STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055988	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Merced Care Center	3170 M Street Merced, CA 95340

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608 48430 Based on observation, interview and record review, the facility failed to provide care in a manner that maintained dignity and respect for two of three sampled residents (Resident 25 and 47) when: 1.Resident 25's urinary catheter (flexible tube inserted into bladder to drain urine) bag was uncovered and visible to other residents and visitors. This failure had the potential to compromise Resident 25's dignity and privacy by exposing their foley catheter bag, leading to embarrassment or psychosocial harm. 2. A 20-minute time limit for morning Activities of Daily Living (ADL- tasks done on a daily basis to take care of your body, like bathing, brushing hair, brushing teeth, eating, and using the bathroom) care, for Resident 47, was implemented by using a timer, resulting in the resident feeling rushed and singled out. This failure resulted in the violation of resident 47's right to dignity leaving her feeling singled out by staff. Findings: 1. During a review of Resident 25's Admission Record (AR) dated 3/19/25, the AR indicated, Resident 25 was initially admitted to the facility on [DATE] with diagnoses of cystitis (inflammation of the bladder), displacement of nephrostomy catheter (nephrostomy tube [a tube that is put into the kidney to drain urine directly from the kidney] tip positioned outside the renal collecting system [a series of tubules and ducts in the kidneys where urine flows and drains], diabetes mellitus (condition that happens when your blood sugar is too high), urinary tract infection (an infection in any part of the urinary system), presence of urogenital implants (artificial material in the urinary organs or genitals), obstructive and reflux uropathy (obstructive and reflux uropathy,), and calculus of kidney (kidney stones). During a review of Resident 25's Order Summary Report (OSR) dated 3/21/25, the OSR indicated, .change foley q (every) 3 weeks .enhanced barrier precautions r/t (related to) nephrostomy tube .foley catheter output every shift for foley . (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's Minimum Data Set (MDS- a standardized assessment tool that measures health status in nursing home residents) dated 12/12/24, the MDS section C indicated, .cognitive skills for daily decision-making score of 3 .severely impaired . During an observation on 3/17/25 at 11:46 a.m. in Resident 25's room, Resident 25's foley catheter was not covered by a dignity bag (a bag used to the cover and hold the catheter drainage/collection bag, so it is not visible). During a concurrent observation and interview on 3/19/25 at 11:55 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 25's room, Resident 25's foley was not covered with a dignity bag. LVN 1 concurred, the foley catheter did not have a dignity bag. LVN 1 stated, the foley catheter drainage bag should have been covered. During an interview on 3/19/25 at 3:35 p.m. with the Director of Nursing (DON), the DON stated, she expected Resident 25's foley catheter bag to be covered with a dignity bag. The DON stated, a dignity bag always needed to cover the foley catheter bag. The DON stated, not having a dignity bag violated dignity, privacy, and HIPPA (Health Insurance Portability and Accountability Act- establishes federal standards protecting sensitive health information from disclosure without patient's consent) regulations. The DON stated, the dignity bag needed to be provided so other residents would not know Resident 25's condition. During a review Resident 25's Care Plan (CP) dated 12/30/24, the CP indicated, .[Resident 25] has a Foley catheter r/t (related to) calculus of kidney (kidney stone), obstructive uropath, (blocking of urine by an object such as a kidney stone) [Resident 25] is at risk for infection . During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 02/21, the P&P indicated, . Residents are treated with dignity and respect at all times .Staff protect confidential clinical information .signs indicating the resident's clinical status or care needs are not openly posted .promote, maintain, and protect resident privacy . 2. During a review of Resident 47's Admission Record (AR) dated 3/19/25, the AR indicated, Resident 47 was initially admitted to the facility on [DATE] with diagnoses of heart failure (a condition in which the heart is unable to pump sufficient blood to meet the body's needs), supraventricular tachycardia (abnormally fast heart rhythm) and morbid obesity (overweight-weight is more than 80 to 100 pounds above the ideal body weight). During a review of Resident 47's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/9/25, the MDS section C indicated Resident 47 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 47 was cognitively intact. During a concurrent observation and interview on 3/17/25 at 10:52 a.m. with Resident 47, in Resident 47's room, Resident 47 was observed seated in a wheelchair in front of the television, dressed, and applying makeup. During the observation, Resident 47 stated that the facility only allows her 20 minutes to receive morning care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/25 at 2:54 p.m. with Resident 47's Family Member (FM), FM stated his frustration regarding the facility's use of a 20-minute timer to limit his mother's morning care. FM stated he felt his mother was being singled out, as no other resident in the facility was known to be subjected to a timed limit for morning care. During a review of Resident 47's Progress note, dated 3/3/25, the Progress note indicated, . Administrator ordered a timer on 2/26/25 to be used by staff to decrease extensive time spent with resident . resident was informed that the use of the timer was being implemented on 3/1/25 and that the timer would be set for 20 minutes for morning care. Resident expressed dissatisfaction . During a concurrent observation and interview on 3/19/25 at 9:34 a.m. with Certified Nursing Assistant (CNA) 2 in Resident 47's room, CNA 2 was providing morning care to Resident 47. CNA 2 stated Resident 47 will take up a lot of time, the use of the timer was implemented to set a limit of 20 minutes for Resident 47's morning care. During a concurrent interview and record review on 3/19/25 at 10:01 a.m. with the Licensed Vocational Nurse (LVN) 4, Resident 47's Progress Note dated 3/3/25 was reviewed, LVN 4 stated Resident 47's Progress note was created by the Interdisciplinary Team (IDT - collaborative group of individuals who work together to achieve a common goal.) who developed the use of the timer to help staff manage the time spent with Resident 47. LVN 4 stated that no other resident in the facility is using a timer to manage time spent. LVN 4 acknowledged the use of a timer would make Resident 47 feel singled out. During an interview on 3/20/25 at 11:38 a.m. with the Director of Nursing (DON) stated, On, paper, this looks like the first attempt at time management, The DON acknowledged implementing a 20-minute timer for Resident 47's ADL care was an extreme first step. The DON stated best practice is to have all proper documentation in the resident's clinical record. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 02/21, the P&P indicated, . Residents are treated with dignity and respect at all times .Residents may exercise their rights without . discrimination or reprisal from any person or entity associated with this facility .signs indicating the resident's clinical status or care needs are not openly posted .Demeaning practices and standards of care that compromise dignity are prohibited . 51284

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33126 Based on observation, interview, and record review the facility failed to ensure residents' food preferences for food brought in from the outside were met by warming food up when the facility microwave was removed from the resident food storage area and staff was instructed, they could no longer warm up food for residents. This failure resulted in residents' frustration and denial of food preferences not being warmed to acceptable temperatures for palatability. This failure resulted in residents not having the ability to warm up their frozen foods which lead to frustration and denial of food preferences not being warmed to acceptable temperatures for palatability. Findings: During a concurrent observation and interview on 3/17/25 at 11:33 a.m. with Resident 102 in Resident 102's room, a collection of canned and packaged food was on the top right side of Resident 102's counter. Resident 102 stated he has food brought in for evening snacks, or to eat if he did not want to eat what was on the menu from the kitchen. Resident 102 stated the Certified Nursing Assistant (CNA), would warm up the food for him. During an interview on 3/18/25 at 1:20 p.m. with Resident 102, Resident 102 stated he was no longer able to have his food warmed up and the facility microwave has been removed from the Resident Food Storage Room (RFSR). Resident 102 stated that he was frustrated and had spent a lot of his own money to buy food that he would normally eat at night at home. Resident 102 stated, . it is my right. Resident 102 stated this afternoon was the first time warming up the food from his room has been an issue since his admission on 3/26/24. During a review of Resident 102's Admission Record (AR) dated 3/20/25, the AC indicated Resident 102 was admitted on [DATE] with diagnosis of . Heart Failure (HF), Diabetes Mellitus (DM) Type II (body does not produce enough insulin or use it properly, leading to high blood sugar levels), Kidney Failure . During a review of Resident 102's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 102's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a scale of 015 [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 102 had no cognitive deficit. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/25 at 2:01 p.m. with Resident 47, Resident 47 stated the facility was violating her rights by not heating up the food her family brings her from home. Resident 47 stated that her family bought her food, and the staff refuse to heat it up. Resident 47 stated that staff used to heat up the food and now they no longer heat it for her, and she cannot eat the food frozen. Resident 47 stated this makes her feel upset During a review of Resident 47's Admission Record (AR) dated 3/19/25, the AR indicated, Resident 47 was initially admitted to the facility on [DATE] with diagnoses of heart failure (a condition in which the heart is unable to pump sufficient blood to meet the body's needs), supraventricular tachycardia (abnormally fast heart rhythm) and morbid obesity (overweight-weight is more than 80 to 100 pounds above the ideal body weight). During a review of Resident 47's Minimum Data Set (MDS- a standardized assessment tool that measures health status in nursing home residents) dated 1/9/25, the MDS section C indicated, .cognitive skills for daily decision-making score of 15 .cognitively intact . During an observation on 3/19/25 at 4:17 p.m. in the hall of the facility, Maintenance Assistant (MA), was observed removing the microwave from the resident food storage room and taking it down the hall to the Medical Records office. During a concurrent observation and interview on 3/19/25 at 5:26 p.m. with Certified Nursing Assistant (CNA) 3, in the resident food storage room, 11 frozen meals were noted in the resident freezer. CNA 3 stated, . residents are no longer able to have their food heated up as of approximately two weeks ago, the administration did not provide an explanation they just stated the staff was no longer able to warm up food for residents. The microwave was then removed from the resident food storage room . several residents have complained, but the facility has not come up with an alternative . During an interview on 3/21/25 at 1:54 p.m. with the Activities Director (AD), the AD stated, . the Administrator (ADM) told us to inform residents during the Resident Council Meeting on 3/6/25, staff will no longer be heating up food in the microwave. The residents were not happy but those were the instructions that were given . During an interview on 3/21/25 at 3:33 p.m. with the Registered Dietitian (RD), the RD stated she was not aware that staff was not warming up food for residents. The RD stated staff could have an in-service training regarding heating up food for residents or have a thermometer available to take the temperature of the food after it has been microwaved. The RD stated there were several options that the facility could look into to provide ways to heat up food for residents. During an interview on 3/21/25 at 5:26 p.m. with the Director of Staff Development (DSD), the DSD stated, the microwave was removed for resident safety. The CNA staff were not equipped with thermometers or trained on how to properly heat up food in the microwave. The facility did not come up with an alternate way to heat up food for residents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/25 at 6:10 p.m. with the ADM, the ADM stated , . the reasons for stopping the staff from heating up resident food were, the time it takes for the staff to reheat the food, the staff are not trained to take the temperature of food, and there was not a thermometer or temperature log for staff to take the temperature of the food or log the temperatures . the facility needs to find a way to heat up food for residents .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51134 Based on interview and record review, the facility failed to implement a significant change of condition for Resident 42 when the resident was admitted to the facility on [DATE], was unable to make her needs known and be her own responsible party (RP- health care decision maker) Resident experienced a major improvement in mentation on 3/3/25 and no significant change of condition was completed. This failure had the potential to result in a lack of further improvement for Resident 72 when there were no updates in plan of care to reflect the change in mentation. Findings: During a record review of Resident 72's Admission Record (AR) dated 3/20/25, the AR indicated Resident 72 was admitted into the facility on [DATE]. The AR indicated, .Diagnosis Information . Cerebral Infarction (medical condition where blood flow to the brain is interrupted, leading to damage or death of brain tissue) . metabolic encephalopathy (condition where brain ' s function is impaired due to an imbalance in the body ' s metabolism) . bipolar disorder . During a record review of Resident 72's Minimum Data Set (MDS - define) section C (cognitive patterns) dated 2/24/25, the MDS section C indicated, . C0100 .0. No (resident is rarely/never understood) . No BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was conducted at this time due to resident scoring a zero in section C0100. During a review of IDT [Interdisciplinary Team] Note dated 3/3/25, the IDT [Interdisciplinary Team] Note indicated, .Resident has a BIMS score of 99 as of 2/24/2025 . resident speaks but it is challenging to understand what she is trying to say . During a review of Social Services Discharge/Preparation Note dated 2/19/25, the Social Services Discharge/Preparation Note indicated, .Welcome Conference held with resident on 2/18/2025, brother and family at bedside. Resident was able to communicate in a limited manner with impaired speech. Resident was able to use a pad of paper and pen to communicate yes and no to some questions. Resident became agitated [related to] difficultly communicating . During a review of Social Services Follow Up Note dated 3/4/2025, the Social Services Follow Up Note indicated, . [Social Services Director] completed a new BIMS assessment due to change in condition, and resident scored a BIMS of 15 [score between 13 to 15 suggests the individual has intact cognitive function]. Writer performed a SLUMS [St. Louis University Mental Status - examination for detecting mild cognitive impairment and dementia] examination with resident, and the resident had a score of 18, which is indicative of dementia [a progressive state of decline in mental abilities] per the scoring guide . (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/20/25 at 4:57 p.m. with the Minimum Data Set (MDS) Coordinator, Resident 72 ' s Social Services Follow up Note dated 3/4/25 was reviewed. The Social Services Follow up Note indicated, . [Social Services Director] completed a new BIMS assessment due to change in condition, and resident scored a BIMS of 15 . The MDS Coordinator was unable to locate a BIMS assessment and a change of condition following this social services visit. The MDS Coordinator stated this change in BIMS can be considered a change of condition. During an interview on 3/21/25 at 2:00 p.m. with the MDS Coordinator, the MDS coordinator stated no formal IDT meeting for change of condition was done for this resident following the social services director's new BIMS scoring of 15. The MDS Coordinator stated, We probably just failed and sounds like we need to do a change of condition for her. During an interview on 3/21/25 at 2:18 p.m. with the Social Services Director (SSD), the SSD stated the IDT should have met on 3/4/25 to discuss the multiple changes in Resident 72's behavior and change in mentation from a BIMS of 99 to a BIMS of 15 and that should have been enough to trigger a change in condition. During an interview on 3/21/25 at 3:46 p.m. with the Director of Nursing (DON), the DON stated it would have been important to conduct a change of condition for Resident 72's change of BIMS from 99 to 15. The DON stated it is important to do a change of condition so new care plan interventions can be implemented to improve the resident's health. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status dated 2/2001, the P&P indicated, .1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental condition; . 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease relation clinical interventions (it is not self-limiting); . d. ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument .5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the residents medical/mental condition or status .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on interview, and record review the facility failed to develop and implement a baseline care plan (a document which specified goals, interventions, and monitoring strategies for patients) for three of nine sampled residents (Residents 221, 222, and 421) when: 1. Residents 221 and 222 did not have their baseline care plans completed within 48 hours of their admission to the facility This failure had the potential to cause Residents 221 and 222 to not have their respiratory care needs met 2. Resident 421 did not have his baseline care plan for a PICC (peripherally inserted central catheter- a thin, flexible tube that is inserted into a vein in the upper arm used to deliver medications directly into the heart) completed within 48 hours of his admission to the facility. This failure had the potential to cause Resident 421 to not have his care needs met potentially leading to poor patient outcomes (adverse effects) such as developing infections that could lead to a decline in health. Findings: 1. During a review of Resident 221's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/21/25, the AR indicated, Resident 221 was admitted to the facility on [DATE] with a primary diagnosis of pleural effusion (buildup of excess fluid between the layers of tissue lining the lungs and chest cavity). During a review of Resident 222's AR, dated 3/21/25, the AR indicated, Resident 222 was admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection of the lungs that causes the air sacs to become inflamed and fill with fluid), chronic obstructive pulmonary disease (COPD- an ongoing lung condition caused by damage to the lungs) and pleural effusion. During a concurrent interview and record review on 3/20/25 at 11:01 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 221 and 222's care plans, dated 3/20/22, were reviewed. Resident 221 and 222's care plan did not include any interventions for their admitting diagnoses or physician orders. LVN 1 stated both Resident 221 and 222 had orders for the use of oxygen and nurses at the facility were responsible for care planning the oxygen order upon admission. LVN 1 stated Residents 221 and 222 had respiratory conditions and staff needed to care plan goals and interventions which would help them breathe better. LVN 1 stated the care plan drives residents' care, and upon admission nurses needed be aware of the basic needs of each resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/25 at 1:46 p.m. with the Minimum Data Set Registered Nurse (MDSRN), the MDSRN stated the nurses caring for the residents were responsible for ensuring baseline care plans were created for newly admitted residents. The MDSRN stated Residents 221 and 222 should have had their diagnoses and physician's orders care planned. The MDSRN stated care planning was important because it ensured staff were aware of a resident's medical needs and what each resident required to help them feel better. Accurate care planning was also needed to better communicate with other nurses who might not know what the resident requires. During an interview on 3/21/25 at 3:03 p.m. with the Director of Nursing (DON), the DON stated baseline care planning should have been done for Residents 221 and 222. The DON stated care planning was important because it created interventions which staff could implement to try to get residents healthy enough to discharge home. During a review of the facility's policy and procedure (P&P) titled, Care Plans-Baseline dated 3/22, the P&P indicated, .A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. physician orders 48430 2. During a review of Resident 421's AR dated 3/20/25, the AR indicated Resident 421 was admitted to the facility on [DATE] with a primary diagnosis of late syphilitic oculopathy (an eye condition that can happen if syphilis isn't treated), type two diabetes mellitus (a condition where the body doesn't use insulin [a type of compound that regulates sugar levels in the blood] well and can't keep blood sugar at normal levels), epilepsy (brain disorder that causes recurring, unprovoked seizures (sudden, uncontrolled bursts of electrical activity in the brain that can cause temporary changes in behavior, consciousness, and body movements), and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 421's Minimum Data Set (MDS-a standardized uniform comprehensive assessment of all residents) dated 3/11/25, the MDS indicated, Resident 421 had a BIMS (Brief Interview for Metal Status-a screening tool used to evaluate a person's cognitive [an individual's thinking, reasoning, and remembering process] ability) score of 15 (a BIMS score of 15 indicated Resident 421 had intact cognitive function). During a review of Resident 421's Order Summary Report (OSR) dated 3/20/25, the OSR indicated, .D/C (discontinue) PICC line after IV (intravenous-in the vein) Antibiotic (medicine to treat bacterial infection) therapy is completed . During a concurrent observation and interview on 3/17/25 at 3:30 p.m. with Resident 421 in his room, Resident 421 had a PICC line on his right upper arm. Resident 421 stated, he was here for short term antibiotic therapy for an eye infection. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/20/25 at 10:27 a.m. with Resident 421 in the facility's lobby, Resident 421 was sitting on a chair waiting for his ride to pick him up. Resident 421's PICC line was removed and was discharged . Resident 421 stated, Registered Nurse (RN) 1 removed his PICC line about 30 to 40 minutes ago. During a concurrent interview and record review on 3/20/25 at 2:14 p.m. with the Director of Nurses (DON), Resident 421's Care Plan (CP-a form where that summarizes a person's health conditions, specific care needs, and current treatments) dated 3/5/25 to 3/20/25 was reviewed. The CP did not indicate PICC line care plans were implemented. The DON stated, there were no CP for Resident 421's PICC line but should have had a baseline care plan implemented when he was admitted . During a concurrent interview and record review on 3/20/25 at 3:11 p.m. with Registered Nurse (RN) 1, Resident 421's CP dated 3/5/25 to 3/20/25 was reviewed. CP did not indicate PICC line care plans were implemented. RN 1 stated, Resident 421 did not have a baseline care plan for his PICC line and should have had one. RN 1 stated, baseline care plans should have been completed within 48 hours of admission. RN 1 stated, a CP was important because it guides resident care and offers a way to measure treatment outcomes. RN 1 stated, if no CP were implemented, the was a potential for Resident 421's health status to decline. During a concurrent interview and record review on 3/20/25 at 3:11 p.m. with RN 1, Resident 421's CP dated 3/5/25 to 3/20/25 was reviewed. The CP did not indicate PICC line care. RN 1 stated, Resident 421 should have had a care plan for his PICC line. RN 1 stated, a baseline care plan should have been completed within 48 hours of admission. RN 1 stated, CPs were important as they guided care and tracked progress of the treatment. RN 1 stated, without a CP, Resident 421's health could have declined. During an interview on 3/21/25 at 5:38 p.m. with the DON, the DON stated, she expected a baseline care plan to be implemented within 48 hours of a resident's admission. The DON stated, it was important because it created interventions which staff could implement to guide care and lead to the resident's optimal health before discharging. During a review of the facility's P&P titled, Care Plans-Baseline dated 3/22, the P&P indicated, .A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. physician orders

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Golden Merced Care Center	3170 M Street Merced, CA 95340

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51134 Based on observation, interview and record review, the facility failed to develop and implement comprehensive care plans for four of 12 sampled residents (Resident 71 and Resident 72, Resident 47 and Resident 223) when: 1. Resident 71 had an incomplete care plan for anxiety medication, and no care plan for Sertraline (anti-depressant medication) and Olanzapine (antipsychotic medication that alters brain chemistry to help reduce symptoms of the mind where there has been some loss of contact with reality). 2. Resident 72 did not have individualized care plans for Quetiapine (antipsychotic [class of drugs used to treat psychotic disorders] medication used to treat schizophrenia [a chronic mental health conditional characterized by significant disruptions in thought processes, perceptions, emotions and behavior] and bipolar disorder [chronic mental health condition characterized by extreme shifts in mood, energy and behavior]), Buspirone (medication used to treat anxiety disorders), and Lorazepam (anti-anxiety medication). These failures had the potential to result in Resident 71 and Resident 72 not having their mental and psychosocial (relating to the interrelation of social factors and individual through and behavior) needs met. 3. Resident 223 did not have a care plan for Apaxiban, Insulin (regulates blood sugar levels in the body), diabetic (the body does not produce insulin resulting in high blood sugar levels), care, or hemodialysis (a treatment that cleans the blood to filter out waste and excess fluid). These failures put Resident 223 at risk for harm by not monitoring or identifying risk of uncontrolled bleeding and harmful side effects and by not monitoring effects of insulin on the Resident's blood sugar. 4. Resident 47 did not have a care plan for apixaban (anticoagulant - prevent blood clots from forming). This failure put Resident 47 at risk for harm by not monitoring or identifying risk of uncontrolled bleeding and harmful side effects. Findings: 1. During a record review of Resident 71's AR dated 3/21/25, the AR indicated resident 71 was admitted into the facility on [DATE]. The AR indicated, . Diagnosis Information .bipolar disorder .post-traumatic stress disorder [PTSD - a disorder in which a person has difficultly recovering after experiencing or witnessing a terrifying event] . (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 record review of Resident 71's Care Plan (CP) Report dated 2/23/25, the CP Report indicated, . Goal: The resident will show decreased number (SPECIFY) episodes or anxiety through the review date. Date initiated: 02/23/2025. Revision on 03/17/2025. Target Date: 03/24/2025 . Did not observe a care plan in place for the medications Sertraline and Olanzapine. During a concurrent interview and record review on 3/21/25 at 8:59 a.m. with LVN 3, Resident 71's CP Report for anti-anxiety medication was reviewed. The CP Report indicated, .Goal: The resident will show decreased number (SPECIFY) episodes or anxiety through the review date . LVN 3 stated this care plan is incomplete and specify was not edited. LVN 3 stated it is important to have a specific number included to know how many behaviors to observe for and to see if the medication is effective. LVN 3 was unable to locate care plans for the medications Sertraline and Olanzapine. LVN 3 stated there should be care plans for these medications because they are antipsychotics and staff need to monitor the resident for behaviors. 2. During a record review of Resident 72's Admission Record (AR) dated 3/20/25, the AR indicated Resident 72 was admitted into the facility on [DATE]. The AR indicated, .Diagnosis Information . Cerebral Infarction (medical condition where blood flow to the brain is interrupted, leading to damage or death of brain tissue) . metabolic encephalopathy (condition where brain's function is impaired due to an imbalance in the body's metabolism) . bipolar disorder . During a record review of Resident 72's Care Plan (CP) dated 3/20/25, the CP indicated, Focus: [Resident 72] uses psychotropic medications [substances that affect the brain and nervous system, altering mood, perception and behavior] (Quetiapine) for bipolar disorder m/b [manifested by] verbal and physical aggression towards staff. She is at risk for drug-related complications. Date initiated: 03/20/2025. Revision on: 03/20/2025 . During a record review of Residents 72's CP dated 3/20/25, the CP indicated, Focus: [Resident 72] uses anti-anxiety medication Buspirone r/t [related to] repetitive statements, I want to go home. She is at risk for drug-related complications. Date initiated: 03/20/2025. Revision on: 03/20/2025 . During a record review of Resident 72's CP dated 03/20/25, the CP indicated, Focus: [Resident 72] uses anti-anxiety medications [Lorazepam] r/t anxiety m/b inability to relax. She is at risk for drug-related complications. Date Initiated: 03/20/2025. Revision On: 03/20/2025 . During a concurrent interview and record review on 3/21/25 at 8:54 a.m. with Licensed Vocational Nurse (LVN) 3, the medication orders for Quetiapine, Buspirone, and Lorazepam and care plans for these medications were reviewed. LVN 3 stated the medication order for Seroquel indicated a start date of 2/18/25. LVN 3 stated the medication order for Buspirone indicated a start date of 2/18/25. LVN 3 stated the medication order for Lorazepam indicated a start date of 3/5/25. LVN 3 stated the care plans for Quetiapine, Buspirone, and Lorazepam were created on 3/20/25. LVN 3 stated the care plans for these medications should have been in place when the medications were ordered. LVN 3 stated it is important to have care plans for these medications because the resident needs to be monitored to determine if the medication is effective for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/25 at 3:23 p.m. with the Director of Nursing (DON), the DON stated the CP for Resident 71 is incomplete because it does not specify the number of episodes to observe for. The DON stated it is important to have specific number of episodes to observe for to see if medication is working or not and determine if the current dose of the medication needs to be adjusted. The DON acknowledged Resident 71's care plans for Quetiapine, Buspirone, and Lorazepam were missing and not created when the medication was ordered. The DON acknowledged for Resident 72 the care plans for Sertraline and Olanzapine were missing and should have been created. The DON stated it is important to have comprehensive care plans so interventions can be implemented, and this is especially important for short term residents so they can be healed and back to bassline prior to discharge. During a record review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 12/2016, the P&P indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident . The P&P indicated, . 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS) . 41608 3. During a record review of Resident 223's Admission Record (AR) dated 3/19/25, the AR indicated Resident 223 was admitted into the facility on [DATE]. The AR indicated, . Gangrene (the death of body tissue, typically due to lack of blood flow or a serious bacterial infection, often affecting limbs like toes, fingers, and feet), post amputation (the surgical removal) of left toes, Type II Diabetes (DM- body does not produce enough insulin or use it properly, leading to high blood sugar levels), End Stage Renal Disease (ESRD-kidneys can no longer adequately filter waste and excess fluid from the blood), Peripheral Vascular Disease (PVD-blood vessels outside the heart and brain narrow or become blocked, reducing blood flow and potentially causing pain, numbness and other issues), Hemodialysis (a treatment that cleans the blood to filter out waste and excess fluid) . During a review of Resident 223's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 223's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a scale of 0-15 [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 223 had no cognitive deficit. During a review of Resident 223's Order Summary (OS), dated 1/2/25, the OS indicated, . MWF dialysis at Satellite Healthcare Merced . pick up 1300 (1 p.m.), chair time 1500 (3 p.m.) . During a review of Resident 223's Medication Administration Record (MAR), dated 2/1/25, the MAR indicated, Resident 223 was prescribed Apaxiban Oral Tablet 5 MG (milligram-unit of measure), Give 1 tablet by mouth two times a day for DVT (Deep Vein Thrombosis - blood clot), prevention .Insulin Glargine Solostar Subcutaneous Solution Pen Injector 100 Unit/ML (milliliter-unit of measure), (Insulin Glargine) inject 5 units subcutaneously (into the skin), at bedtime for Diabetes . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/21/25 at 6:38 p.m. with Director of Nurses (DON), Resident 223's Care Plans (CP) dated 2/1/25 were reviewed. The CP indicated, no Care Plan for anticoagulants, insulin, diabetic care, or hemodialysis were created. The DON stated, the care plan provides directions for staff to care for residents, without a care plan the resident may not get the care that is needed. During a review of the facility's policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team, dated 09/13, the P&P indicated, .A comprehensive, person centered care plan that included measureable objectives and timetables to meet the resident'sphysical, psychosocial and functional needs is developed and implemented for each resident . 51284 4. During a review of Resident 47's Admission Record (AR) dated 3/19/25, the AR indicated, Resident 47 was initially admitted to the facility on [DATE] with diagnoses of heart failure (a condition in which the heart is unable to pump sufficient blood to meet the body's needs), supraventricular tachycardia (abnormally fast heart rhythm) and morbid obesity (overweight-weight is more than 80 to 100 pounds above the ideal body weight). During a review of Resident 47's Minimum Data Set (MDS- a standardized assessment tool that measures health status in nursing home residents) dated 1/9/25, the MDS section C indicated, .cognitive skills for daily decision-making score of 15 .cognitively intact . During a review of Resident 47's Order Summary Report (OSR) dated 12/3/24, the OSR indicated .apixaban 5 mg tablet twice a day for supraventricular tachycardia . During an interview on 3/19/25 at 5:45 p.m. with the Minimum Data Set Nurse (MDSN), The MDSN stated Resident 47 did not have a care plan for apixaban. The MDSN stated it is important to have a care plan for apixaban, apixaban is an anticoagulant (medication that is used to prevent blood clots). The MDSN stated Resident 47 is at risk for bleeding. During a concurrent interview and record review on 3/21/25 at 4:35 p.m. with LVN 5, Resident 47's Care Plan, dated 3/19/25 and OSR, dated 12/3/24 were reviewed. LVN 7 stated the order for apixaban was started on 12/3/25. LVN 7 stated Resident 47's care plan for apixaban should have been entered sooner. LVN 7 stated care plans are important because it provides a form of communication to care for each resident. During an interview on 3/21/25 at 4:55 p.m. with the DON, The DON stated it is the expectation of the facility to document completely and timely. DON stated care plans are resident centered. During a review of the facility's policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team, dated 09/13, the P&P indicated, .The comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment .care plans are revised as information about the residents and residents' condition change .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on observation, interview, and record review the facility failed to meet professional standards of quality for three of six sampled residents (Residents 4, 221, and 321) when 1. Resident 221's physician order for routine oxygen administration was not followed This failure had the potential to cause Resident 221 to experience negative health effects from lack of oxygen. 2. Resident 321 had an incorrect medication order for a Lidocaine Patch (medication that is used to relieve pain). This failure had the potential to result in incorrect placement of the Lidocaine Patch and the potential for the resident to experience ineffective pain control. 3. Resident 4's order for use of Pressure Reduction mattress for pressure redistribution was not being followed. This failure had the potential for Resident 4 to experience delayed healing of a wound, and to not receive necessary wound care. Findings: 1. During a review of Resident 221's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/21/25, the AR indicated, Resident 221 was admitted to the facility on [DATE] with a primary diagnosis of pleural effusion (buildup of excess fluid between the layers of tissue lining the lungs and chest cavity). During a concurrent observation and interview on 3/17/25 at 11:09 a.m. in Resident 221's room with Resident 221, Resident 221's nasal cannula (a thin, flexible tube with two prongs, used to deliver supplemental oxygen through the nostrils) was stored in a bag and her oxygen concentrator (a medical device that takes in air from the surrounding environment and delivers a concentrated, purified stream of oxygen to the resident) was turned off. Resident 221 stated she needed oxygen and did not know why it was turned off. During a concurrent interview and record review on 3/19/25 at 9:43 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 221's Order Summary Report, dated 3/17/25 was reviewed. The Order Summary Report indicated Resident 221 was to receive one to four liters (L- a unit of measurement) of oxygen via her nasal cannula. LVN 6 stated Resident 221 had a pleural effusion which meant she had trouble breathing and needed more oxygen than a regular person. LVN 6 stated Resident 221's order was for continuous oxygen delivery and not a PRN (as needed) order. LVN 6 stated if nurses were choosing when to administer Resident 221's oxygen then they needed to call the doctor to get a new order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON), the DON stated if Resident 221 did not need continuous oxygen then the nurses needed to call the doctor to obtain an order for the PRN use of oxygen. The DON stated Resident 221 may have received the inappropriate amount of oxygen if her order was not correct During a review of the facility's policy and procedure (P&P) titled, Medication Order dated 4/08, the P&P indicated, .(b) All drug orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The name, quantity or specific duration of therapy, dosage and time or frequency of administration of the drug, and route of administration if other than oral shall be specified. P.R.N. order shall include the indication for use of a drug .1) Medication orders specify the following .c. Dosage and frequency of administration. 51134 2. During an observation on 3/19/25 at 8:31 a.m. with Licensed Vocational Nurse (LVN) 2 at the South one medication cart in front of Resident 321's room, LVN 2 was observed referring to medication administration record (MAR - a report that details the medications to be administered to a resident) for a Lidocaine Patch order. LVN 2 proceeded to walk into Resident 321's room with the Lidocaine patch and explained to the resident the Lidocaine Patch was a pain medication and was to be placed behind the right shoulder. Resident 321 stated she needed the patch on her right shoulder and a Lidocaine patch on her stomach below the colostomy bag because that is where she felt pain. LVN 2 stepped out of the room and referred to the MAR for the order. LVN 2 re-entered Resident 321's room and explained the medication order was for the right shoulder and proceeded to place the Lidocaine patch. During a record review of Admission Record (AR) dated 3/20/25, the AR indicated Resident 321 was admitted into the facility on [DATE]. During a record review of Resident 321's Order Summary Report (OSR) dated 3/20/25, the OSR indicated, . Lidocaine External Patch 4% (Lidocaine) Apply to affected area topically [medication that is applied directly to the surface of the body] one time a day for pain . Order Date: 3/18/2025 . During a concurrent interview and record review on 3/20/25 at 9:10 a.m. with LVN 3, Resident 321's Lidocaine Patch order was reviewed. The Lidocaine Patch order indicated, .Lidocaine External Patch 4% (Lidocaine) Apply to affected area topically one time a day for pain . LVN 3 stated the medication order does not specify where the Lidocaine Patch should be placed. LVN 3 stated, I would not know where to put [the Lidocaine Patch] looking at this order. LVN 3 stated it is important for the order to state where to place the patch, so it is placed in the correct location, and it is effective for the resident. During an interview on 3/21/25 at 11:02 a.m. with the Pharmacy Consultant (PC), the PC stated the Lidocaine Patch order for Resident 321 is incomplete and does not state where the patch needs to be applied. The PC stated it is important to have a complete order to know where the medication should be placed and to relieve the resident of pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/21/25 at 3:12 p.m. with the Director of Nursing (DON) the Lidocaine patch order for Resident 321 was reviewed. The DON stated the order should have clarified where to place the patch. The DON stated it is important for the medication order to have the affected site listed so the area of pain for the resident is addressed. The DON stated if the affected site is not listed and the Lidocaine patch is placed in the wrong location, the resident will have ineffective pain control. During a review of the facility's policy and procedure (P&P) titled, Medication Order dated 4/2008, the P&P indicated, .1) Medication orders specify the following .e. Route of administration (If facility policies allow, orders are assumed to be P.O. unless otherwise specified) . The P&P indicated, .Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe . The P&P indicated, . Procedures . c. The prescriber is contacted to verify or clarify an order ([example] when the resident has allergies to the medication, there are contraindications to the medication, the directions are confusing) . 51284 3. During a concurrent observation and interview on 3/17/25 at 11:20 a.m. with Resident 4, in Resident 4's room, Resident 4 was observed lying in bed facing the entry way of his door. Resident 4 was alert and oriented. Resident 4 stated he has been lying in bed for months. During a review of Resident 4's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/19/25, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses of Paraplegia (Condition causes partial or complete loss of function of the lower half of the body), Type 2 Diabetes Mellitus (condition where the body does not use insulin properly or does not produce enough insulin), and Pressure ulcer of the sacral region unstageable [a full thickness [injury extends beyond the two outer layers of skin and into fat and muscle], to the bottom of the back. During a review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/5/25, the MDS Section C indicated, Resident 4's Brief Interview for Mental Status (BIMS- an assessment to be used by facility to screen and Identify memory, orientation, and judgement status of the resident) assessment score was 15 out of 15, (0-15 scale- 0-6 severe cognitive deficit, 7-12 moderate cognitive deficit 13 -15 no cognitive deficit) indicating Resident 4 was cognitively intact. During a review of Resident 4's Braden scale- (a standardized clinical tool that assesses 6 risk areas for pressure ulcers), dated 1/15/25, indicated a total score of 12 which is high risk for developing pressures ulcers. With scoring ranging from 1-3 or 4 and total scoring ranging from 6 to 23. A lower Braden Scale indicates a lower level of functioning and, therefore, higher level of risk for pressure ulcer development. During review of Resident 4's Order Summary Report (OSR), dated 3/19/25, the OSR indicated, .Pressure Reduction mattress for Pressure redistribution every shift . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/19/25 at 9:34 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 was observed helping Resident 4 change positions in bed. CNA 2 stated Resident 4 had a regular mattress and not a Pressure Reduction mattress for pressure redistribution. During a concurrent interview and record review on 3/19/25 at 10:01 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 4's OSR, dated 3/19/25, was reviewed. LVN 4 stated the physician orders were to be followed. LVN 4 stated Resident 4 had refused the use of the mattress. LVN 4 stated Resident 4's refusal of Pressure Reduction Mattress was not documented. LVN 4 stated the use of the Pressure reduction mattress is important for Resident 4's wound healing. During an interview on 3/20/25 at 11:38 a.m. with the Director of Nursing (DON), the DON stated Resident 4 had no documentation of refusal of Pressure Reduction Mattress. The DON stated nurses should have informed the physician of Resident 4's refusal. The DON stated not following physician orders could result in Resident 4's wounds worsening. During a review of the facility's P&P titled, Pressure Injury Prevention, dated 4/2018, the P&P indicated, . document an individual's significant risk factors of developing pressure ulcers . evaluate and document the progress . despite existing interventions . During a review of facility's P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, dated 2/2024, the P&P indicated, .Detailed information relating to the request, refusal, or discontinuation of treatment are documented in the resident's medical record . The healthcare practitioner must be notified of refusal or treatment .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview and record review, the facility failed to administer parenteral fluids (Parenteral fluids administered by injection through the tissue and circulatory system) in accordance with professional standards of practice for two of three sampled residents (Resident 421 and 422), when: 1. Resident 421 was admitted to the facility on [DATE] with a peripherally inserted central catheter (PICC, tube that is inserted into a vein in the upper arm to the heart) for the purposes of administering intravenous (IV - through the vein) antibiotics (medicines that fight bacterial infections). The facility did not have an approved policy and procedure that followed the standards of practice to instruct and guide nurses on the care of the PICC line. Two of Two Registered Nurses (RN [RN 1 and RN 4]) and the Assistant Director of Nursing (ADON) were not trained and did not follow the standards of practice in the care of the PICC line. 2. Resident 422 was admitted to the facility on [DATE]/25 and a midline (a long, thin, flexible tube that is inserted into a large vein in the upper arm) was inserted on 03/20/25 for the purposes of administering intravenous antibiotics. The facility did not have an approved policy and procedure that followed the standards of practice to instruct and guide nurses on the care of the PICC line. Two of Two Registered Nurses (RN [RN 1 and RN 4]) and the Assistant Director of Nursing (ADON) were not trained and did not follow the standards of practice in the care of the Midline line. These failures had the potential to cause Resident 421 and Resident 422 to experience adverse outcomes such as life-threatening blood infection and an air emboli (a blood vessel blockage caused by one or more bubbles of air or other gas in the circulatory system) due to nursing staff not having the knowledge, training, and competency to safely care for Resident 421 and Resident 422's PICC line and administer their IV antibiotics. Findings: 1. During a review of Resident 421's, Admission Records (AR) dated 3/20/25, the AR indicated Resident 421 was admitted to the facility on [DATE] with a primary diagnosis of late syphilitic oculopathy (an eye condition that can happen if syphilis isn't treated), type two diabetes mellitus (a condition where the body doesn't use insulin [a type of compound that regulates sugar levels in the blood] well and can't keep blood sugar at normal levels), epilepsy (brain disorder that causes recurring, unprovoked seizures [sudden, uncontrolled bursts of electrical activity in the brain that can cause temporary changes in behavior, consciousness, and body movements]), and essential hypertension (high blood pressure that is not due to another medical condition) During a review of Resident 421's Minimum Data Set (MDS-a standardized uniform comprehensive assessment of all residents) dated 3/11/25, the MDS indicated, Resident 421 had a BIMS (Brief Interview for Metal Status-a screening tool used to evaluate a person's cognitive [an individual's thinking, reasoning, and remembering process] ability) score of 15 (a BIMS score of 15 indicated Resident 421 had intact cognitive function). (continued on next page)

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	055988	A. Building B. Wing	03/21/2025

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 421's Order Summary Report (OSR) dated 3/20/25, the OSR indicated, .D/C (discontinue) PICC line after IV (intravenous-in the vein) Antibiotic (medicine to treat bacterial infection) therapy is completed . During a concurrent observation and interview on 3/17/25 at 3:30 p.m., with Resident 421 in his room, Resident 421 had a PICC line on his right upper arm. Resident 421 stated he was here for short term antibiotic therapy for an eye infection. During a concurrent observation and interview on 3/20/25 at 10:27 a.m. with Resident 421 in the facility's lobby, Resident 421 was sitting on a chair waiting for his ride to pick him up. Resident 421's PICC line was removed, and a brown band-aid covered the site where the PICC line had been removed. Resident 421 stated, Registered Nurse (RN) 1 removed his PICC line about 30 to 40 minutes ago and only put a band-aid to cover the site. Resident 421 stated RN 1 did not tell him to lay flat after the PICC line was removed. Resident 421 stated RN 1 did not provide instructions for post PICC line removal. During an interview on 3/20/25 at 10:38 a.m. with the Infection Preventionist (IP), the IP stated she was familiar with what a PICC and Midline were but was not responsible for the care and maintenance for PICC or Midlines. The IP stated, only RNs were allowed to provide care for patients with PICCs and Midlines. The IP stated, RNs must be trained on PICCs and Midlines by their preceptor (a teacher, or someone who trains people how to do a job) before being allowed to provide care and maintenance for PICCs and Midlines. During a phone interview on 3/20/25 at 11:02 a.m. with the Third-Party Vendor Chief Nursing Officer (TPVCNO), the TPVCNO stated the RN should have applied an occlusive dressing (an air and water tight dressing [a piece of material such as a pad applied to a wound]) consisting of petroleum-infused (mixed and saturated[full of]) 2x2 (two inches by two inches-unit of measure indicating size) gauze (a type of cotton cloth used for covering and protecting wounds) covered with a tegaderm (a thin clear sterile dressing that keeps out water, dirt and germs) to seal the site. The TPVCNO stated, the RN should have instructed the resident to remain flat for at least 30 minutes and provided post-removal instructions. The TPVCNO stated, the RN should have informed the resident to keep the dressing on for at least 24 hours. During an interview on 3/20/25 at 11:37 a.m. with the Minimum Data Set Registered Nurse (MDSRN), the MDSRN stated, Resident 421 was in the facility for short term antibiotics and was admitted from [acute care hospital name] with a PICC line on his right arm. The MDSRN stated, RNs were responsible in the care and management of central lines such as PICCs. The MDSRN stated new RNs were paired with experienced RNs to provide their central line management training. The MDSRN stated, there are no official training materials on paper and all training regarding PICCs were verbal in nature. The MDSRN stated, nurses who were not trained in PICC line management should not be allowed to provide care for residents with PICCs, Midlines or any other central lines. The MDSRN stated when a PICC line was removed, pressure and an occlusive dressing was needed to cover the site. The MDSRN stated, RN 1 should not have used a band aid to cover Resident 421's PICC line site.The MDSRN stated this was an incorrect practice and could have caused an air emboli to Resident 421 potentially leading to his death. The MDSRN stated, That's wrong .I've never put a band aid . The MDSRN stated RN 1 did not follow the correct procedure when she removed Resident 421' s PICC line. MDSRN stated RN 1 needed more training. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/20/25 at 12:18 p.m. with RN 1, RN 1's LVN (Licensed Vocational Nurse)/RN Skills List Orientation (SLO) dated 2/28/25 was reviewed. The SLO indicated, no signatures were present from RN 2 that indicated RN 1 completed the training for .IV/Hydration therapy/antibiotic therapy . RN 1 stated she was trained by RN 2. RN 1 stated RN 2 was her preceptor and was responsible for training her in how to manage PICC lines. RN 1 stated, .there isn't training regarding central line care . RN 1 stated RN 2 should have signed the IV/Hydration therapy/antibiotic therapy as soon as she completed the training. RN 1 stated she was trained by the ADON to change PICC dressings but had to resort back to educational materials from nursing school to familiarize herself with removing a PICC line. RN 1 stated she thought residents should remain laying down for at least two minutes after a PICC was removed. RN 1 stated, .I think the normal is 2-5 minutes . RN 1 stated she made a guess on how long Resident 421 should have laid flat. RN 1 stated no one ever told her how long a resident should have laid flat. RN 1 stated when she removed Resident 421's PICC line, she used a band aid to cover the site. RN 1 stated she should have used an occlusive dressing. RN 1 stated a band aid could have potentially caused an air emboli to develop and could have resulted in Resident 421's death. During a concurrent interview and record review 3/20/25 at 12:48 p.m. with the Assistant Director of Nursing (ADON), RN 1's SLO dated 2/28/25 was reviewed. The SLO stated no signatures were present from RN 2 that indicated RN 1 completed the training for .IV/Hydration therapy/antibiotic therapy . The ADON stated the SLO was not signed by RN 2. The ADON stated she did not see any trainings that were specific to central line care and management. During an interview on 3/21/25 at 5:16 p.m. with the ADON, the ADON stated nurses had been insufficiently trained to care for residents receiving parenteral fluids in central lines and central line care and management. The ADON stated she had not received formal training in central line care and management from the facility. The ADON stated she had relied on her past job experiences to determine her own job competency in caring for residents with central lines and managing parenteral fluid administration. The ADON stated nurses should have been educated, trained, and required to perform a return demonstration to determine their competencies in the care and management of central lines. The ADON stated nurses should not have been assigned to residents with PICCs or central lines if they were not competent. During an interview on 3/21/25 at 5:38 p.m. with the Director of Nursing (DON), the DON stated the facility was not obligated (forced to) offer IV therapy services (a way to give fluids, medicine, nutrition, or blood directly into the bloodstream though a vein [blood vessels located throughout the body] using a central line such as a PICC or midline). The DON stated nurses needed to be competent in central line management. The DON stated nurses should have received trainings from the ADON or DON and completed a return demonstration to determine their competency. The DON stated inadequate training in managing and administering medications through central lines could potentially harm residents, leading to complications such as blood infections or air embolisms, which could have resulted in death. During a review of the facility's policy and procedure (P&P) titled, General Policies For IV Therapy dated 06/18, the P&P indicated, .Only an RN or IV Certified LVN may start intravenous infusion or administer approved IV solutions . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, PICC Removal dated 06/18, the P&P indicated, .to be performed by .RNs according to state law and facility policy .equipment .transparent dressing .sterile gloves .sterile gauze .antimicrobial solution .sterile tape .measuring tape .mask .don clean gloves assess the catheter site for evidence of local complication .remove the tape and dressing .done sterile gloves .apply pressure with sterile gauze until the bleeding stops .secure with sterile occlusive dressing .monitor resident for signs/symptoms of embolism .resident teaching . During a review of the facility's P&P titled, Nursing Personnel Education and Training dated 11/16, the P&P indicated, .nursing personnel education and competency validation is conducted to promote the provision of care and services consistent with professional standards of practice .Competency .means validating acceptable performance and knowledge associated with required skill .care competencies are determined through evaluation of center specific trends, resident populations served, and individual performance evaluation .education provided to new employees .provided as part of orientation and scheduled annually, includes .infection control .state and federal required education . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Journal of Infusion Nursing The Official Publication of the Infusion Nurses Society Infusion Therapy Standards of Practice, dated January/February 2016, indicated, . Standard 1.1 The Infusion Therapy Standards of Practice is applicable to any patient care setting in which vascular access devices (VADs) [a sterile tube that provides access to your veins for the delivery of intravenous (in the vein) medication such as a PICC (Peripherally inserted central catheter- external device placed in upper arm) line] are placed and/or managed and where infusion therapies are administered. 1.2 Infusion therapy is provided in accordance with laws, rules and regulations . federal and state regulatory and accrediting bodies . 1.3 Infusion therapy practice is established in organizational policies, procedures, practice guidelines, and/or standardized written protocols/orders . 3. SCOPE OF PRACTICE .Practice Criteria . D. Nursing Personnel . 5. Registered Nurse (RN) a. Complete an organized educational program on infusion therapy due to the lack and/or inconsistency of infusion therapy in basic nursing criteria . b. Do not accept assignments and tasks when one . is inadequately prepared to perform the assignment or task . d. Delegate tasks, activities, and components of care after determination of competency to perform the specific task . f. Use critical thinking and nursing judgement to apply the Five Rights of Delegation . 4. INFUSION TEAM . A. Assign vascular access device (VAD) . management and surveillance only to individuals and or teams with infusion therapy education, training, and validated competency . 5. COMPETENCY ASSESSMENT AND VALIDATION Standard . 5.2 The clinician is responsible and accountable for attaining and maintaining competence with infusion therapy administration . 5.3 Competency assessment and validation is performed initially and on an ongoing basis. 5.4 Competency validation is documented in accordance with organizational policy . C. Validate clinician competency by documenting the knowledge, skills, behaviors, and ability to perform the assigned job. 1. Validate initial competency before providing patient care . when the scope of practice changes, and with the introduction of new procedures, equipment, or technology. 2. Validate continuing competency on an ongoing periodic basis . 10. DOCUMENTATION IN THE MEDICAL RECORD Standard 10.1 Clinicians document their initial and ongoing assessments . 10.2 Documentation contains accurate, complete, chronological, and objective information in the patient's medical record regarding the patient's infusion therapy and vascular access with the clinician's name, licensure or credential to practice, date, and time. 10.3 Documentation is legible, timely, accessible to authorized personnel, and efficiently retrievable. 10. 4 Documentation reflects the continuity, quality, and safety of care . Practice Criteria A. Documentation includes . 1. Patient . responses to therapy, interventions, and education. 2. Specific site preparation, infection prevention, and safety precautions taken, using a standardized tool for documenting . 3. The type, length, and gauge/size of the vascular access device (VAD) inserted . date and time inserted . 6. peripherally inserted central catheters (PICCs): a. External catheter length and length of catheter inserted. b. Arm circumference: before insertion of a PICC and when clinically indicated to assess the presence of edema [swelling] and possible deep vein thrombosis [DVT-blood clot] . 7. Condition of site, dressing, type of catheter stabilization, dressing change, site care, patient report of discomfort or any pain with each regular assessment of the access site, and patient report of changes related to the VAD or access site. 9. condition of the . access site prior to and after infusion therapy. 10. Results of VAD functionality assessment including patency, absence of signs and symptoms of complications, lack of resistance when flushing, and presence of a blood return upon aspiration. 41. VASCULAR ACCESS DEVICE (VAD) ASSESSMENT, CARE AND DRESSING CHANGES . H. Perform dressing changes . 1. Change transparent semipermeable membrane (TSM) dressings at least every 5 to 7 days and gauze dressing at least every 2 days . 4. Change the dressing . if dressing becomes loose/dislodges . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 422's AR dated 3/21/25, the AR indicated Resident 422 was admitted to the facility on [DATE] with a primary diagnosis of pneumonia, unspecified organism (a disease that causes inflammation and fluid in the lungs caused by an unidentified organism), end stage renal disease (ESRD- a disease, your kidneys no longer work as they should) anemia in chronic kidney disease (a condition where there is not enough red blood cells due to malfunctioning kidneys), and chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys). During a review of Resident 422's MDS dated [DATE], the MDS indicated, Resident 422 had a BIMS score of 15 which indicated Resident 422 had intact cognitive function. During a review of Resident 422's OSR dated 3/21/25, the OSR indicated, .Enhanced Barrier Precautions (EBP- infection control intervention designed to reduce transmission of multidrug-resistant organisms) . wound/IV atb (antibiotics) .may insert midline .midline dressing to right upper arm .order date . 03/20/2025 . change dressing every 7 days or prn (whenever necessary) .Midline IV Flush Protocol (manual injection of 0. 9% (concentration) 5 ml (milliliter-a unit of measure) daily .Ceftazidime (an antibiotic) 1G (gram-a unit of measure) for 30 days . During a concurrent observation and interview on 3/20/25 at 4:55 p.m. with LVN 9 in Resident 422's room, Resident's midline dressing was saturated with blood. LVN 9 stated the dressing was dirty, bloody, and needed to be changed. LVN 9 stated the central line dressing needed to be clean or there was potential for infections to occur. LVN 9 stated RNs were responsible for managing central line care. During a concurrent observation and interview on 3/20/25 at 5:04 p.m. with the ADON, the ADON changed Resident 422's dirty bloody dressing. Resident 422 did not wear a face mask, the uncovered midline actively bled from the insertion site, and the line lay on the bed linens without a sterile barrier between the midline and the linens. The midline's length measured 17 cm (centimeter-a unit of measure). The ADON stated Resident 422 should have worn a mask during the dressing change. The ADON stated the uncovered midline touched the bed linen and was not sterile. The ADON stated she had initially measured the midline at 10cm. The ADON sated the midline was no longer in the proper placement and had to be removed. The ADON admitted to making multiple errors during the procedure which included, not putting a face mask on Resident 422, allowing the midline to touch the nonsterile linens and generally failed to follow appropriate sterile technique (use of practices that restrict microorganisms in the environment and prevent contamination of the procedural area). The ADON stated it was important to follow sterile technique while changing central line dressings so bacteria would not be introduced into the central line which leads directly into the heart, and potentially could have resulted in a life-threatening blood infection. During an interview on 3/21/25 at 8:24 a.m. with RN 1, RN 1 stated she served as the RN for Resident 422 that day and had to be retrained in central line management, including care for his midline, by the DON that morning. RN 1 stated the DON validated her training, and RN 4 provided the retraining for central line management. RN 1 sated she had to explain the procedure and perform a return demonstration to validate her competencies. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/25 at 9:13 a.m. with RN 4, RN 4 stated she retrained RN 1 in the central line management this morning. RN 4 stated nurses needed to be competent in central line management before being assigned to care for those residents. RN 4 stated she rarely encountered residents with central lines. RN 4 stated she was unaware of proper positioning for a resident during central line removal. RN 4 stated she was unsure how long a resident had to remain flat after central line removal and estimated about 15 minutes. RN 4 stated inadequate training or competency in dressing change or central line removal could have led to adverse consequences such as infections and air embolisms, both of which could have resulted in death. RN 4 stated her own knowledge in central line management was insufficient and needed to be re-enforced to assure competency. During an interview on 3/21/25 at 11:23 a.m. with the IP, the IP stated the expectation was nurses had to verbalize and had to provide a return demonstration for the trainings they have received to be considered competent. During an interview on 3/21/25 at 5:16 p.m. with the ADON, the ADON stated nurses had been insufficiently trained to care for residents receiving parenteral fluids in central lines and central line care and management. The ADON stated she had not received formal training in central line care and management from the facility. The ADON stated she had relied on her past job experiences to determine her own job competency in caring for residents with central lines and managing parenteral fluid administration. The ADON stated nurses should have been educated, trained, and required to perform a return demonstration to determine their competencies in the care and management of central lines. The ADON stated nurses should not have been assigned to care for residents with PICCs or central lines if they were not competent. During an interview on 3/21/25 at 5:38 p.m. with the Director of Nursing (DON), the DON stated the facility was not obligated (forced to) offer IV therapy services (a way to give fluids, medicine, nutrition, or blood directly into the bloodstream though a vein [blood vessels located throughout the body] using a central line such as a PICC or midline). The DON stated, nurses needed to be competent in central line management. The DON stated nurses should have received trainings from the ADON or DON and completed a return demonstration to determine their competency. The DON stated inadequate training in managing and administering medications through central lines could potentially harm residents, leading to complications such as blood infections or air embolisms, which could have resulted in death. The DON stated sterile technique was supposed to be followed during central line dressing changes. The DON stated if the procedure was not sterile, there was a potential for bacteria and other pathogens to be introduced to the central line which led directly into the heart and could have caused a life-threatening blood infection ultimately leading to death. During a review of the facility's P&P titled, PICC Dressing Change dated 06/18, the P&P indicated, .dressing changes using transparent dressings are performed .if the integrity of the dressing has been compromised (wet, lose or soiled) .equipment .clean gloves .antimicrobial disc .hand sanitizer .mask .antimicrobial solution . label, sterile gauze and tape .transparent dressing .sterile gloves .securement device .measuring tape . procedure .don sterile gloves . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, PICC Removal dated 06/18, the P&P indicated, .to be performed by .RNs according to state law and facility policy .equipment .transparent dressing .sterile gloves .sterile gauze .antimicrobial solution .sterile tape .measuring tape .mask .don clean gloves assess the catheter site for evidence of local complication .remove the tape and dressing .done sterile gloves .apply pressure with sterile gauze until the bleeding stops .secure with sterile occlusive dressing .monitor resident for signs/symptoms of embolism .resident teaching . During a review of the Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011 https://www.cdc.gov/infectioncontrol/pdf/guidelines/bsi-guidelines-H.pdf, dated October 2017, indicated, 1. Use either sterile gauze or sterile, transparent, semipermeable dressing to cover the catheter site 2. If the patient is diaphoretic (sweating heavily) or if the site is bleeding or oozing, use a gauze dressing until this is resolved. 3. Replace catheter site dressing if the dressing becomes damp, loosened, or visibly soiled. 4. Do not use topical antibiotic ointment or creams on insertion sites, except for dialysis catheters, because of their potential to promote fungal infections and antimicrobial resistance. 5. Do not submerge the catheter or catheter site in water. Showering should be permitted if precautions can be taken to reduce the likelihood of introducing organisms into the catheter (e.g., if the catheter and connecting device are protected with an impermeable cover during the shower). 6. Replace dressings used on short-term CVC sites every 2 days for gauze dressings. 7. Replace dressings used on short-term CVC sites at least every 7 days for transparent dressings, except in those pediatric patients in which the risk for dislodging the catheter may outweigh the benefit of changing the dressing. 8. Replace transparent dressings used on tunneled or implanted CVC sites no more than once per week (unless the dressing is soiled or loose), until the insertion site has healed 14. Monitor the catheter sites visually when changing the dressing or by palpation through an intact dressing on a regular basis, depending on the clinical situation of the individual patient. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or bloodstream infection, the dressing should be removed to allow thorough examination of the site. 15. Encourage patients to report any changes in their catheter site or any new discomfort to their provider. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Journal of Infusion Nursing The Official Publication of the Infusion Nurses Society Infusion Therapy Standards of Practice, dated January/February 2016, indicated, . Standard 1.1 The Infusion Therapy Standards of Practice is applicable to any patient care setting in which vascular access devices (VADs) [a sterile tube that provides access to your veins for the delivery of intravenous (in the vein) medication such as a PICC (Peripherally inserted central catheter- external device placed in upper arm) line] are placed and/or managed and where infusion therapies are administered. 1.2 Infusion therapy is provided in accordance with laws, rules and regulations . federal and state regulatory and accrediting bodies . 1.3 Infusion therapy practice is established in organizational policies, procedures, practice guidelines, and/or standardized written protocols/orders . 3. SCOPE OF PRACTICE .Practice Criteria . D. Nursing Personnel . 5. Registered Nurse (RN) a. Complete an organized educational program on infusion therapy due to the lack and/or inconsistency of infusion therapy in basic nursing criteria . b. Do not accept assignments and tasks when one . is inadequately prepared to perform the assignment or task . d. Delegate tasks, activities, and components of care after determination of competency to perform the specific task . f. Use critical thinking and nursing judgement to apply the Five Rights of Delegation . 4. INFUSION TEAM . A. Assign vascular access device (VAD) . management and surveillance only to individuals and or teams with infusion therapy education, training, and validated competency . 5. COMPETENCY ASSESSMENT AND VALIDATION Standard . 5.2 The clinician is responsible and accountable for attaining and maintaining competence with infusion therapy administration . 5.3 Competency assessment and validation is performed initially and on an ongoing basis. 5.4 Competency validation is documented in accordance with organizational policy . C. Validate clinician competency by documenting the knowledge, skills, behaviors, and ability to perform the assigned job. 1. Validate initial competency before providing patient care . when the scope of practice changes, and with the introduction of new procedures, equipment, or technology. 2. Validate continuing competency on an ongoing periodic basis . 10. DOCUMENTATION IN THE MEDICAL RECORD Standard 10.1 Clinicians document their initial and ongoing assessments . 10.2 Documentation contains accurate, complete, chronological, and objective information in the patient's medical record regarding the patient's infusion therapy and vascular access with the clinician's name, licensure or credential to practice, date, and time. 10.3 Documentation is legible, timely, accessible to authorized personnel, and efficiently retrievable. 10. 4 Documentation reflects the continuity, quality, and safety of care . Practice Criteria A. Documentation includes . 1. Patient . responses to therapy, interventions, and education. 2. Specific site preparation, infection prevention, and safety precautions taken, using a standardized tool for documenting . 3. The type, length, and gauge/size of the vascular access device (VAD) inserted . date and time inserted . 6. peripherally inserted central catheters (PICCs): a. External catheter length and length of catheter inserted. b. Arm circumference: before insertion of a PICC and when clinically indicated to assess the presence of edema [swelling] and possible deep vein thrombosis [DVT-blood clot] . 7. Condition of site, dressing, type of catheter stabilization, dressing change, site care, patient report of discomfort or any pain with each regular assessment of the access site, and patient report of changes related to the VAD or access site. 9. condition of the . access site prior to and after infusion therapy. 10. Results of VAD functionality assessment including patency, absence of signs and symptoms of complications, lack of resistance when flushing, and presence of a blood return upon aspiration. 41. VASCULAR ACCESS DEVICE (VAD) ASSESSMENT, CARE AND DRESSING CHANGES . H. Perform dressing changes . 1. Change transparent semipermeable membrane (TSM) dressings at least every 5 to 7 days and gauze dressing at least every 2 days . 4. Change the dressing . if dressing becomes loose/dislodges .

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Golden Merced Care Center	3170 M Street Merced, CA 95340

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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. 51134 Based on observation, interview, and record review the facility failed to properly store medication in three of five medication carts and one of two medication storage rooms when: 1. South one medication cart contained: a. An unopened insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) pen intended for refrigeration storage for Resident 56, and b. No open dates were placed on medications for Resident 78, Resident 99, Resident 322, Resident 222, and Resident 72. 2. South two medication cart contained: a. Six insulin pens with no open dates for Resident 68, Resident 53, Resident 5, and Resident 17. b. Expired medication for Resident 66, c. Four eye drop bottles did not have an open date, and d. Three respiratory medications did not have an open date. 3. North one medication cart contained: a. Discontinued medication for Resident 2, b. Two multi-dose (bottle or vial of liquid medication that contains more than one dose of medication) medications did not have open dates for Resident 15 and Resident 63, and c. One over the counter (OTC) medication was expired. 4. North medication storage room contained: a. Two expired medications, b. One medication bottle with an incorrect expiration date, c. Three opened bottles stored on the shelves for unopened OTC medications, and d. Medication refrigerator contained a discontinued medication for Resident 100. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These failures had the potential to result in decreased medication potency that could compromise the therapeutic effectiveness of stored medications and result in adverse reactions from medications stored incorrectly, expired and improperly labeled. Findings: 1. During an observation on 3/19/25 at 9:25 a.m. at South one medication cart with Licensed Vocational Nurse (LVN) 2, observed: a. For Resident 56 an unopened Glargine (a long-acting synthetic insulin used to treat type 1 diabetes [condition where pancreas makes little or no insulin which leads to high blood sugar levels] and type 2 diabetes [long term condition where the body has trouble controlling blood sugar and using it for energy]) pen. Pen was not stored in refrigerator as recommended by manufacturer b. For Resident 78 and Resident 99, observed Insulin Glargine with no open date. For Resident 322 observed two eye drop medications, Brinzolamide ophthalmic (eye drop used to treat increased eye pressure caused by glaucoma [eye disease that damages the optic nerve, which connects the eye to the brain] or ocular hypertension [when pressure inside the eye is high than normal]) suspension (liquid medication prepared when the drug doesn't dissolve but is crushed into fine particles) and brimonidine tartrate (eye drop used to treat glaucoma and lower intraocular pressure), and one inhaler (a handheld medical device used to deliver medication directly into the lungs through inhalation), fluticasone propionate and salmeterol (combination of medication used to treat asthma and COPD), with no open date on the bottle. For Resident 222 observed four inhalers, that included albuterol sulfate (short acting medication that provides relief from an asthma attack by relaxing the smooth muscles in the airways), tiotropium bromide (bronchodilator medication breathed in through the mouth to help open up air passages in the lungs), levalbuterol (medication that can treat or prevent bronchospasm [sudden narrowing of the airways in the lungs resulting in difficulty breathing])and breztri aerosphere (medication used to treat long term chronic obstructive pulmonary disease [COPD- a chronic lung disease causing difficulty in breathing]), with no open date. For Resident 72 observed a bottle of dabigatran (medication that can treat and prevent blood clots) with no open date. During a review of Resident 56's Order Summary Report (OSR) dated 3/20/25, the OSR indicated, Insulin Glargine Solution 100 UNIT/ML [milliliter- unit of volume] Inject 20 unit subcutaneously [under the skin] one time a day for diabetes [chronic disease where the body either doesn't produce enough insulin or cant effectively use the insulin in produces, leading to high blood sugar levels] . Order Status: Active . Start Date: 02/12/2025 . During a review of Resident 78's OSR dated 3/20/25, the OSR indicated .Insulin Glargine Subcutaneous Solution 100 UNIT/ML . Inject 30 unit subcutaneously two times a day for [diabetes] . Order Status: Active . Start Date: 06/18/2024 . During a review of Resident 99's OSR dated 3/20/25, the OSR indicated, . [Insulin Glargine] Subcutaneous Solution Pen-Injector 100 UNIT/ML .Inject 16 unit subcutaneously at bedtime for TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS .Order Status: Active . Start Date: 02/15/2024 . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 322's OSR dated 3/20/25, the OSR indicated, .Brimonidine Tartrate Ophthalmic Solution 0.2% (Brimonidine Tartrate) Instill 1 drop in both eyes every 12 hours for glaucoma . Order Status: Active . Start Date: 03/18/2025 . [Brinzolamide] . Instill 1 drop in both eyes every 12 hours for glaucoma . Order Status: active . Start Date: 03/18/2025 . The OSR indicated, .Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT . I puff inhale orally one time a day . Order Status: Active . Start Date: 03/19/2025 . During a review of Resident 222's OSR dated 3/20/25, the OSR indicated, .Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 6 hours . Order Status: Active . Start Date: 03/13/2025 . Breztri Aerosphere Inhalation Aerosol 160-9-4.8 MCG/ACT (Budesonide-Glycopyrrolate-Formoterol Fumarate) 2 puff inhale orally two times a day . Order Status: Active . Start Date: 03/13/2025 . The OSR indicated, Tiotropium Bromide Monohydrate Inhalation Capsule 18 MCG (Tiotropium Bromide Monohydrate) . 1 capsule inhale orally one time a day . Order Status: Active . Start Date: 03/14/2025 .[Levalbuterol] 1.25 MG/3ML .3 ml inhale orally via nebulizer [a device for producing a fine spray of liquid] every 6 hours as needed for shortness of breath while awake . Order Status: Active . Start Date: 03/13/2025 . During a review of Resident 7's OSR dated 3/20/25, the OSR indicated, . [Dabigatran] oral capsule 150 MG Give 1 capsule by mouth every 12 hours for prevent blood clots . Order Status: Active . Start Date: 03/13/2025 . During an interview on 3/19/25 at 10:30 a.m. with LVN 2, LVN 2 stated it is important to have an open date on the medication itself because if the medication gets separated from the box, the nurse will be unaware when the medication was opened. 2. During an observation on 3/19/25 at 10:35 a.m. at South two medication cart with LVN 6, observed: a. Six insulin pens with no open date. These medications included Resident 68's Insulin glargine and lispro [short-acting human made insulin helps to control blood sugar levels], Resident 53's insulin glargine, Resident 5's Insulin glargine and insulin lispro, and Resident 17's Insulin glargine; b. For Resident 66, observed an expired Insulin glargine; c. For Resident 17, observed two eye drop medications, brimonidine 0.2% and latanoprost 0.005%, with no open date; and d. For Resident 66, observed two inhalers, Combivent Respimat inhaler and albuterol, with no open date and for Resident 20 a bag of levalbuterol with no open date. During a review of Resident 68's OSR dated 3/20/25, the OSR indicated, .Humalog Injection Solution 100 UNIT/ML . Inject 14 unit subcutaneously three times a day for [diabetes type 2] . Order Status: Active . Start Date: 12/25/2024 .Insulin Glargine Solution 100UNIT/ML Inject 45 unit subcutaneously at bedtime for [diabetes type 2] hold if [blood sugar] 150 [greater than] and notify [Medical Doctor] . Order Status: Active . Start Date: 04/01/2024 . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's OSR dated 3/20/25, the OSR indicated, . Insulin Glargine subcutaneous solution 100 UNIT/ML (Insulin Glargine) Inject 15 unit subcutaneously at bedtime for type 2 diabetes mellitus without complications . Order Status: Active . Start Date: 3/12/25 During a review of Resident 5's OSR dated 3/20/25, the OSR indicated, .[Humalog] Injection Solution 100 UNIT/ML .Inject as per sliding scale . Order Status: Active . Start Date: 10/13/2023 . [Insulin Glargine] subcutaneous solution 100 UNIT/ML . Inject 20 unit subcutaneously at bedtime . Order Status: Active . Start Date: 8/11/2024 . During a review of Resident 17's OSR dated 3/20/25, the OSR indicated, . [Insulin Glargine] Subcutaneous Solution Pen-Injector [device used to inject medication under the skin] 300 UNIT/ML .Inject 24 unit subcutaneously in the morning for diabetes hold for blood sugar [less than] 100 . Order Status: Active . Start Date: 10/07/2024 . During a review of Resident 66's Order Review undated, the Order Review indicated, .Insulin Glargine Subcutaneous Solution 100 UNIT/ML . Directions: Inject 10 unit subcutaneously one time a day for TYPE 2 DIABETES MELLITTUS WITHOUT COMPLICATIONS for 5 days . Status: Completed . End Date: 3/13/2025 . During a review of Resident 17's OSR dated 3/20/25, the OSR indicated, Brimonidine Tartrate Ophthalmic Solution 0.2% (Brimonidine Tartrate) Instill 1 drop in both eyes three times a day for Glaucoma . Order Status: Active . Start Date: 08/23/2024 .[Latanoprost] .Instill 1 drop in both eyes at bedtime for Glaucoma . Order Status: Active . Start Date: 06/17/2023 . During a review of Resident 66's OSR dated 3/20/2025, the OSR indicated, . Albuterol Sulfate Inhalation Nebulization Solution 1.25 MG/3ML .1.25 mg inhale orally every 4 hours as needed for shortness of breath or wheezing while awake . Order Status: Active . Start Date: 03/07/2025 . [Ipratropium-Albuterol] Inhalation Aerosol Solution 20-100 MCG/ACT .1 puff inhale orally two times a day . Order Status: Active . Start Date: 03/08/2025 . During a review of Resident 20's OSR dated 3/20/25, the OSR indicated, .Levalbuterol HCL Inhalation Nebulization Solution 1.25 MG/3ML (Levalbuterol HCL) ml inhale orally via nebulizer three times a day . Order Status: Active . Start Date: 03/05/2025 . During a concurrent interview and record review on 3/21/25 at 9:08 a.m. with LVN 1, the insulin order for Resident 66 was reviewed. The insulin order indicated, .Insulin Glargine Subcutaneous Solution 100 UNIT/ML . Directions: Inject 10 unit subcutaneously one time a day for TYPE 2 DIABETES MELLITTUS WITHOUT COMPLICATIONS for 5 days . Status: Completed . End Date: 3/13/2025 . LVN 1 stated this medication has been discontinued and the medication should not be in the medication cart. LVN 1 stated expired or discontinued medications should not remain in the medication cart because a medication error (preparation or administration of medication is not in accordance with prescriber's orders, manufacturers specifications or professional standards) could occur. 3. During an observation on 3/19/25 at 12:04 p.m. with LVN 8 at North one medication cart, observed: a. For Resident 2, observed a discontinued bubble pack (card that packages doses of medications within small, clear or light-resistant, amber-colored plastic bubbles) of Lorazepam; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. For Resident 15 observed a multi-dose Lactulose (medication to treat constipation) bottle with no open date, Resident 63 ' s multi-dose Sucralfate (medication that treats stomach ulcers) bottle with no open date; and c. Observed an expired cetirizine hydrochloride (antihistamine medication used to treat allergy symptoms like itchy eyes, sneezing, stuffy nose or hives). During a review of Resident 2's OSR dated 3/21/25, the OSR indicated, .[Lorazepam] Oral Tablet 0.5 MG . Give 1 tablet by mouth every 6 hours as needed for inability to relax for 14 days . Order Status: Discontinued . Revision Date: 03/12/2025 . During a review of Resident 15's OSR dated 3/20/25, the OSR indicated, .Lactulose oral solution 10 GM/15ML .45 mL by mouth every 6 hours . Order Status: Active .Start Date: 03/04/2025 . During a review of Resident 63's OSR dated 3/20/25, the OSR indicated, .Sucralfate Oral Suspension 1 GM/10ML .Give 10 mL by mouth before meals for [treatment] and prevention . Order Status: Active . Start Date: 03/07/2024 . During an interview on 3/19/25 at 12:21 p.m. with LVN 3, LVN 3 stated it is important to remove expired medication from the medication cart because the strength of the medication will not be as effective. 4. During an observation on 3/19/25 at 3:38 p.m. with the Infection Preventionist (IP) at the North medication storage room, observed: a. Three medication bottles, including Reguloid (medication used to treat constipation) with a written open date of 5/29/24, Fish oil (dietary source of omega-3 fatty acids) with a written open date of 4/24/24, and Nephro vitamins (medication used to treat or prevent vitamin deficiency) with a written open date of 1/8/25, stored on shelves designated for unopened OTC medications; b. Observed two packets of topical analgesics (medication applied directly to the skin to relieve pain) that were expired; c. Observed a bottle of unopened Famotidine with an incorrect expiration of 3/27 written on the bottle when manufacturer date was 01/2026; and d. Observed Resident 100's discontinued Latanoprost Ophthalmic Solution 0.005% in the medication refrigerator. During a review of Resident 100's Order Audit Report dated 3/21/25, the Order Audit Report indicated, . Latanoprost Ophthalmic Solution 0.005% .Instill 1 drop in both eyes at bedtime for glaucoma . Order Status: Discontinued . During an interview on 3/19/25 at 3:59 p.m. with the IP, the IP stated it is important to not have expired medication in the medication storage room because the potency (power) of the medication will not be what it needs to be, and the resident will not be receiving an accurate dose of medication. The IP stated if a medication is labeled incorrectly, like an incorrect expiration date, a nurse could be giving an expired medication. (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 observation and interview on 3/20/25 at 8:29 a.m. with Central Supply (CS) in the North medication storage room, medications that were expired and medications with open dates were reviewed. CS stated the expiration date written on Famotidine was an incorrect date. CS stated only unopened OTC medications are to be placed in the medication room. CS stated when OTC medications are seen with an open date in the medication storage room, they should be placed in the bin labeled, Discontinued medication for destruction. CS stated for the topical analgesics that were expired, they should have been removed from the medication room. During an interview on 3/20/25 at 8:38 a.m. with LVN 9, LVN 9 stated open bottles should not be put back into the medication storage room because these medications can expire without staff being aware. LVN 9 stated open dates for medications should be placed directly onto the bottle and not just the packaging because the packaging can be thrown away and a medication could end up with no open date written on it. LVN 9 stated for OTC medications, such as eye drops, staff should place the resident's name and open date on the bottle. LVN 9 stated placing only the room number for a resident on the bottle should not be done because the resident may be moved, and the medication may be given to another resident. During an interview on 3/21/25 at 11:02 a.m. with the Pharmacy Consultant (PC), the PC stated for labeling medications, at a minimum an open date needs to be placed directly onto the medication, or on an open date sticker on the medication, and not just the packaging the medication comes in. The PC stated it is important to remove expired medications from the medication cart such as insulins and eye drops because expired medications may not be as effective and expired eye drops could be an infection control issue. The PC stated discontinued medications should be removed from the medication cart because these medications may continue to be administered without an order. During an interview on 3/21/25 at 3:33 p.m. with the Director of Nursing (DON), the DON stated it is important to put open dates on the medication itself because some medications have a shelf life (length of time an item remains usable) and expire when the medication is opened. The DON stated for the medication storage room, opened OTC medications should not be placed back onto the shelves because the medication could expire past its shelf life. The DON stated expired medications in the medication carts and the medication storage rooms should be removed because if they are not, they may be administered and lead to a medication error. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the facility: Storage of Medications dated 4/2008, the P&P indicated, .F. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area .M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608 Based on observation, interview and record review, the facility failed to store and distribute food in accordance with professional standards for food service safety when: 1. The facility had a clear plastic bag of what appeared to be frozen chicken with no labels or closure device, stored in one of two freezers. 2. The chest freezer did not have a thermometer to monitor the internal freezer temperature. 3. The cook did not take the temperature of the tray of meat loaf or the tray of au gratin potatoes during the lunch tray line service. These failures had the potential to place residents in the facility at risk for food born illness. Findings: 1. During a concurrent observation and interview on [DATE] at 9:52 a.m. with the District Manager of the kitchen (DMK), in one of two freezers, a clear plastic bag of what appeared to be frozen, and frost bitten (the surface of frozen food dries out and becomes leathery or discolored due to moisture loss), chicken had no labels or closure device on the bag. The DMK stated the meat should be in a labeled, airtight container for food freshness and safety. The DMK stated without placing the meat in an airtight container, ice could form on the meat causing the meat to lose flavor and moisture. The DMK stated the food needs to have a label to prevent the residents from being served expired foods which could lead to food born illness. 2. During a concurrent observation and interview on [DATE] at 10:10 a.m. with the Dietary Aid (DA), there was not a thermometer in the chest freezer. The DA stated, there should be a thermometer in the freezer and the thermometer should be checked every day and recorded and put on a log. During a concurrent observation and interview on [DATE] at 10:11 a.m. with the DMK in the facility's kitchen, the DMK stated the freezer should have had an internal thermometer to monitor the temperature inside the freezer to ensure food is being kept at a temperature to prevent bacterial growth and food born illness. 3. During a concurrent observation and interview on [DATE] at 11:30 a.m. with the DMK during the lunch tray line observation, the Lead [NAME] (LC), did not take the temperature of the au gratin potatoes or the meat loaf before serving. The DMK stated the LC should have taken the temperature of the au gratin potatoes and meat loaf prior to serving. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 2:41 p.m. with the DMK, the facility's policy and procedure (P&P) titled, Food and Storage dated ,d+[DATE] was reviewed. The P&P indicated, . All food . shall be stored I in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption .Date and rotate items; first in first out .discard food past the use-by or expiration date . must be stored in containers that have tight fitting lids . The DMK stated all food should be handled following the food and safety codes to help prevent residents from food borne illness. During a review of California Code of Regulations (CCR), Title 22 Security, Division 5 - Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, Chapter 8.5 - Intermediate Care Facilities/Developmentally Disabled-Habilitative, Article 3 - Services Section 76888 - Food and Nutrition Services-Food Storage dated, [DATE], the CCR indicated, . All readily perishable foods or beverages shall be maintained at temperatures of 7 C (45 F) or below, or at 60 C (140 F) or above, at all times, except during necessary periods of preparation and service. Frozen foods shall be stored at minus 18 C (0 F) or below at all times. There shall be an accurate thermometer in each refrigerator and freezer and in any other storage space used for perishable food . Keep hot food hot-at or above 140 F. Place cooked food in chafing dishes, preheated steam tables, warming trays, and/or slow cookers .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections for four of 12 sampled residents (Residents 25, 20, 12, 371, and all residents who received medications from South one medication cart) when: 1. Resident 25's visibly soiled, uncovered, and unlabeled graduated cylinder (a plastic container with calibration marks [evenly spaced lines marked along the cylinder that indicate volume measurements] used for measuring volumes of liquids) was on top of a toilet shared by two residents. This failure had the potential to cause cross-contamination and the spread of bacteria and other pathogens (disease causing microorganisms) leading to the risk of infection for residents. 2. Resident 20's nasal canula (a device that delivers extra oxygen through a tube and into the nose) was touching the ground and nebulizer equipment (drug delivery device that turns liquid medicine into a fine mist that is breathed in through a mask or mouthpiece) was stored in the same bag where the nasal canula tubing was supposed to have been stored. These failures had the potential to increase the risk of cross-contamination and infections. 3. Resident 12's humidifier bottle and solution (a container filled with sterile [free of germs] or distilled [water is purified to remove contaminants] water that adds moisture to oxygen before it is delivered to a patient, preventing dryness in the airways) was expired and not replaced. This failure had the potential to lead to bacterial growth in the humidifier solution, increasing the risk of respiratory infections. 4. LVN 5 did not don appropriate personal protective equipment (PPE-specialized clothing, equipment, or devices worn to protect a person from hazards in the workplace or environment) when performing a dressing change for Resident 371's left leg wound. This failure had the potential to cause Resident 371's wound to become infected and lead to other residents becoming infected if LVN 5's clothing became cross contaminated (the physical movement or transfer of harmful bacteria from one person, object or place to another). 5. An envelope containing resident money was stored in the South one medication cart. This failure had the potential to result in transfer of infectious microorganisms (a living thing, such as bacterium, virus or fungus, that is so small it must be viewed with a microscope) onto the medications, equipment and surfaces inside the medication cart. Findings: (continued on next page)

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	055988	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Merced Care Center	3170 M Street Merced, CA 95340

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 25's Admission Record (AR) dated [DATE], the AR indicated, Resident 25 was initially admitted to the facility on [DATE] with diagnoses of cystitis (inflammation of the bladder), displacement of nephrostomy catheter (nephrostomy catheter a tube that is put into the kidney to drain urine directly from the kidney) tip positioned outside the renal collecting system (a series of tubules and ducts in the kidneys where urine flows and drains), diabetes mellitus (condition that happens when your blood sugar is too high), urinary tract infection (an infection in any part of the urinary system), presence of urogenital implants (artificial material in the urinary organs or genitals), obstructive and reflux uropathy (obstructive and reflux uropathy,), and calculus of kidney (kidney stones). During a review of Resident 25's Order Summary Report (OSR) dated [DATE], the OSR indicated, .change foley q (every) 3 weeks .enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms) r/t (related to) nephrostomy tube .foley catheter (a device that drains urine [pee] from your urinary bladder into a collection bag). output every shift for foley . During a review of Resident 25's Minimum Data Set (MDS- a standardized assessment tool that measures health status in nursing home residents) dated [DATE], the MDS section C indicated, .cognitive skills for daily decision-making score of 3 .severely impaired . During a concurrent observation and interview on [DATE] at 11:55 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 25's bathroom, a visibly soiled, uncovered, and unlabeled graduated cylinder was on top of the toilet. LVN 1 stated the graduated cylinder was visibly soiled with brown stains with small amount of dried urine on the bottom of the container and was unlabeled. LVN 1 stated the graduated cylinder was used to measure Resident 25's urine output from her foley catheter. During an interview on [DATE] at 9:20 a.m. with the Infection Preventionist (IP), the IP stated a used and visibly soiled graduated cylinder should not have been stored atop the toilet in the bathroom. The IP stated the graduated cylinder should have been thoroughly cleaned after each use, free of stains and any other contents inside or outside, placed in a plastic bag, and stored in a separate location inside the resident's closet. The IP stated the graduated cylinder should have had resident identifiers written on it such as the resident's name. The IP stated there was a potential for cross-contamination if another resident touched the soiled graduated cylinder . The IP stated it was important to have resident identifiers written on the graduated cylinder so it would not be used on other residents, which posed a potential for cross-contamination and risk of infection. During an interview on [DATE] at 5:08 p.m. with the Assistant Director of Nursing (ADON), the ADON stated a container used to empty urine should not have been left on top of the toilet as it was not clean. The ADON stated the container should have been cleaned and labeled, stored in a bag, and placed in area where there was no risk for cross-contamination with other residents. The ADON stated there was a potential for cross-contamination that could have led to other residents getting sick. During an interview on [DATE] at 5:15 p.m. with the Director of Nursing (DON), the DON stated she expected the graduated cylinder to have been labeled with the resident's name, cleaned after each use, stored in separate bag, and stored away from contact with other residents. The DON stated there was a potential for cross-contaminations and the spread of infection if another resident or staff used the soiled and unlabeled graduated cylinder. (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 Resident 25's Care Plan (CP) dated [DATE], the CP indicated, . monitor and document intake and output from right nephrostomy collection bag . During a review of the facility's policy and procedure (P&P) titled, Infection Control Policies and Practices dated [DATE], the P&P indicated, .This Center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .the objectives of our infection control policies and practices are to . maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .the Governing Board .have adopted our infection control policies and procedures and practices as outlined herein, to reflect he Center's need and operational requirements for preventing transmission of infections and communicable diseases . During a review of the professional reference (PR) found on https://www.vumc. org/periop-services/sites/default/files/public_files/L-Care-of-the-Patient-with-Catheters-and-Drains.pdf titled, Overview Care Of The Patient With Catheters And Drains dated 2012, the PR indicated, .use a clean graduated cylinder that is only used for that patient . 2. During a review of Resident 20's AR dated [DATE], the AR indicated, Resident 20 was initially admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD-a common lung disease causing restricted airflow and breathing problems), acute on chronic systolic (congestive) hearth failure (refers to the heart being unable to pump enough blood around the body), covid 19 (a contagious disease caused by the coronavirus), and obstructive sleep apnea (a sleep disorder that affects breathing while you sleep). During a review of Resident 20's OSR dated [DATE], the OSR indicated, .change foley q (every) 3 weeks . enhanced barrier precautions r/t (related to) nephrostomy tube .foley catheter output every shift for foley . During a review of Resident 20s MDS dated [DATE], the MDS section C indicated, Resident 20 had a BIMS (Brief Interview for Mental Status (BIMS) is an assessment used in nursing homes and other long-term care facilities to monitor cognition) score of 10. A score of 10 indicated, Resident 20 had moderately impaired cognition (condition in which people have more memory or thinking problems than other people their age). During a review of Resident 20's OSR dated [DATE], the OSR indicated, .O2 (oxygen) at 4 liters (L-a unit of measure) via nasal canula every shift for COPD .oxygen ,d+[DATE] Liters continuous O2 via Nasal Canula or face mask to keep Oxygen above 90% .levalbuterol HCL (medication used to treat COPD) inhalation nebulization solution 1.25 mg/3ml (milligram/milliliter-a unit of measure) . During an observation on [DATE] at 2:50 p.m. in Resident 20's room, Resident 20 was asleep. Resident 20's oxygen concentrator (machines that take air from the surroundings, extract oxygen and filter it into purified oxygen for patients to breathe) was set to 2.5L. Resident 20's nasal canula was on the floor and nebulizer equipment was stored in a plastic bag hanging from the oxygen concentrator. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:34 a.m. with the IP, the IP stated the nasal canula tubing should not have been on the floor. The IP stated this put Resident 20 at risk for infection because the floor was not clean, and bacteria could have travelled up the nasal canula to Resident 20's nose. The IP stated the nasal canula delivered oxygen directly into the resident's mucosal membrane (the moist, inner lining of some organs and body cavities such as the nose) in her nose. The IP stated the nebulizer equipment should not have been stored in the bag used to store the nasal canula. The IP stated nasal canula and the nebulizer equipment should have been stored in their own dedicated bags. The IP stated there was a potential for cross-contamination with the nebulizer equipment being stored in the nasal canula bag because they were two completely different pieces of equipment and should have been stored separately. The IP stated the Central Supply Clerk (CSC) was responsible for ensuring the nasal canula and the nebulizer equipment were stored in different bags. During an interview on [DATE] at 10:09 a.m. with the CSC, the CSC stated she was responsible for replacing the nasal canula and nebulizer equipment every week. The CSC stated the nasal canula and nebulizer equipment should be stored in different bags to prevent cross-contamination. During an interview on [DATE] at 4:47 p.m. with the ADON, the ADON stated the nasal cannula should not have touched the floor, and the nebulizer equipment should not have been stored in the same bag as the nasal cannula. The ADON stated the nasal cannula on the ground posed an infection risk to Resident 12 because the dirty floor could have contained bacteria, which might have come into contact with Resident 12's mucosal membrane and caused an infection. The ADON stated staff were expected to store the nasal canula and nebulizer equipment in separate bags to prevent cross-contamination. During an interview on [DATE] at 4:57 p.m. with the DON, the DON stated she expected the nasal cannula tubing to remain off the floor and for the nebulizer equipment to be stored in its own bag. The DON stated, allowing the nasal cannula tubing to the touch the floor posed a risk of cross-contamination and infection due to the presence of pathogens (disease causing organisms). The DON stated the nasal cannula and nebulizer tubing were two different pieces of equipment used on different parts of the body, further increasing the risk of cross-contamination if improperly stored. During a review of Resident 20's CP dated [DATE], the CP indicated, . [Resident 20] has COPD. [Resident 20] is at risk for sob (shortness of breath) .the resident will have no s/sx (signs or symptoms) of poor oxygen absorption with oxygenation saturation greater than 90% .give aerosol or bronchodilators (medication that make breathing easier) as ordered . During a review of the facility's P&P titled, Infection Control Policies and Practices dated [DATE], the P&P indicated, .This Center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .the objectives of our infection control policies and practices are to .maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .the Governing Board . have adopted our infection control policies and procedures and practices as outlined herein, to reflect he Center's need and operational requirements for preventing transmission of infections and communicable diseases . During a review of the facility's P&P titled, Respiratory Care; Oxygen Administration dated ,d+[DATE], the P&P indicated, .Oxygen equipment, tanks, humidifier bottles, cannulas, masks, and other related items are checked with administration .equipment that is soiled .is replaced . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 12's AR dated [DATE], the AR indicated, Resident 12 was initially admitted to the facility on [DATE] with a diagnosis of mild intermittent asthma (a type of asthma [a chronic condition that inflames and narrows the airways in the lungs] wherein a person has symptoms on no more than 2 days per week), encounter for screening with other viral diseases (a routine test done to a population to identify unrecognized disease carrier state), muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), personal history of transient (temporary) ischemic attack and cerebral infarction (a temporary lack of blood flow to part of the brain). During a review of Resident 12's OSR dated [DATE], the OSR indicated, .Administer Oxygen ,d+[DATE] liter per min via NC (nasal canula) as needed for shortness of breath (SOB) of O2 sat <(above) 90% every shift for SOB .change oxygen tubing, concentrator bottle and clean filter every week every night shift every Sun (Sunday) . During a review of Resident 12s MDS dated [DATE], the MDS section C indicated, Resident 12 had a BIMS score of 08. A score of 08 indicated, Resident 12 had moderately impaired cognition. During an observation on [DATE] at 3:03 p.m. in Resident 12's room, Resident 12 was sitting in her wheelchair asleep. An oxygen humidifier bottle that was nearly full of humidifier solution was connected to her oxygen concentrator and had a date of ,d+[DATE]. During a concurrent observation and interview on [DATE] at 3:16 p.m. with Certified Nursing Assistant (CNA) 1, Resident 12's humidifier bottle and solution had a date of ,d+[DATE]. CNA 1 stated the humidifier bottle, and solution was dated ,d+[DATE] and was out of date. During an interview on [DATE] at 9:28 a.m. with the IP, the IP was shown a picture, taken by surveyor, of the humidifier bottle and solution taken in Resident 12's room. The IP stated the humidifier bottle and solution were dated ,d+[DATE]. The IP stated the humidifier bottle and solution were out of date and should have been replaced. The IP stated, the humidifier bottle should have been changed weekly because stagnant (lack of movement or flow, becoming stale) humidifier solution could have potentially allowed bacteria and mold to grow that could have caused and worsened respiratory illnesses for Resident 12. The IP stated, the CSC was responsible for changing the humidifier bottle weekly and should have changed the bottle a week after ,d+[DATE]. During an interview on [DATE] at 9:57 a.m. with the CSC, the CSC stated she was responsible for changing the supplies of residents on oxygen. The CSC stated she kept track of the rooms with oxygen concentrators. The CSC stated she was supposed to change the humidifier bottles every week. The CSC stated she failed to change Resident 12's humidifier bottle and solution. The CSC stated it was important to have changed the humidifier bottle and solution because if the solution runs out, the oxygen could potentially have dried out Resident 12's mucosal membrane leading to cracking, bleeding, and discomfort. The CSC stated bacteria could have potentially grown in the expired and stagnant humidifier solution and had the potential to cause infections to Resident 12. During an interview on [DATE] at 4:49 p.m. with the ADON, the ADON stated the humidifier solution with a date of ,d+[DATE] was three weeks out of date and should have been replaced. The ADON stated she expected the humidifier bottle and solution to have been changed every week by the CSC or nurse. The ADON stated it was important to change the humidifier bottle and solution weekly so the solution inside did not become stagnant and allowed bacteria to grow. The ADON stated bacteria in the solution could have potentially caused respiratory infections to Resident 12 and worsened her asthma. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:01 p.m. with the DON, the DON stated she expected the humidifier bottle and solution to be changed weekly. The DON stated an expired and potentially stagnant humidifier solution had the potential to cause bacteria to grow in the solution and cause respiratory infections to Resident 12. During a review of Resident 12's CP dated [DATE], the CP indicated, . [Resident 12] has oxygen therapy r/t mild intermittent Asthma AEB (as evidenced by) SOB .Administer ,d+[DATE] LPM (liters per minute) oxygen . monitor oxygen therapy every shift .Resident is on Oxygen Therapy . During a review of the facility's job description (JD) titled, Central Supply Clerk undated, the JD indicated, . determine if inventory quantities are sufficient .rotate stock using first in first out .stocking nursing stations with the appropriate nursing supplies .orders and maintains inventory of supplies and fills requests according to procedures . During a review of the facility's JD titled, Registered Nurse dated 2022, the JD indicated, .Registered Nurse . follow company policy and procedures to ensure a safe and comfortable environment .deliver and maintain optimum resident care and comfort by demonstrating knowledge and skills of current nursing practices . During a review of the facility's P&P titled, Infection Control Policies and Practices dated [DATE], the P&P indicated, .This Center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .the objectives of our infection control policies and practices are to .maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .the Governing Board . have adopted our infection control policies and procedures and practices as outlined herein, to reflect he Center's need and operational requirements for preventing transmission of infections and communicable diseases . During a review of the facility's P&P titled, Respiratory Care; Oxygen Administration dated ,d+[DATE], the P&P indicated, .Oxygen equipment, tanks, humidifier bottles, cannulas, masks, and other related items are checked with administration .equipment that is soiled .is replaced . 48424 4. During a review of Resident 371's AR, dated [DATE], the AR indicated, Resident 371 was admitted to the facility on [DATE] with diagnoses which included acute embolism and thrombosis of left lower extremity (a blood clot forming in a vein in the left leg, potentially blocking blood flow and leading to complications) and acquired absence of the left leg (surgical removal of the leg). During an observation on [DATE] at 4:20 p.m. in Resident 371's room, LVN 5 was changing resident 371's dressing. LVN 5 was not wearing a gown. LVN 5 stated Resident 371 had an amputated leg, and a wound had developed on it. LVN 5 stated Resident 371 was at risk for infection. LVN 5 stated Resident 371 was on enhanced barrier precautions (equipment such as gown and gloves, designed to reduce the transmission of multidrug-resistant organisms), and staff were required to wear a gown and gloves when entering the room to provide care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:23 a.m. with the IP, the IP stated Resident 371 was on enhanced barrier precautions and nursing staff were required to wear gloves and a gown when providing care to him. The IP stated Resident 371 had a recent left leg amputation and had a wound to the surgical site, LVN 5 should have worn a gown when doing his dressing change because that helped protect the resident from infection and it helped protect the nurse from cross contaminating her own clothes. During an interview on [DATE] at 3:03 p.m. with the DON, the DON stated LVN 5 should not have gone into Resident 371's room without a gown. The DON stated not wearing the proper PPE when caring for residents could spread infections to other residents if any contamination attached to LVN 5's clothes. The DON stated LVN 5 not wearing the appropriate PPE did not follow the facility's infection control policy. During a review of the facility's P&P titled, Infection Control Policies and Practices dated [DATE], the P&P indicated, .This Center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .the objectives of our infection control policies and practices are to .maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .the Governing Board . have adopted our infection control policies and procedures and practices as outlined herein, to reflect the Center's need and operational requirements for preventing transmission of infections and communicable diseases . During a review of the Professional Reference (PR) found on https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated [DATE], the PR indicated, . [Multi Drug Resistant organisms] (MDROs - germs which have become resistant to medications) may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply . 51134 5. During a concurrent observation and interview on [DATE] at 9:15 a.m. at South one medication cart with Licensed Vocational Nurse (LVN) 2, when inspecting the locked drawer for scheduled medications, a folder with two 10-dollar bills was found. The folder was labeled, Weekend and after hours trust $20.00 only for residents who have trust account. **See list inside folder. LVN 2 stated the money is kept in this cart for residents with a trust who ask for money after hours when the business office is closed or on the weekends. LVN 2 stated there is a list inside the envelope with residents who have a trust, and this gets updated daily by the business office and this list is given to the LVN responsible for the cart. During a concurrent observation and interview on [DATE] at 8:50 a.m. with LVN 3 at South one medication cart, an envelope containing money was observed in the locked drawer. LVN 3 stated she was unaware there was money in the cart. LVN 3 stated, I haven't been told about the money in this cart but if it is here, I am responsible for it. LVN 3 stated resident money should not be in the cart. LVN 3 stated money held in the medication cart could be an infection control issue because money is dirty, and medications are stored there . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:23 a.m. with the Infection Preventionist (IP), the IP stated she was unaware money was stored in the medication cart and stated money should not be stored in the medication cart. The IP stated money is one of the dirtiest things and having it near medications is not acceptable. The IP stated having money stored next to medication could make the medications dirty. During an interview on [DATE] at 11:42 a.m. with the Pharmacy Consultant (PC), the PC stated he was unaware money was being kept in the South one medication cart. The PC stated money should not be stored in the medication cart because of how dirty it is, and it is mixing with clean medications. During an interview on [DATE] at 3:33 p.m. with the Director of Nursing (DON), the DON stated she was unaware money was kept in the South one medication cart. The DON stated the money should not remain in the medication cart and should be moved. The DON stated money kept in the medication cart can be an infection control issue and everything in the medication cart needs to remain clean. During a review of the facility ' s policy and procedure (P&P) titled, Infection Control Policies and Practices dated ,d+[DATE], the P&P indicated, .This Center ' s infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .