 stated, Gabapentin can cause drowsiness, sleepiness, tiredness, and sedation and these effects are worsened if the patient was taking other medications that has the same effects. LN 2 confirmed Resident 19 did not have gabapentin monitoring on MAR and a care plan. LN 2 added that care plan was important to have for gabapentin, and stated, So nurses know what to do and what to monitor before giving the medication because of the patient's other medication like amitriptyline. During a concurrent interview and record review on 7/10/24 at 1:51 p.m. with the MDS Coordinator (MDSC), the MDSC indicated that nurses needed to have monitoring before administering a medication that could cause drowsiness and sedation especially for multiple medications that had the same effects. The MDSC confirmed that there was no care plan for gabapentin administration for Resident 19. During a concurrent interview and record review on 7/10/24 at 1:15 p.m. with the DON, the DON stated that, Gabapentin should have a care plan and monitoring before administration of the medication. The DON confirmed that there was no care plan for gabapentin monitoring for Resident 19. The DON confirmed that gabapentin could cause sedation and drowsiness and if given with amitriptyline, could exacerbate the effects. (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, Comprehensive Care Plans, dated 3/23, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record .The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38528 Based on observation, interview, and record review, the facility failed to review and revise the comprehensive care plan for one of 18 sampled residents (Resident 153), when the fall risk care plan was not updated after a fall incident. This failure had the potential to result in further falls and injuries. Findings: Resident 153 was admitted to the facility in late 2023 with diagnoses which included stroke, difficulty walking, muscle weakness, and expressive language disorder. During a review of Resident 153's Nursing Care Plan (NCP) dated 2/2/24, the NCP indicated, [Resident 153] is at risk for falls and/or injuries related to falls .poor safety awareness . During a review of Resident 153's Minimum Data Set (MDS, an assessment tool) dated 5/6/24, the MDS indicated Resident 153 had moderate memory impairment, had a history of falls, non-English speaker, and needed extensive assistance with activities of daily living (ADLs). During a review of Resident 153's Nursing Progress Notes (NPN), dated 7/6/24, the NPN indicated, Fall Risk .Disoriented x3 at all times .1-2 falls in past 3 months. During a review of Resident 153's document titled, Change in Condition Evaluation [CICE], dated 7/6/24, the CICE indicated Resident 153 had a fall incident. During an observation on 7/8/24 at 9:41 a.m., Resident 153 was found asleep in bed with the fall mat pushed away from the side of the bed close to the wall. During a concurrent observation and interview on 7/8/24 at 9:49 a.m. with Certified Nursing Assistant 5 (CNA 5), CNA 5 verified the fall mat was away from the bed, and stated, [Resident 153] is a fall risk. I don't know why the fall mat is pushed away from the bed. It should be closer to the bed to serve its purpose to prevent injuries. During a concurrent observation and interview on 7/8/24 at 9:54 a.m. with the Director of Nursing (DON), the DON verified the fall mat was far from the bed, and stated, If [Resident 153] is a fall risk resident, the fall mat is too far away from the bed and would defeat its purpose. During an interview on 7/10/24 at 10:15 a.m. with Licensed Nurse 7 (LN 7), LN 7 stated, [Resident 153] is alert and does not speak English .His ambulation is not stable. He likes to transfer himself to his chair .He had multiple falls He's a fall risk. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 10:18 a.m. with LN 7, LN 7 indicated the care plan needed to be revised and updated when new interventions were added. LN 7 verified the fall mat was not added as an intervention, and stated, [Resident 153] has frequent falls. He just had a fall recently. The fall mat was not added in the interventions. During an interview on 7/11/24 at 8:40 a.m. with the Infection Preventionist/Director of Staff Development (IP/DSD), the IP/DSD stated, Every problem and concern that the resident has needs to be care planned .the care plan has to be updated and revised and intervention has to be put in there for them to know what to do. During an interview on 7/11/24 at 8:55 a.m. with the Director of Nursing (DON), the DON stated, The nurses need to develop and implement a care plan for any problem the residents have, and the care plan needs to be revised and updated and documented. During a review of the facility's policy and procedure (P&P) titled, Fall Management Policy, dated 9/23, the P&P indicated, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls .The nurse will indicate on the update the resident's fall risk care plan and initiate interventions in accordance with the resident's level of risk. During a review of the facility's P&P titled, Comprehensive Care Plans, dated 3/23, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will be reviewed and revised by the interdisciplinary team. 42255

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43258 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with acceptable professional standards of quality for one of eight sampled residents (Resident 45) when nursing staff failed to verify the contents of a probiotic (a supplement to support and promote gut health) administered to Resident 45. This failure resulted in Resident 45 receiving the incorrect probiotic and the potential for worsening of their clinical condition or complications related to gut health such as diarrhea, nausea and vomiting. Findings: During a medication pass observation on 7/8/24 at 12:15 a.m. with Licensed Nurse 3 (LN 3), LN 3 was observed preparing ten medications for Resident 45, including lactobacillus with pectin (a probiotic used to maintain or promote gut health) 200 million cells per capsule, 2 capsules. A review of Resident 45's medical record indicated a physician's order, dated 5/23/24, for saccharomyces boulardii (a probiotic), 1 capsule three times a day for supplement. During a concurrent interview and record review on 7/8/24 at 1:45 p.m. with LN 3, Resident 45's probiotic order was reviewed. LN 3 was unaware the lactobacillus that was administered to Resident 45 did not match the physician's order. She acknowledged the error and stated nurses were expected to verify the name of the medication with the physician's order to ensure they matched prior to administration. During an interview on 7/9/24 9:56 a.m. with Director of Nursing (DON), DON stated nursing staff were expected to review the medication administration record (MAR) and the physician's orders to ensure they administered medications accurately. He stated nursing staff were expected to obtain the correct probiotic if what was available in the medication cart did not match the order, or to contact the physician to update the order. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 3/1/23, the P&P indicated, Policy: Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .Policy Explanation and Compliance Guidelines .10. Review MAR to identify medication to be administered. 11. Compare medication source . with MAR to verify resident name, medication name, form, dose route, and time. a. Refer to drug reference material if unfamiliar with the medication .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42255 Based on interview and record review, the facility failed to ensure that the facility provided care and services consistent with professional standards for one of 18 sampled residents (Resident 15) when a pressure ulcer/injury (PU/PI, localized damage to the skin and/or underlying tissue from prolonged pressure on the skin) was found on his right heel. This failure resulted in Resident 15 developing an unstageable pressure ulcer (full thickness skin and tissue loss) to his right heel. Findings: Resident 15 was admitted to the facility in mid-2023 with diagnoses which included diabetes (uncontrolled blood sugar), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), dependence on renal dialysis, acute kidney failure (a disorder of the kidneys when they cannot filter waste products from the blood). A review of Resident 15's clinical record did not include the following documents: a care plan with interventions for a skin assessment, repositioning, monitoring, offloading, heel protectors and/or hygiene/shower. During a concurrent observation and interview on 7/9/24 at 12:10 p.m. with Administrative Assistant/Clerk (AA/C), the AA/C helped to observe Resident 15's right heel which had a slight odor and an open wound the size of a half dollar. The wound bed had a dark black hard crust in the center, with flakes of dry skin surrounding the outside. The AA/C stated, This is not right, I'll have to check to see what going on, it should at least be offloaded. During a concurrent interview and record review on 7/9/24 at 12:20 p.m. with the Licensed Nurse (LN) 5, the LN 5 stated, I just saw that wound and received orders for treatment, every day I check the left foot but not the right. LN 5 confirmed that there was no care plan with interventions for his heels, I don't have one [care plan] for skin protection. During an interview on 7/10/24 at 9:16 a.m. the Director of Nursing (DON), the DON stated, There should be an available care plan for the risk of the development of PU/PI [pressure ulcer/pressure injury] .There should always be care plans in place to assist the staff in the care of resident. During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention and Management, revised 3/23, the P&P indicated, This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessments and treatment .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49814 Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status when two of 5 sampled residents (Residents 16 and Resident 33) lost 20 pounds or more over 6 months, without an identified cause and food preferences were not obtained. These failures had the potential to negatively affect Resident 16's and Resident 33's overall health by leading to malnutrition and muscle wasting. Findings: Resident 33 was admitted to the facility in early 2023 with diagnoses of mild cognitive impairment, anemia (low levels of healthy red blood cells to carry oxygen throughout your body), essential hypertension (high blood pressure), type 2 diabetes mellitus without complications (disease that affects the body's ability to regulate blood sugar levels), and muscle weakness. A review of Resident 33's Face Sheet (FS), dated 7/10/24, indicated Resident 33's primary language was Spanish. Review of Resident 33's weight history includes the following: 1/1/24=111 pounds 4/1/24=99 pounds 7/2/24=87 pounds Resident 33 was noted to have lost 12 pounds over 3 months (between 1/2/24 and 4/1/24) which was a loss of 12% of body weight which is a severe weight loss. Between 1/1/24 and 7/2/24, Resident 33 lost 24 pounds or 21.6% of the body weight which was a severe weight loss. During a review of Resident 33's baseline care plan (BCP), dated 3/3/23, the BCP indicated, Resident 33's dietary preferences as n/a [not available] with no information if food preferences were discussed on admission or during the period of weight loss. During a review of Resident 33's Registered Dietitian (RD) progress note, dated 4/24/24, the RD note indicated, Diet orders .Supplement health shake BID [twice a day] snacks TID [three times a day]. There were no indications that these interventions were discussed with the resident or representative, nor information as to whether these interventions were assessed for effectiveness. During a review of Resident 33's Interdisciplinary Care Team Note (IDT), dated 6/13/2024, the IDT indicated the following was reviewed: low oral intake and significant weight loss. The note contained no information regarding new interventions, changes to the current plan of care, or discussion with the resident or family regarding these topics. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 33's RD progress note, dated 6/24/24, the note indicated Resident 33 had poor oral intake (43% over six days) and the RD recommended supplemental nutrition drinks and an appetite stimulant. During an interview on 7/10/24 at 11:18 a.m. with the RD regarding dealing with weight loss, the RD stated she would speak to social services regarding possible resident issues. She would then meet separately with the Director of Nursing (DON) and the Wound Care Nurse to discuss possible causes and solutions for weight loss and develop future plans. The RD further explained that her approach to dealing with weight loss included visits with residents to update food preferences, fortifying the diet by giving more calories and protein, adding nutritional supplements, and suggesting appetite stimulants. Resident 16 was admitted to the facility in mid-2021 with diagnoses of dementia, generalized anxiety disorder, osteoporosis (bone loss), essential hypertension, chronic hepatitis (inflammation of the liver), and dependence on a wheelchair. A review of Resident 16's FS, dated 7/10/24, indicated Resident 16's primary language was Spanish. During an observation on 7/8/24 at 12:06 p.m. in the dining room, Resident 16 was seated with three bowls of food in front of her but was not feeding herself. A Certified Nursing Assistant (CNA) sat down with the resident for about 30 minutes, allowed the resident to direct her to which foods she was interested in and communicated with the resident in Spanish. The meal consisted of a fortified, no added salt (NAS), mechanical soft diet. The resident shook her head when she was done, having eaten about 25% of the meat and potatoes, but none of the vegetables. During a review of Resident 16's weight records included the following: 1/1/24=160 pounds 4/1/24=143 pounds 7/2/24=134 pounds Resident 16 experienced a loss of 9 pounds which was a loss of 6.3% of her body weight over 3 months (1/1/24 to 4/1/24) which was a significant loss. Resident 16 lost 26 pounds which was 16.3% of her body weight over 6 months (from 1/1/24 to 7/2/24) which was a severe weight loss. During a review of Resident 16's progress notes from 2024, the Alert Notes dated: 5/7, 5/11, 5/12, 5/15, 5/28, 5/29, 6/11, 6/16, 6/21, 6/26, 6/28, and 7/6 all indicated, The resident ate less than 50% of her meals for the last three meals. The notes did not mention any steps the facility took to assess the cause of her reduced meal intake or assess the current nutritional interventions for effectiveness. During a review of Resident 16's IDT Note, dated 5/29/24, the IDT note indicated Resident 16, Had weight loss . receives snacks twice daily .is medically stable with no new conditions impacting the treatment plan. The note did not discuss assessing the current nutritional interventions for effectiveness and did not mention attempts to discuss food preferences with the resident's family/representative. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 16's RD progress note, dated 7/3/24, the RD note recommended an appetite stimulant and maintaining the current weight appropriate for the resident. The RD progress note had no indications as to what actions were taken to obtain resident food preferences or to address the cause of her poor food intake. There were no RD progress notes found for May or June of 2024. During an interview on 7/10/24 at 1:10 p.m. with the Dietary Supervisor (DS 1), the DS 1 stated, I use staff members to help communicate in Spanish with residents like [Resident 16]. I wasn't working when [Resident 16] and [Resident 33] were admitted . The DS 1 indicated she was unable to locate a nutrition screen for either resident. During an interview on 7/11/24 at 10:02 a.m. a call was made to Resident 16's family member, who stated, The facility never consulted me regarding food preferences for my mother. During a review of the Nutrition Care Manual, section titled, Unintended Weight Loss, dated 2024, the Care Manual indicated, If an older adult is in the end stages of a terminal disease, including dementia, the more invasive and advanced interventions may not be appropriate .In these cases, the interventions may only include providing favorite or comfort foods and allowing the patient to enjoy whatever foods he or she likes . Nutrition Interventions: Involve the patient/client and caregiver/family .Liberalize diet.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43258 Based on observation, interview and record review, the facility failed to implement their policy and procedure (P&P) for the accurate accountability of controlled medications (medications with a high potential for abuse and addiction) when controlled drug count records (a record used to reconcile inventory of controlled medications in the medication cart by the outgoing and incoming nurse during a shift change) were not routinely signed by the outgoing and incoming nursing shifts, and ensure controlled substance medications were accurately accounted for on the medication administration record (MAR) and Controlled Drug Record (CDR) for two of three randomly selected residents (Residents 6 and 45). These failures resulted in the facility not having accurate accountability of controlled medications, and the potential for abuse or misuse of these medications. Findings: During a concurrent interview and record review on 7/8/24 at 1:54 p.m. with Licensed Nurse 3 (LN 3), the controlled drug sign-in/sign-out sheets, dated April 2024 to July 2024, for Medication Cart B were reviewed. The controlled drug sign-in/sign-out sheets indicated missing signatures by the outgoing and incoming nurse for each shift (7 a.m., 3 p.m., and 11 p.m.). LN 3 acknowledged and confirmed the records were missing signatures between nursing shift changes. A review of both controlled drug sign-in/sign-out sheets, dated 4/1/24 to 7/8/24, indicated a total of 82 missing signatures (for the dates indicated) between nursing shift changes. LN 3 stated it was important to document in both the MAR and CDR to be able to have accountability of controlled drugs and to know when to follow up with the resident to assess if a dose was effective in providing pain relief. During an interview on 7/9/24 at 10:05 a.m. with Director of Nursing (DON), DON stated nursing staff were expected to count the controlled drugs between shift changes. He stated the oncoming and outgoing nurse were both were expected to sign the Controlled Drug Count Record once the count was reconciled. During a review of the facility's P&P titled, Controlled Substance Administer & Accountability, dated 5/1/23, the P&P indicated, Policy Explanation and Compliance Guidelines .9. Inventory Verification .b. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. The controlled medication CDR for three random residents receiving as-needed controlled medications were requested for review during the survey. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 6 had a physician's order, dated 7/3/24, for hydrocodone/APAP (a narcotic medication to treat pain) 5/325 milligrams (mg, a unit of measurement), one tablet every 8 hours as needed for moderate to severe pain. The CDR indicated hydrocodone/APAP was removed from the medication cart on the following dates and times, but their respective administrations were not documented on the MAR: 1 tablet on 6/28/24 at 12:45 p.m., 1 tablet on 7/5/24 at 12:40 p.m., 1 tablet on 7/5/24 at 4:45 p.m., 1 tablet on 7/6/24 at 6:40 p.m., and 1 tablet on 7/7/24 at 6:30 p.m. Review of the MAR dated July 2024 indicated 1 tablet was administered to Resident 6 on 7/5/24 at 3:37 p.m. but was not documented as removed from the medication cart on the CDR. Resident 45 had a physician's order, dated 6/1/24, for oxycodone (a narcotic medication to treat pain) 5 mg, one tablet every 4 hours as needed for moderate pain or take 2 tablets every 4 hours as needed for severe pain. The CDR was requested on 7/8/24 at approximately 9:45 a.m. Review of the CDR indicated oxycodone was removed from the medication cart on the following dates and times, but their respective administrations were not documented on the MAR when the CDR was requested: 2 tablets on 7/4/24 at 7:50 a.m., 2 tablets on 7/7/25 no time documented, 2 tablets on 7/8/24 at 8:50 a.m. Review of the MAR dated July 2024 indicated 1 tablet was administered to Resident 45 on 7/5/24 at 7 a.m. but was documented as removed from the medication cart on the CDR. During a concurrent interview and record review on 7/8/24 at 1:48 p.m. with LN 3, Resident 6's physician's order for Resident 45's MAR dated July 2025 and CDR for oxycodone were reviewed. She confirmed she had forgotten to document in the MAR the oxycodone that she administered to Resident 45 on 7/7/24 and 7/8/24. She stated it important to document in the MAR and CDR whenever a controlled pain medication was administered to a resident to have accurate accountability of narcotics and to also know when to follow up with the resident to determine if the dose was effective or not. During an interview on 7/9/24 at 10:07 a.m. with DON, DON stated nursing staff were expected to document administered doses of controlled medications in both the MAR and CDR. He stated it was important to document in both records for accountability and ensuring a resident was not overdosed. During a review of the facility's P&P titled, Medication Administration, dated 3/1/23, the P&P indicated, Policy Explanation and Compliance Guidelines .17. Sign MAR after administered .18. If medication is a controlled substance, sign narcotic book. During a review of the facility's P&P titled, Controlled Substance Administration & Accountability, dated 5/1/23, the P&P indicated, 1. General Protocols .f. All controlled substances (Schedule II,III, IV, V) are accounted for in one of the following ways .ii. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided .h. The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. i. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic disposed from the pharmacy.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43258 Based on observation, interview, and record review, the facility failed to ensure one of 18 sampled residents (Resident 10) was free of a significant medication error when he received Advair Diskus (generic name fluticasone/salmeterol, a medication to treat asthma) 42 times (doses) past the expiration date. This deficient practice had the potential for ineffective use of the Advair Diskus, resulting in breathing complications and worsening of Resident 10's clinical condition. Findings: Resident 10 was admitted to the facility in [DATE] with diagnoses which included asthma. A review of Resident 10's medical record indicated a physician's order for fluticasone/salmeterol ,d+[DATE] micrograms (mcg, a unit of measurement)/puff, 1 inhalation orally every 12 hours related to unspecified asthma, dated [DATE]. During a concurrent record review and inspection of Medication Cart B on [DATE] at 10:03 a.m. alongside Licensed Nurse 3 LN 3, a Advair Diskus inhaler labeled opened on [DATE] was identified. The manufacturer's labeling on the inhaler indicated, Device should be discarded 1 month after removal from foil pouch, or when dosing indicator reads '0' (whichever comes first). LN 3 confirmed the inhaler expired on [DATE] and stated Resident 10 received doses of medication from the inhaler after it had expired. A review of Resident 10's [DATE] Medication Administration Record (MAR) indicated Advair Diskus was administered to Resident 10 forty-two times past the expiration date. During an interview on [DATE] at 10:01 a.m. with Director of Nursing (DON), DON stated nursing staff were expected to check the expiration date of a medication prior to administration. He stated if an expired medication was given to a resident, the physician was to be notified. A review of the manufacturer's specifications for Advair Diskus dated [DATE] indicated, Safely throw away Advair Diskus in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated [DATE], the P&P indicated, Policy: Medications are administered by licensed nurses .in accordance with professional standards of practice .Policy Explanation and Compliance Guidelines .12. Identify the expiration date. If expired, notify nurse manager. During a review of the facility's P&P titled, Medication Storage, dated [DATE], the P&P indicated, Policy Explanation and Compliance Guidelines .8 .The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications .These medications are destroyed .

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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** 43258 Based on observation, interview, and record review, the facility failed to ensure multi-dose medications were dated with an open and discard date to ensure they were not used beyond the discard date, prescription medications were appropriately labeled with a pharmacy label or name to correctly identify which resident they were for, medications with different routes of administration were stored in accordance with facility policy and procedures (P&P), and expired medications were not available for resident use. The deficient practices had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date, incorrect medications from inadequate labeling, medications given incorrectly through the wrong route of administration. Findings: During a concurrent observation and interview on 7/8/24 at 8:27 a.m. with Licensed Nurse 2 (LN 2) in Medication Storage room [ROOM NUMBER], the following was identified: 1 box hemorrhoidal (medication to treat swollen and inflamed veins around the anus) suppositories expired 5/2024, 1 box bisacodyl (a medication to treat constipation) expired 6/2024, and 1 bottle dry mouth moisturizing spray expired 4/2024. LN 2 confirmed the finding and stated expired medications were to be pulled from facility stock and given to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) for destruction. During a concurrent inspection and interview on 7/8/24 at 8:47 with LN 2, the following were identified in Medication Cart A: two Lantus Solostar (long-acting insulin to treat diabetes) pens without open dates, two vials ipratropium/albuterol (a medication to treat asthma) 0.5 milligrams/3 milligrams (mg/mg, a unit of measurement) per 3 milliliter (ml, a unit of measurement) loose in the drawer without a pharmacy label, one vial One-Care Pro test strips (used to test blood sugar levels) without an open date, and one box haloperidol (a medication to treat behavioral disorders) 5 mg/ml injectable stuffed between bubble packs containing oral medications. LN 2 confirmed the findings and stated insulin had a shorter shelf life once removed from the refrigerator. LN 2 reviewed the manufacturer's labeling on the One-Care Pro test strips and stated they expired 90 days after opened. He stated the injectable medication was stored with the oral medications because the drawer dedicated to injectable medications was too full. According to UpToDate [NAME]-Drug, a drug information provider for health care professionals, storage of Lantus Solostar indicated, Store unopened vials and prefilled pens under refrigeration .until expiration date, or at room temperature .for 28 days .Store in-use prefilled pens at room temperature .and use within 28 days; do not freeze or refrigerate. (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 concurrent inspection and interview on 7/8/24 at 9:45 a.m. with LN 2, the follow inhalers used to treat asthma were identified in Medication Cart B without open dates or resident specific labeling: one Incruse Ellipta, one Combivent Respimat 20 microgram/100 microgram (mcg/mcg, a unit of measurement), one Symbicort 160 mcg/4.5 mcg, and one Airsupra 90 mcg/80 mcg inhaler. A Symbicort 160/4.5 mcg/mcg inhaler, one Spiriva Respimat 2.5 mcg/puff inhaler, and one Dulera 100/5 mcg/mcg inhaler were also identified without patient labels. One Advair Diskus (an inhaler to treat asthma) 250/50 mcg/mcg inhaler expired 5/11/24 was identified. LN 2 confirmed the inhalers should have had resident specific labeling with open dates to know when they expire. She confirmed expired medications should have been removed from the medication cart. According to UpToDate [NAME]-Drug, storage of Incruse Ellipta indicated, Discard inhaler 6 weeks after opening the foil tray or after the labeled number of inhalations have reached zero, whichever comes first. Storage of Combivent Respimat indicated, Discard 3 months after first actuation or after labeled number of actuations has been reached and locking mechanism is engaged, whichever comes first. Storage of Symbicort indicated, Discard inhaler after the labeled number of inhalations have been used (the dose counter will read '0') or within 3 months after removal from foil pouch; and storage of Airsupra indicated, Discard inhaler after the labeled number of inhalations have been used, when the dose indicator pointer reaches zero, or 12 months after removal of the foil pouch (whichever comes first). During an interview on 7/9/24 at 10:01 a.m. with DON, DON stated nursing staff were expected to check the expiration of a medication prior to administration to a resident. DON stated inhalers should have had a pharmacy label on the exterior box as well as the inhaler to ensure they were used for the correct resident. DON stated medications administered through different routes should have been stored separately in the medication cart. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 3/1/23, the P&P indicated, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .Policy Explanation and Compliance Guidelines .4. Internal Products: Medications to be administered by mouth are stored separately from other formulations (i.e., eye drops, ear drops, injectables) . 8. Unused Medications: The pharmacy and all mediation rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed . (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 the facility's P&P titled, Labeling of Medications and Biologicals, dated 2/1/24, the P&P indicated, Policy Explanation and Compliance Guidelines .4. Labels for individual drug containers must include: a. The resident's name; b. The prescribing physician's name; c. The medication name .d. The prescribed dose .e. The prescription number (if applicable); f. The date the drug was dispensed; g. Appropriate instructions and precautions .h. The expiration date when applicable; i. The route of administration .8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed .b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. c. Unopened or accessed (needle-punctured) vials should be discarded according to the manufacturer's expiration date. 9. Labels for medications designed for multiple administrations (such as inhalers, eye drops), the label will identify the specific resident for whom it was prescribed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41838 Based on observation and record review, the facility failed to puree zucchini by methods that conserved nutritive value and flavor. This had the potential of leading to poor intake and malnutrition for the four residents (Resident 5, Resident 33, Resident 49, and Resident 153) eating pureed meals. Findings: During an observation on 7/9/24 at 11:03 a.m., [NAME] 1 (Ck 1) pureed the hot foods for the lunch meal service. CK 1 removed 10 quarter pieces of zucchini from the oven and placed the zucchini into the processor bowl. She next added an unmeasured amount of melted butter to the bowl and proceeded to blend the mixture. When processing stopped, the mixture was found to be too thin and runny. Ck 1 proceeded to add an unmeasured (approximately 1/4 cup) amount of thickener to the bowl and turned the food processor back on to blend. When Ck1 stopped the processor, she was happy with the consistency and placed the zucchini into a steam table pan and put it into the oven. Review of facility provided Pureed Vegetables Recipe (Healthcare Menus Direct, LLC.) indicated the following ingredients and steps: Recipe for 6 servings: 6 servings of vegetables, 2 Tbsp (tablespoon) to 1/3 cup Warm fluid such as milk, or low sodium broth. These are suggested amounts and may vary .Some vegetables may not require any liquid at all. If needed: 0-6 Tbsp Stabilizer (instant potatoes or commercial instant food thickener). Directions: 1. Complete regular recipe. Measure out the total number of portions . 2. Puree on low speed to a paste consistency before adding any liquid. 3. Gradually add warm liquid (low sodium broth or milk) if needed .starting with the smaller amount and adding in more as needed to achieve the desired consistency. 4. Puree on low speed, adding stabilizer where needed . 5. Puree should reach the consistency of applesauce .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 41838 Based on observation, interview and record review, the facility failed to provide alternatives to the meal entree that were of similar nutritive value. This had the potential of leading to protein/calorie malnutrition for the 44 residents eating facility prepared meals. Findings: During a concurrent observation and interview on 7/8/24 at 10:34 a.m., in the hallway outside the kitchen, Dietary Supervisor 1 (DS 1) showed the alternatives that residents can choose if they did not desire the menu meal. Included on the list was a grilled cheese sandwich. DS 1 explained that when ordered 2.5 hours prior to the meal, she would cross off the entree and write in the desired item onto the meal ticket. During an observation of the lunch meal plating on 7/9/24 at 12:21 p.m., DS 1 stated that the dialysis lunch bags contained shelf stable items such as fruit cups, but when the nurse came to collect the bag for the resident, staff would add a sandwich such as peanut butter and jelly. During an interview on 7/10/24 at 11:18 a.m. with the Registered Dietitian (RD), the RD explained that she had worked for the facility two days a week for the past year. In regards to the alternatives, she stated that she was concerned about the calories the that alternatives provided, and well as the visual appeal, as she wanted to make sure that the meal was colorful. When asked did the facility monitor the protein content of the alternatives, she responded she was unsure. Review of facility provided Nutritional Breakdown (Healthcare Menus Direct, LLC) for the current meal cycle indicated that the average amount of calories proved per day were 2,197 which would be approximately 732 calories per meal. The average amount of protein was 97 grams per day, or approximately 32 grams per meal. Review of the US Department of Agriculture website, indicated a typical peanut butter and jelly sandwich provided 363 calories and 11.5 grams of protein (approximately 36% of the typical meal). Review of the US Department of Agriculture website, indicated a typical grilled cheese sandwich provided 336 calories and 11 grams of protein (approximately 34% of the typical meal).

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 41838 Based on observation, interview and record review, the facility failed to ensure that dietary staff provided the correct portions when plating the consistent carbohydrate diet. This had the potential of leading to poor blood sugar control for the 11 residents (Residents 9, 13, 18, 28, 30, 33, 41, 153, 253, 255, and 453) eating the controlled carbohydrate diet (CCHO). Findings: During an observation of the lunch meal plating on 7/9/24 at 11:50 a.m., [NAME] 1 (Ck 1) was setting up the steamtable for the meal service. The meal included polenta which was noted to have two scoops, one with a grey handle (1/2 cup) and one with a green handle (1/3 cup). During an observation of the meal plating on 7/9/24 starting at 12:00 p.m., the residents receiving a CCHO diet were given polenta using the green handle scoop. Review of the facility provided Cook's spreadsheet for the Summer Menus, Week 2 Tuesday indicated that the CCHO diet was to receive a #16 scoop which was equal to 1/4 of a cup. During this same meal plating, those on the CCHO diet were observed to receive a half portion of chocolate cake (approximately 1x1 1/4 inches) without frosting. Review of the Cook's spreadsheet indicated the cake serving was a 2x2 1/2 inch piece of cake without frosting. During an interview of the Registered Dietitian (RD) on 7/10/24 at 11:18 a.m., the RD stated that dietary staff should follow the cook's spreadsheet for the portion sizes to ensure the correct calories and nutrients (such as carbohydrate) were provided. Providing smaller portions could lead to weight loss while inconsistent amounts of carbohydrate could be a problem for residents receiving insulin, leading to poor blood sugar control. Review of the facility provided Diet Manual section on Controlled Carbohydrate Diet (Healthcare Menus Direct, LLC, 2023) indicated that A controlled carbohydrate diet, (CCHO), is a meal plan .typically used for diabetic residents and those with other metabolic concerns. Instead of counting calories, the carbohydrates are evenly, systematically, and consistently distributed through three meals and H.S. (bedtime) snack in an effort to maintain a stable blood sugar levels throughout the day .The carbohydrates are controlled through portion control and avoiding some concentrated sweets .Residents will see a regular dessert approximately 3 times per week .depending on their total carbohydrate count for the day.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49814 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards of food safety in order to prevent the outbreak of foodborne illness when: 1) Opened food items were not protected and sealed after opening; 2) Food labeling process was not followed when drinks on a tray in the refrigerator were not labeled and dated, and almond extract did not have a readable use-by date; 3) Unclean food service items, including a food processor bowl, were found with brown build-up, along with a cutting board which was noted to have food residue on the cutting surface; 4) Paint on the kitchen walls, sink backsplash, and ceilings were found to be chipped, stained, and covered with glue-like build-up; 5) Two packages of lunch meat were not thawed per standards when they were observed in a steam table container filled with static (non-running) water in the cook's sink; 6) Two alcohol sanitizer containers were accessible by dietary staff in the kitchen; 7) Dishwashing was not done according to standards when two steam table pans were found put away wet, and the air-drying area was not protected from handwash sink splash; 8) Air gaps were not found on the ice machine or fruit and vegetable wash sink; 9) Air temperature in the dry storage in the kitchen was 82 degrees Fahrenheit (F, a measurement of temperature); 10) Resident refrigerator found with temperatures ranging between 30-59 F; and 11) Kitchen can opener metal blade was found to be chipped. These failures presented a potential risk of foodborne illnesses for the 44 residents eating facility prepared meals. Findings: 1. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. the following items were observed stored in an exposed manner: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In one of the reach-in kitchen freezers, a box of hamburger patties and a box of turkey patties were in bags that had not been tightly sealed and were exposed to the freezer environment; In the dry storage: a container of baking soda and a container of sugar were not closed or sealed and were exposed to the kitchen environment. During an interview on 7/8/24 at 9:10 a.m. with the Dietary Supervisor 1 (DS 1), DS1 confirmed the observed items were not stored and sealed correctly. During a review of the US (United States) FDA 2022 Food Code (FDA FC), section 3-202.15, titled, Package Integrity, dated 1/18/23, the Food Code indicated, FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION [degrading] or potential contaminants .Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. 2. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. the following items were observed to be un-labeled or undated: A tray of prepared drinks in the reach-in refrigerator was not labeled or dated. A bottle of Almond extract did not have a readable use-by date. During an interview on 7/8/24 at 9:26 a.m. with the DS 1, during the initial kitchen tour, DS 1confirmed the tray of drinks in the refrigerator were unlabeled and undated. During the same kitchen tour, at 9:47 a.m. the DS 1 confirmed the bottle of Almond extract did not have a readable use-by date. During an interview on 7/10/24 at 3:16 p.m. with DS 1 and DS 2, DS 1 stated, If prepared drinks are not labeled by kitchen staff, they wouldn't know if the drinks would be good. Both confirmed that prepared drinks and food items should be labeled and dated. During a review of the facility's policy and procedure (P&P) titled, Date Marking for Food Safety, dated 3/23, the P&P indicated the following procedures, .2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. 3. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. the following food service items were observed to be unclean: A food processor bowl had a latch with significant brown colored build up. A cutting board used for meat was found with a dark brown food residue measuring approximately 1 inch by 2 inches on the cutting surface. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/8/24 at 9:51 a.m. with DS 1, during the initial kitchen tour, DS 1 confirmed the food processor bowl had significant brown colored build up on its latch. DS 1 also confirmed that a cutting board stored under a cooking table (which indicated it was ready for use) had a dark brown food residue on one edge and stated, It's dirty. It should be washed. The brown material is cooked meat. During an interview on 7/10/24 at 3:16 p.m. with DS 1 and DS 2, DS 1 indicated that if a kitchen staff member were to pick up a dirty kitchen equipment, it could contaminate their hands. During a review of the facility P&P titled, Food Safety Requirements, dated 9/23, the P&P indicated, .6. All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. 4. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. the following was observed in disrepair (old, broken, or needing repairs): Paint on the kitchen walls, sink backsplash, and ceilings were found chipped, stained, and covered in glue build-up. During an interview on 7/9/24 at 9:20 a.m. with the Maintenance Supervisor (MS), during the initial kitchen tour, the MS stated, The ceiling is like that because new light fixtures were put in and is in the process of repair .The paint chipping above the sink is a back splash that was painted over and is now chipping away . the dried glue above the sink back splash should be removed and was from previous signs that were put up. During a review of the US FDA FC, section 4-202.16, titled, Nonfood-Contact Surfaces, dated 1/23, the food code indicated, Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms. Well-designed equipment enhances the ability to keep nonfood-contact surfaces clean . NonFOOD-CONTACT SURFACES shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. 5. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. two packages of lunch meat were observed thawing inside a steam table container filled with static water in the cook's sink. During an interview on 7/10/24 at 3:16 p.m. with DS 1 and DS 2, DS 1 stated, We should use cool running water for thawing deli meats. The temperature can increase and lead to potential foodborne illnesses. During a review of the US FDA FC, section 3-501.13, titled, Thawing, dated 1/23, the food code indicated, Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed .(B) Completely submerged under running water: (1) At a water temperature of 21C [Celsius, a measurement of temperature] (70F) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5C (41F) . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. two alcohol sanitizer containers were observed to be accessible by dietary staff in the kitchen: one above the hand-washing sink in the kitchen and the other on the wall of the kitchen entrance. During an interview on 7/10/24 at 11:15 a.m. with the Registered Dietitian (RD), the RD stated, The hand sanitizer is not adequate for kitchen and should not be above the sink. During a review of the US FDA FC, section 2-301.12, titled, Cleaning Procedure, dated 1/23, the food code indicated, (A) Except as specified in (D) of this section, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound .(B) FOOD EMPLOYEES shall use the following cleaning procedure . (1) Rinse under clean, running warm water; (2) Apply an amount of cleaning compound recommended by the cleaning compound manufacturer. 7. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. dishwashing was not done according to FDA FC standards when two steam table pans were found put away wet and the air-drying area was not protected from hand wash sink splash. During an interview on 7/8/24 at 9:51 a.m. with DS 1, during the initial kitchen tour, DS 1 was shown the two steam table pans stored under a food preparation table and stated, Yes, they are wet, and took them to the dishwashing area. During an interview on 7/10/24 at 3:16 p.m. with DS 1 and DS 2, DS 1 stated, Wet pans should be air dried first before putting away. She also indicated not doing so has the potential for bacterial growth. During a review of the US FDA FC, section 4-901.11, titled, Equipment and Utensils, Air-Drying Required, dated 1/23, the food code indicated, After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining . 8. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m., air gaps were observed to be missing on the facility ice machine and the fruit and vegetable wash sink. During a concurrent observation and interview on 7/8/24 at 3:45 p.m. with the MS, the MS stated, The ice machine has no air gap because everything gets sucked into a drain. The drain line from the ice machine was observed to be connected to the drainpipe of an adjacent hand washing sink without an air gap and the facility was unable to provide evidence that an air gap on the ice machine was installed. During an interview with the MS on 7/9/24 at 9:20 a.m. in front of the fruit and vegetable wash sink, the MS stated, The sink has no air gap. During a review of the US FDA FC, section 5-202.13 titled Backflow Prevention, Air Gap, the FC indicated, During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the US FDA FC, section 5-203.14, titled, Backflow Prevention Device, When Required, dated 1/23, the FC indicated, A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT . 9. During the initial kitchen tour on 7/8/24 beginning at 9:10 a.m. the temperature in the dry storage area of the kitchen was observed to be 82 F. DS 1 stated, The temperature is 82 degrees. During an interview on 7/10/24 at 11:15 a.m. with RD, RD stated, For dry storage temps, the range is 70 to 75 F. It's good to have those temps because it can affect food quality and affect degradation of foods. During an interview on 7/10/24 at 3:16 p.m. with DS 1 and DS 2, DS 1 stated, Some foods can have their integrity affected by the heat. Dry storage temperatures should be no higher than 75-80 F. 10. During a concurrent interview and observation on 7/8/24 at 10:21 a.m. the facility refrigerator used to store resident food brought in from outside the facility was observed to be 52 F. A temperature taken using a food temperature probe read 59.7 F. The Director of Nursing (DON) confirmed the temperature reading of 59. 7 F. A temperature reading of the resident refrigerator taken on 7/9/24 at 10:38 a.m. read 34 F. A review of the resident refrigerator logs for June and July of 2024, indicated that the resident refrigerator temperatures ranged between 32 and 40 F. During an interview on 7/10/24 at 11:15 a.m. with RD, RD stated, The resident refrigerator should stay within the guidelines for food safety. A temperature reading of the resident refrigerator taken on 7/10/24 at 12:45 p.m. read 28 F. During an interview on 7/10/24 at 3:16 p.m. with DS 1 and DS 2, DS 1 stated, The resident fridge should be in the temperature range of refrigeration. The safe zone temperature is below 40 F and above the freezing range. A temperature reading of the resident refrigerator taken on 7/11/24 at 8:30 a.m. read 28 F. During an interview on 7/11/2024 at 8:35 a.m. with the Infection Preventionist/Director of Staff Development (IP/DSD), the IP/DSD stated, 28 F is a freezing temperature and not appropriate for the resident fridge. During a review of the US FDA FC, section 3-501.16, titled, Time/Temperature Control for Safety Food, Hot and Cold Holding, dated 1/23, the food code indicated, Holding .TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained .(2) At 5 C (41 F) or less. 11. During an observation on 7/9/24 at 9:01 a.m. in the kitchen, the metal on the can opener blade was chipped. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24 at 3:16 p.m. with DS 1 and DS 2, DS 2 confirmed that a chipping metal on the can opener blade had the potential to make its way to residents' meals during food preparation. During a review of the US FDA FC, section 4-501.11, titled, Good Repair and Proper Adjustment, dated 1/23, the FC indicated, The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury.

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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. 38528 Based on observation, interview, and record review, the facility failed to maintain infection control guidelines and practices for a census of 44 when: 1. Transmission based precautions were not followed for contact/droplet infection for Resident 18; 2. Bandage scissors were not cleaned during wound care treatment for Resident 13; 3. There were no Enhanced Barrier Precautions (EBP, involves use of gown and gloves during high contact resident care designed to reduce transmission of Multi Drug Resistant Organisms [MDRO, bacteria resistant to antibiotics]) in place for Resident 2's wound care and indwelling catheter; 4. There was no EBP in place for Resident 19; 5. Resident 453's isolation trashcan was not covered; and 6. A toothbrush, balled up paper towels were found on the floor, and a commode with white spots over the seat were found in an adjoining resident bathroom. These failures increased the risk for transmission of infections. Findings: 1. Resident 18 was admitted to the facility in early 2024 with diagnoses which included chronic lung disease and pneumonia (lung infection). During a review of Resident 18's Baseline Care Plan (BCP), dated 4/16/24, the BCP indicated, Special Treatment: Contact/droplet isolation. During a review of Resident 18's Physician's Orders (PO), dated 4/17/24, the PO indicated, Contact/Droplet Precautions d/t [due to] MRSA [methicillin resistant staphylococcus aureus, an infectious bacteria]/nares [nostrils] & ESBL [extended spectrum beta-lactamase, enzyme produce by infectious bacteria causing resistance to antibiotics]/urine - (staff to wear gown and gloves when providing care to resident). During an observation on 7/8/24 at 9:11 a.m. outside Resident 18's room, the room door was closed with signs posted which indicated, Contact Precautions, and other guidelines to follow before entering the room. There was no sign posted for Droplet Precautions. During a concurrent observation and interview on 7/8/24 at 9:12 a.m. in Resident 18's room, Certified Nursing Assistant (CNA) 6 opened the door not wearing a face mask, and indicated the room was on isolation precautions, and stated, [Resident 18] has ESBL in urine and MRSA in nostrils .Not all of [the residents] in this room are on isolation. The one on isolation is just [Resident 18]. (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 concurrent observation and interview on 7/9/24 at 8:45 a.m. with Licensed Nurse 2 (LN 2), LN 2 stated, [Resident 18] is on droplet precautions. LN 2 verified there was no sign for droplet precautions, and stated, [Resident 18] has MRSA nares and ESBL urine. So, when I go in there, I usually wear masks because of the droplet . During an interview on 7/9/24 at 11:38 a.m. with LN 4, LN 4 stated, [Resident 18] has ESBL in urine and MRSA in the nares. LN 4 verified the listed diagnoses did not indicate ESBL and MRSA but the orders indicated what type of isolations, and stated, There should be diagnosis. The order indicates contact and droplet precautions. During an interview on 7/9/24 at 11:40 a.m. with LN 4, LN 4 verified the physician's order for contact/droplet precautions was dated 4/17/24, and stated, It has been three months .There should have been a posted sign about the droplet precautions .I'm not sure if [staff] know about the droplet precautions. LN 4 confirmed there was no posted sign for droplet precautions on the resident's door, and stated, The roommates are not on isolation .I think it's not safe for the other residents. During an interview on 7/9/24 at 11:42 a.m. with the DON at the nurse's station, the DON confirmed there was no posted sign for droplet precautions on Resident 18's room door, and stated, When the [Resident 18] came from the hospital, she was admitted with the droplet infection. During an interview on 7/11/24 at 8:55 a.m. with the IP/DSD, the IP/DSD stated, On infection control . because of the patients that we're getting from the hospital with certain infections like ESBL and MRSA .staff should follow infection control and prevention policies and procedures so they know how to be careful to not cross contaminate other residents. During an interview on 7/11/24 at 8:55 a.m. with the DON, the DON stated, Staff need to follow infection control procedures and guidelines to prevent the transmission of infection. During a review of the facility's policy and procedure (P&P) titled, Transmission-Based (Isolation) Precautions, dated 5/24, the P&P indicated, It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission Droplet Precautions - Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing, or talking) .A private room is preferential, but if not available, the resident can be cohorted with a resident with the same infectious agent .If a resident who requires droplet precautions has to share a room with a resident who does not have the same infection, the facility will make a decision regarding resident placement on a case-by-case basis after considering infection risks to other residents in the room and available alternatives .Draw curtain between beds in multi-bed rooms when one resident is infected with a pathogen that is transmitted by the droplet route . Healthcare personnel will wear a facemask for close contact with an infectious resident. 42255 5. Resident 453 was admitted to facility in mid-2024 with diagnoses which included escherichia coli (E-Coil, bacteria that is commonly found in the lower bowels), urinary tract infection (infection in any part of the urinary system) and bacteremia (the presence of bacteria in the blood). (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 concurrent observation and interview on 7/9/24 at 9:44 a.m. with the IP/DSD, the IP/DSD confirmed the trash can was not covered and stated, It [trash can] should be covered. During an interview on 7/10/24 at 8:17 a.m. with the DON, the DON stated, Yes, they should have trash cans with lids for the isolation residents. 6. During an observation on 7/8/24 at 8:10 a.m. a toothbrush, balled up paper towels were found on the floor, and a commode with white spots over the seat were found in adjoining resident bathrooms. During a concurrent observation and interview on 7/8/24 at 8:16 a.m. with Certified Nursing Assistant (CNA 1), CNA 1 confirmed the items on the floor and stated, Oh that stuff, I guess the housekeeper hasn't been able to come through because breakfast was out, the toothbrush should definitely not be there and the toilet seat I'm not sure what it is. During an interview on 7/10/24 at 8:17 a.m. with the DON, the DON stated, The bathroom should be clean and not have the toothbrush on the floor or trash. I would expect the staff to follow up on it. 46995 2. Resident 13 was admitted to the facility mid-2024 with diagnoses which included necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin) abscess of vulva (external female genitalia), and sepsis (life threatening complication of an infection). During a review of Resident 13's Physicians Orders (PO) dated 6/24/24, the PO indicated, WOUND .NPWT [negative pressure wound therapy, wound treatment that uses a vacuum system to assist in wound closure] . During an observation on 7/8/24 at 10:32 a.m. of Resident 13's NPWT dressing change, Licensed Nurse (LN 5) prepared the bandage outside of Resident 13's room. LN 5 placed a pair of bandage scissors on top of the medication cart, picked up the scissors and used them to cut open a package of foam bandage, used the scissors to cut the foam, placed the scissors inside a clean plastic trash bag filled with wound care supplies and entered Resident 13's room. LN 5 took the scissors from the plastic bag and placed them directly onto the bedsheets of Resident 13's bed. Without cleaning the scissors, LN 5 used the scissors to cut foam dressing, then placed the foam dressing directly into Resident 13's wound. LN 5 placed the uncleaned scissors onto Resident 13's uncovered bedside table. LN 5 picked up the scissors, used them to cut the clear bandage that covered the wound, then placed the uncleaned scissors into her pants pocket. During an interview on 7/8/24 at 10:59 a.m. with LN 5, LN 5 confirmed she did not clean her scissors during the bandage change. LN 5 stated, I usually have two pairs of scissors, today I do not. I should have disinfected them or placed them in a dirty bag. When asked why clean scissors were important, LN 5 stated, . the risk of infection. During a review of the facility's policy and procedure (P&P) titled, Wound Treatment Management, dated 11/23, the P&P indicated, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 2 was admitted to the facility in early 2024 with diagnoses which included retention of urine, Stage 4 pressure injury (full thickness skin loss with exposed bone, tendon or muscle caused by pressure), and carrier or suspected carrier of methicillin resistant staphylococcus aureus (MRSA, bacteria that has become resistant to many antibiotics). During a review of Resident 2's PO dated 2/18/24, the PO indicated, SACRUM- STAGE 4 NPWT dressing . There were no orders for EBP prior to 7/9/24. During an observation on 7/8/24 at 9:14 a.m. of Resident 2's NPWT dressing change, LN 5 did not wear a disposable gown over her clothes. Her uniform shirt touched Resident 2's bed linens during the dressing change. There were not any signs outside Resident 2's door that indicated EBP. During an interview on 7/8/24 at 9:42 a.m. with LN 5, LN 5 confirmed there was not an EBP sign outside the door of Resident 2's room and she did not wear a gown during NPWT dressing change. LN 5 stated, We don't have to wear a gown when we do a wound vac [NPWT] change . During an interview on 7/8/24 at 3:15 p.m. with the Infection Preventionist/Director of Staff Development (IP/DSD) the IP/DSD was asked if the facility followed EBP and stated, Yes we do. When asked how the staff would know if a resident had EBP, the IP/DSD stated, We use signs on the doors. We in-service nurses and CNA's. The IP/DSD was asked what type of residents would be on EBP and stated, Residents at risk for MDRO and catheters. When asked is staff was expected to wear a gown with a NPWT dressing change the IP stated, Most definitely. When asked why it was important to wear a gown the IP/DSD stated, Because she is more acceptable (sic) to MDRO's. I would expect her to gown up and I would expect signs outside the door . The IP/DSD confirmed there was not any type of signage outside Resident 2's room to indicate she was on EBP. 4. Resident 19 was admitted to the facility late 2022 with diagnoses which included renal dialysis (process of removing excess water from the blood in people whose kidneys no longer work). During a review of Resident 19's PO dated 3/31/24, the PO indicated, Hemodialysis Access Site Monitoring (Central Catheter [long thin tube in a vein that exits near the heart]) .dressing changes at dialysis center and as needed. There were no orders for EBP prior to 7/10/24. During an observation on 7/10/24 at 12:20 p.m. of Resident 19's room, there were no EBP signs or gowns outside his room. During an interview on 7/10/24 at 12:24 p.m. with LN 6, LN 6 was asked if staff came in contact with Resident 19's dialysis catheter and stated, Not me specifically, but the treatment nurse typically cares for the port [catheter]. So yes, the staff does come in contact with the port. LN 6 confirmed there was not any type of EBP signage or gowns outside the door. When asked what type of resident would require EBP, LN 6 stated, Residents that are at high risk . When asked if Resident 19 would be considered high risk and require EBP LN 6 stated, I would think yes because he has an opening [indicated to her chest where the catheter was located]. During an interview on 7/10/24 at 12:39 p.m. with the IP/DSD, the IP/DSD confirmed Resident 19 did not have signs for EBP. The IP/DSD stated there should be EBP because of the dialysis catheter. (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 policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 5/24, the P&P indicated, It is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug resistant organisms .An order for enhanced barrier precautions will be obtained for residents with any of the following .Wounds .indwelling medical devices [e.g., central lines, urinary catheters .hemodialysis catheters .] .Implementation of Enhanced Barrier Precaution .make gowns and gloves available immediately near or outside of the residents' room .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 41838 Based on observation and interview the facility failed to maintain one of the reach-in freezers. This had the potential of leading to food-borne illness for the 44 residents eating facility prepared meals. Findings: During the initial kitchen tour on 7/8/24 at 9:10 a.m. with Dietary Supervisor 1 (DS 1) two reach-in freezers were observed on the wall leading the outside door. The freezer closet to the outside door was stuffed with roughly 75% meat products and 25% frozen desserts. During a concurrent interview with DS 1, she stated that the freezer usually contained meat products but that one of the freezers was not working and they had to move those items into this freezer. During this same observation on 7/8/24 at 9:16 a.m., the freezer next to it had a temperature of 38 degrees Fahrenheit (F). This freezer contained 3 frozen apple pies, a frozen peach pie, and a box of donuts. During a concurrent interview with the DS 1, she stated that this was the freezer that was not working and would be fixed today or tomorrow. During a visit to the kitchen on 7/9/24 at 10:56 a.m., the DS was putting away frozen foods from the food delivery earlier that morning. DS 1 was noted to have difficulty finding space in freezer to store new food product. During an interview on 7/9/24 at 3:45 p.m. with the DS 1, she stated, the freezer was not fixed yet and she would need to check with the administrator as to when the repair company would be at the facility. During an interview on 7/10/24 at 3:19 p.m., the Corporate Chief Nursing Officer (CNO) stated that cooling companies were busy this time of year, and did not know when someone would be able to look at the freezer. During an interview on 7/11/24 at 8:44 a.m., DS 1 stated a repair company will be out to look at the freezer between 10 and 12 that morning. At 11:23 a.m., DS 1 reported that a fan in the freezer was out and it would take a few more days before it would be repaired. Review of website www.energy.gov on Refrigerator Freezer Use and Temperature Tips section indicated that Don't put too much food in the freezer. Chilled air must be able to move evenly around the food to keep it frozen. Review of website www.allareaappliance on Why You Should Never Overload Your Refrigerator or Freezer indicated the following: - When you pack your freezer or refrigerator with too many foods . it leads to deterioration of the food products. Too many containers and packets inside block air circulation in the interior spaces. This can catalyze bacterial growth in them, causing you stomach problems when you consume them. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of US Food and Drug Administration's 2022 Food Code section 4-501.11 on Good Repair and Proper Adjustment indicated that (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed.