STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056076	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Terrace Care Center	141 South Knott Avenue Anaheim, CA 92804

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 55) reviewed for psychotropic use was informed of the use of psychotropic medications (medication affecting brain activities associated with mental processes and behavior). * The facility failed to ensure Resident 55's informed consent was obtained prior to administering the increased dosage of mirtazapine (antidepressant medication). This failure had the potential for Resident 55 to not be informed of the medication and potential side effects of mirtazapine. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 6/2021 showed the facility shall verify informed consent prior to administration of a psychotropic medication for a resident. Review of the facility's P&P titled Informed Consent revised on 3/2024 showed prior to initiating the administration of a psychotherapeutic medication or physical restraint or a device, licensed nursing staff shall verify with the resident or surrogate decision maker that he/ she has given informed consent for the proposed psychotherapeutic medication or physical restraint or device to the prescriber. Psychotherapeutic medications may not be administered until informed consent has been verified. The prescribing physician shall seek the consent of the resident to inform the resident's family of a prescription, order or increase of an order for psychotherapeutic medication within 48 hours of the order. Medical record review for Resident 55 was initiated on 6/10/24. Resident 55 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 55's H&P examination dated 5/28/24 showed Resident 55 had fluctuating capacity to understand and make decisions. Review of Resident 55's Order Summary Report as of 6/10/24, showed an order dated 5/28/24, for mirtazapine 15 mg oral tablet by mouth at bedtime for depression on 5/28/24. Review of Resident 26's MAR for June 2024 showed Resident 55 received mirtazapine 15 mg oral tablet by mouth at bedtime since 5/29/24. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 55's Psychotropic Medication Administration Informed Consent form dated 4/23/21, showed Remeron (brand name for mirtazapine) 15 mg one tablet at bedtime was discontinued on 10/24/21, and Remeron 7.5 mg one tablet at bedtime was started 10/24/21. Review of Resident 55's medical record failed to show the licensed nurse verified an informed consent was obtained for mirtazapine 15 mg oral tablet by mouth at bedtime ordered on 5/28/24. On 6/11/24 at 1537 hours, a concurrent interview and medical record review was conducted with LVN 7. LVN 7 verified Resident 55 was receiving mirtazapine 15 mg by mouth at bedtime for depression. LVN 7 verified the informed consent forms in Resident 55's medical record were not filled out and the facility failed to show verification of informed consent obtained from and by the facility staff for mirtazapine 15 mg ordered on 5/28/24. On 6/11/24 at 1548 hours, a concurrent interview and medical record review was conducted with the Medical Records Director. The Medical Records Director verified the informed consent forms in Resident 55 medical records were not filled out and the facility failed to show verification of informed consent obtained from and by the facility staff for mirtazapine 15 mg ordered on 5/28/24. On 6/12/24 at 1147 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 55 was receiving mirtazapine 15 mg oral tablet by mouth at bedtime for depression and the facility failed to obtain verification of the increase dosage for psychotherapeutic medication.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs for two of 22 final sampled residents (Residents 5 and 55). * The facility failed to ensure Resident 5's head of bed was elevated to allow the resident to reach her meal tray. * The facility failed to ensure Resident 55's call light was within the resident's reach. These failures had the potential to negatively impact the residents' psychosocial well-being or result in a delay to receive care. Findings: 1. On 6/10/24 at 0815 hours, during the initial tour of the facility, Resident 5 was observed lying in bed with head of bed elevated at 45 degrees and was waving for assistance. Residenr 5 was pointing to the breakfast tray on the table. The table was observed too high for the resident to see and reach her food. Medical record review for Resident 5 was initiated on 6/10/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's MDS Quarterly assessment dated [DATE], showed the resident required set-up or clean up assistance when eating. On 6/10/24 at 0820 hours, Resident 5 was observed trying to reach for the toast from her meal tray, waving and waiting for assistance. On 6/10/24 at 0828 hours, an interview with the DSD was conducted. The DSD verified the resident was positioned too low in the bed to be able to see and eat the food from the tray. The DSD stated she would reposition the resident. 2. Review of facility's P&P titled Answering the Call Light revised 9/2023 showed to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. On 6/10/24 at 0926 hours, during the initial tour of the facility, Resident 55 was lying in bed and stated he was looking for his call light to call for help from staff. The call light was observed clipped on the privacy curtain away from the resident's reach. Medical record review for Resident 55 was initiated on 6/10/24. Resident 55 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 55's H&P examination dated 5/28/24, showed Resident 55 had fluctuating capacity to understand and make decision. Review of Resident 55's MDS 5-day assessment dated [DATE], showed BIMS score of 10. Section B of the MDS showed Resident 55 was able to make self-understood and usually understands others. On 6/10/24 at 0938 hours, an interview with CNA 7 was conducted. CNA 7 stated Resident 55 was able to call for help. CNA 7 verified the call light was not within Resident 55's reach and was clipped on the privacy curtain.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide two nonsampled residents (Residents 394 and 395) with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055. This failure had the potential for not allowing the residents or their representatives to make informed decisions regarding their healthcare. Findings: Review of the facility's P&P titled Medicare Advanced Beneficiary Notice dated 4/2021 showed the residents are informed in advance when changes will occur to their bills. Review of the SNF ABN Form CMS-10055 dated 2018 showed the SNF ABN Form CMS-10055 provided information to allow beneficiaries to decide whether to receive care that may not be paid for by Medicare and allow for the beneficiary to assume the financial responsibility. 1. Medical record review for Resident 394 was initiated on 6/10/24. Resident 394 was admitted to the facility on [DATE]. On 6/13/24 at 0910 hours, an interview and concurrent medical record review was conducted with the Business Office Manager (BOM). Review of Resident 394's SNF Beneficiary Protection Notification Review Form CMS-20052 completed by the BOM showed Resident 394's Medicare Part A skilled services episode start date was 11/29/23, with the last covered day of Part A service on 12/20/23. The facility initiated the discharge from Medicare Part A services when the benefit days were not exhausted. The BOM was asked if the SNF ABN Form CMS-10055 was provided to Resident 394 or Resident 394's representative. The BOM stated the SNF ABN Form CMS-10055 was not provided to Resident 394 or Resident 394's representative due to an oversight. 2. Medical record review for Resident 395 was initiated on 6/10/24. Resident 395 was admitted to the facility on [DATE]. On 6/13/24 at 0910 hours, an interview and concurrent medical record review was conducted with the BOM. Review of Resident 395's SNF Beneficiary Protection Notification Review Form CMS-20052 completed by the BOM showed Resident 395's Medicare Part A skilled services episode start date was 11/24/23, with the last covered day of Part A service on 12/12/23. The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The BOM was asked if the SNF ABN Form CMS-10055 was provided to Resident 395 or Resident 395's representative. The BOM stated the SNF ABN Form CMS-10055 was not provided to Resident 395 or Resident 395's representative due to an oversight.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the privacy was provided for three of 22 final sampled residents (Residents 3, 8, and 244). * The privacy curtain was not pulled completely in Resident 8's room when the license nurse administered the medications via GT. Additionally, Resident 8's window had the missing blind slats showing a walkway outside the window during the medication administration via GT. * The computer screen on Medication Cart 3 was left unattended showing Resident 3 and other residents' names and care information. * The computer screen was left on unattended with no privacy screen in Nursing Station 2 showing Resident 244's personal information. These failures had the potential to negatively affect the dignity of the residents and violate the resident's rights to privacy. Findings: Review of the facility's Policy Statement on Dignity revised in February 2021 showed under paragraph 11, the staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 1. On 6/11/24 at 0906 hours, LVN 3 went inside Resident 8's room to check the blood pressure prior to giving medications. LVN 3 did not completely pull the curtain to close. Additionally, Resident 8's window located on the right side of the resident had missing vertical blind slats showing outside walkway in full view. LVN 3 checked Resident 8's blood pressure and proceeded to administer GT medications. On 6/11/24 at 0958 hours, an interview was conducted with LVN 3. LVN 3 verified she did not provide complete privacy for Resident 8 during the blood pressure check and medication administration. LVN 3 also verified Resident 8's window had missing blind slats. 2. Review of the Policy Statement on Confidentiality of Information and Personal Privacy showed the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records and access to resident personal and medical records will be limited to authorized staff and business associates. On 6/12/24 at 0820 hours, the computer screen on top of Medication Cart 3 was left open and unattended by LVN 4. LVN 4 subsequently went inside Resident 3's room. The computer screen was left unattended and exposed multiple residents' names and care information including Resident 3. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 1024 hours, during an interview with LVN 4, LVN 4 verified the computer screen was left unattended and acknowledged the computer needed to be closed. LVN 4 acknowledged she did not ensure the confidentiality of Resident 3's medical record. 3. On 6/11/24 at 1024 hours, the computer screen in Station 2 was left on unattended with no privacy screen. Resident 244's personal information was visible to anyone walking by the hallway. On 6/11/24 at 1028 hours, an interview was conducted with the DSD. The DSD acknowledged and verified the computer screen was left on unattended with no privacy screen with Resident 244's personal information. The DSD acknowledged this did not ensure the personal privacy and confidentiality of the resident's personal and medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and facility P&P review, the facility failed to maintain a clean and homelike environment for four of 22 final sampled residents (Residents 14, 65, 74, and 75) and two nonsampled residents (Residents 8 and 71). * Residents 65 and 74 complained about the condition of the carpet in the resident hallways throughout the facility, stating the carpets were dirty. * Two resident's rooms (Residents 14 and 75) were observed with missing paint and scrapes on the walls. * Resident 8's window was observed with missing blind slats. * Resident 71's room was observed with an improperly hung curtain. These failures had the potential to negatively impact the residents' quality of life. Findings: Review of the facility's P&P titled Homelike Environment revised 2/2021 showed the residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximize, to the extent possible, homelike setting. 1. Medical record review for Resident 74 was initiated on 6/10/24. Resident 74 was admitted to the facility on [DATE]. On 6/10/24 at 0946 hours, an interview and concurrent observation was conducted with Resident 74. Resident 74 stated she had a concern with the condition of the carpet in the hallways throughout the facility. The carpets throughout the resident hallways were observed with multiple stained areas. Resident 74 stated the carpets were dirty and when she utilized her front wheel walker, the carpet grabbed the front wheel walker and caused it to move in an unintended direction. Resident 74 stated she notified the Administrator, and the Administrator informed her that the facility was in the process of replacing the carpet. 2. Medical record review for Resident 65 was initiated on 6/10/24. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE]. On 6/11/24 at 1240 hours, an interview and concurrent observation was conducted with Resident 65. Resident 65 stated he felt the carpets in the hallway needed to be cleaned. Resident 65 stated several of the dirty areas observed on the carpets were from spilled food which occurred during mealtime. On 6/11/24 at 1253 hours, an interview was conducted with the Administrator. The Administrator was informed the residents had concerns related to the cleanliness of the carpets. The Administrator stated the facility was in the process of obtaining bids to have the carpet in the hallways replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46787 3. On 6/10/24 beginning at 0800 hours, during an initial tour of the facility, the following was observed: - The wall close to the entrance of Resident 14's room had missing paint and scrapes. - The wall close to the entrance of Resident 75's room had missing paint and scrapes. On 6/13/24 at 0958 hours, a concurrent observation and interview was conducted with the Administrator. The Administrator acknowledged the above findings. 50787 4. On 6/11/24 at 0934 hours, during the medication pass observation in Resident 8's room, the window on the right side of the resident's bed had missing 17 vertical blind slats showing a walkway outside of the window. On 6/11/24 at 958 hours, post medication administration, LVN 3 was asked if she was aware of the missing window vertical blind slats. LVN 3 stated she was not aware and did not notice the missing blind slats until today and it should have been replaced to provide full privacy to Resident 8. LVN 3 stated she would notify the management ASAP. 5. On 6/10/24 at 0936 hours, during the initial tour of the facility and concurrent interview with CNA 8 and Resident 71, Resident 71's room was observed with curtains not properly hooked on the window curtain railings. CNA 8 was inside Resident 71's room and verified the findings. Resident 71 stated the curtains had been like that for a couple of months and it was reported to someone who took the trash out; however, that staff only cleaned and did not fix the curtains. Resident 71 stated the curtains made her feel a little uncomfortable because it was not in the right place.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to notify the resident's representatives of the transfer and reasons for the transfer to the acute care hospital in writing and send a copy of the notice of transfer to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for two of three sampled residents (Residents 55 and 72) reviewed for hospitalization . This failure posed the risk of the resident's representatives not being aware of their appeal rights and the Ombudsman not being aware of the circumstances of the resident's transfer/ discharge should an appeal be filed or requested by the resident or their representatives regarding the transfer. Findings: Review of the facility's P&P titled Transfer or Discharge, Facility Initiated dated 10/2022, showed notice of transfer is provided to the resident and representative as soon as practicable before the transfer and to the LTC ombudsman when practicable. When a resident is transferred or discharged from the facility, the following in documented in the medical record. Notices are provided in a form and manner that the resident can understand. Taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. 1. Medical record review for Resident 55 was initiated on 6/10/24. Resident 55 was admitted to the facility on [DATE], transferred to the acute care hospital on 5/23/24 and readmitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 5/28/24, showed Resident 55 had fluctuating capacity to understand and make decisions. Review of Resident 55's Physician Orders showed an order dated 5/23/24, to transfer the resident to the acute care hospital. Further review of Resident 55's medical record failed to show the written notification of transfer/discharge for the above date was provided to the resident's representative. In addition, Resident 55's medical record failed to show the copy of written notices of transfer/discharge was sent to the LTC Ombudsman. 2. Medical record review for Resident 72 was initiated on 6/11/24. Resident 72 was admitted to the facility on [DATE], transferred to the acute care hospital on 5/2/24, and readmitted to the facility on [DATE]. Review of Resident 72's H&P examination dated 5/21/24, showed Resident 72 had the capacity to understand and make decisions. Review of Resident 72's Physician Orders showed an order dated 5/2/24, to transfer the resident to the acute care hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 1635 hours, an interview and concurrent medical record review was conducted with the MRD. The MRD verified the physician's orders for Residents 55 and 72's transfers to the acute care hospital. The MRD also verified Residents 55 and 72's medical records failed to show the written notification of transfer and discharge provided to the resident's representatives. The MRD stated it was the Medical Records Department's responsibility to send the notice of transfer or discharge to the resident's representatives; however, the MRD was not able to send the written notices for the transfer date identified.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident or the resident's representative was provided a written bed hold policy upon transfer to the acute care hospital for two of three sampled residents (Resident 55 and 72) reviewed for hospitalization . This failure had the potential for the resident or the resident's representative to not be informed of their rights to return to the facility following a hospitalization . Findings: Review of the facility's P&P titled Transfer or Discharge, Facility Initiated dated 10/2022 showed the notice of facility bed-hold and returns policies are provided to the resident and representative within 24 hours of emergency transfers. 1. Medical record review for Resident 55 was initiated on 6/10/24. Resident 55 was admitted to the facility on [DATE], transferred to the acute care hospital on 5/23/24, and readmitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 5/28/24, showed Resident 55 had fluctuating capacity to understand and make decisions. Review of Resident 55's Physician Orders showed an order dated 5/23/24, to transfer the resident to the acute care hospital. Further review of Resident 55's medical record failed to show the written bed hold notice was provided to the resident's representative for the above transfer. 2. Medical record review for Resident 72 was initiated on 6/11/24. Resident 72 was admitted to the facility on [DATE], transferred to the acute care hospital on 5/2/24, and readmitted to the facility on [DATE]. Review of Resident 72's H&P examination dated 5/21/24, showed Resident 72 had the capacity to understand and make decisions. Review of Resident 72's Physician Orders showed an order dated 5/2/24, to transfer the resident to the acute care hospital. Further review of Resident 72's medical record failed to show the written bed hold notice was provided to the resident's representative for the above transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 1635 hours, an interview and concurrent medical record review was conducted with the MRD. The MRD verified the physician's orders for Residents 55 and 72's transfers to the acute care hospital. The MRD also verified Residents 55 and 72's medical records failed to show the written bed hold notice was provided to the resident's representative for the above transfer. The MRD stated it was the Medical Records Department's responsibility to send the bed hold notice to the resident's representatives; however, the MRD was not able to send the written notice for the transfer date identified.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on interview and medical record review, the facility failed to coordinate an assessment with Pre-Admission Screening and Resident Review (PASRR) program for one of 22 final sampled residents (Resident 15) when the resident had a newly evident mental disorder for level II review. This failure posed the risk for Resident 15 not receiving the necessary specialized services specific to treat mental illness and had the potential for inappropriate placement in a long-term nursing home. Findings: Medical record review for Resident 15 was initiated on 6/10/24. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's History and Physical examination dated 4/24/24, showed Resident 15 had no diagnosis of mental illness. Review of Resident 15's level I PASRR dated 4/20/24, showed Resident 15 had no diagnosis of mental illness and had not been prescribed of a psychotropic medications. Review of Resident 15's Order Summary Report dated June 2024 showed a physician's order dated 4/30/24, for quetiapine fumarate (antipsychotic medication) 50 mg by mouth at bedtime for psychosis manifested by sudden change in mood from pleasant to anger. Review of Resident 15's Order Summary Report dated June 2024 showed a physician's order dated 4/30/24, for olanzapine (antipsychotic medication) 5 mg by mouth two times a day for psychosis manifested by inconsolable screaming. Further review of the medical record showed no documented evidence of coordination for a level II assessment when the resident was started on the antipsychotice medication for psychosis on 4/30/24. On 6/11/24 at 1414 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 stated she was one of the staff members responsible for coordinating the PASRR assessments. RN 1 verified the above findings and stated a level II assessment should have been coordinated when Resident 15 received a new diagnosis of psychosis and was prescribed antipsychotic medications on 4/30/24.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to ensure the level 1 PASRR Screening was conducted after an acute care hospital discharge exemption lapsed for one of four residents (Resident 65) reviewed for PASRR. * Resident 65's Level I PASRR Screening dated 4/3/24, showed Resident 65 had a diagnosed mental illness and had been prescribed psychotropic medications. Resident 65's Level 1 Screening was negative, and a Level II mental health evaluation referral was not required due to an exempted hospital discharge. Further review of Resident 65's Level 1 PASRR Screening dated 4/3/24, showed if Resident 65 remained in the facility longer than 30 days, the facility should resubmit a new Level 1 PASRR Screening on the 31st day. However, the facility failed to resubmit a new Level 1 PASRR Screening when Resident 65 had remained in the facility longer than 30 days. This failure posed the risk for Resident 65 not receiving a Level II Mental Health Evaluation, which had the potential for the facility to fail to incorporate recommendations from the PASARR Level II determination and evaluation report into Resident 65's resident assessment, care planning, and transition of care. Findings: Medical record review for Resident 65 was initiated on 6/10/24. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE]. On 6/12/24 at 1459 hours, an interview and concurrent medical record review was conducted with RN 1. Review of Resident 65's Level I PASRR Screening dated 4/3/24, showed Resident 65 had a diagnosed mental illness and had been prescribed psychotropic medications. However, Resident 65's Level 1 Screening was negative and a Level II mental health evaluation referral was not required due to an exempted acute care hospital discharge. Resident 65's Level 1 PASRR Screening dated 4/3/24, showed if Resident 65 remained in the facility longer than 30 days, the facility should resubmit a new Level 1 PASRR Screening on the 31st day. RN 1 reviewed Resident 65's PASRR submissions and verified the facility failed to resubmit a new Level 1 PASRR Screening when Resident 65 had remained in the facility longer than 30 days as evidenced by Resident 65 having resided in the facility for approximately two months after the Level 1 PASRR Screening was conducted on 4/3/24.

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F 0655 Level of Harm - Potential for minimal 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** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the baseline care plan for one of 22 final sampled resident (Resident 55) was initiated upon admission. * The facility failed to ensure Resident 55's baseline care plan included the necessary information to properly care for the resident using anticoagulant medication, necessary interventions to prevent bleeding. This failure had the potential for Resident 55 not receiving necessary resident-centered care. Findings: Review of the facility's P&P titled High Risk Medications - Anticoagulant revised 2/2023 showed the resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants include a. bleeding and hemorrhage (bleeding gums, nose bleed, unusual bruising, blood in urine or stool); b. fall in hematocrit or blood pressure; and c. thromboembolism (obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation). Medical record review for Resident 55 was initiated on 6/10/24. Resident 55 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 55's H&P examination dated 5/28/24, showed Resident 55 had fluctuating capacity to understand and make decisions. Review of Resident 55's Physician Orders as of 6/10/24, showed a physician order dated 5/28/24, to administer heparin sodium (a medication used to prevent and treat blood clots in the lungs or the legs) injection solution 5000 units every 8 hours for 30 days. Review of Resident 55's MAR for the Month of June 2024 showed Resident 55 received heparin sodium injection solution 5000 units every eight hours since 5/29/24. Further review of Resident 55's plan of care failed to identify the resident's care plan for use of heparin sodium, individualized goal, and interventions for staff to monitor for and prevent adverse consequences. On 6/11/24 at 1530 hours, a concurrent interview and medical record review was conducted with LVN 7. LVN 7 verified Resident 55 was receiving heparin sodium injection solution 5000 units every eight hours. LVN 7 verified Resident 55's medical record failed to show a care plan for the resident's use of heparin sodium. On 6/13/24 at 1445, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Potential for minimal 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** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was developed for one of 22 final sampled residents (Resident 393). * The facility failed to develop the comprehensive resident-centered care plan to address the use of oxygen for Resident 393. This failure placed the resident at risk of not being provided appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Care Plan Comprehensive dated 8/25/21, showed the purpose of an individualized comprehensive care plan includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs, and shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical well-being. Medical record review for Resident 393 was initiated on 6/10/24. Resident 393 was admitted to the facility on [DATE]. Review of Resident 393's Order Summary Report showed a physician's order dated 6/5/24, for oxygen to be administered at 2 to 3 liters per minute as needed to keep the oxygen saturation levels above 90%. On 6/10/24 at 0948 hours, an observation and concurrent interview was conducted with LVN 1. Resident 393's nasal cannula was observed lying on the floor. LVN 1 verified the findings and stated Resident 393's nasal cannula needed to be stored in a clean bag for infection control and not on the floor. On 6/12/24 at 0920 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. Review of Resident 393's Medication Administration Record dated 6/5/24 at 1650 hours, showed Resident 393 received the oxygen therapy which was administered at 2 to 3 liters per minute to maintain the oxygen saturation levels above 90%. Review of Resident 393's medical record failed to show a comprehensive care plan was developed for the use of the oxygen. The MDS Coordinator verified the findings and stated the nurse who obtained the oxygen order should have initiated a comprehensive care plan to ensure Resident 393's plan of care was comprehensive, accurate, and included the monitoring of the oxygen usage.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure three of 22 final sampled residents (Residents 25 and 93) attained and maintained their highest practicable well-being. * The facility failed to ensure Resident 93's medication order for Insulin Regular Human (Regular Insulin is a short-acting type of insulin) Injection Solution per sliding scale was administered as ordered by the physician. This failure posed risk for Resident 93 to have hyperglycemic episode and to receive unnecessary short acting insulin dose. * Resident 25's change in skin integrity were not assessed and documented. This failure posed the risk of Resident 25 not receiving appropriate care. Findings: 1. Medical record review for Resident 93 was initiated on 6/3/24. Review of Resident 93's H&P examination dated 6/3/24, showed the resident had a capacity to understand and make decisions. Review of Resident 93's Physician Order Summary Report showed an order dated 6/3/24, for Regular Human Insulin per the following sliding scale three times a day: - For blood sugar (BS) below 70 mg/dl call MD - BS 0 - 150 mg/dl = 0 unit - BS 151 - 200 mg/dl = 2 units subcutaneously - BS 201 - 250 mg/dl = 4 units subcutaneously - BS 251 - 300 mg/dl = 6 units subcutaneously - BS 301 - 350 mg/dl = 8 units subcutaneously - BS 351 - 400 mg/dl = 10 units subcutaneously - BS greater than 400 mg/dl 12 units subcutaneously and call MD, Review of Resident 93's MAR for June 2024 showed the blood sugar check for 6/8/24 at 0630 hours, was not done or blank. Review of the MAR failed to show documentation the blood sugar check was held for any reason. Further review of MAR showed on 6/8/24 at 1130 hours, Resident 93's BS level was 379 mg/dl, and 10 units of Regular Human Insulin was administered to Resident 93. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/24 at 1513 hours, an interview with LVN 7 was conducted. LVN 7 verified the blood sugar check on 6/11/24, was blank or no documentation. LVN 7 stated the licensed nurses were expected to document the blood sugar results and administer Regular Human Insulin per sliding scale as ordered. On 6/13/24 at 1445 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings. 35346 2. Review of the facility's P&P titled Skin Integrity management effective 5/26/21, showed an intervention to a resident's skin integrity management included staff continually observing and monitoring residents for changes and performing skin inspections weekly. On 6/11/24 at 0935 hours, a concurrent observation and interview was conducted with Resident 25. Resident 25 verbalized he had difficulty putting on his socks. Resident 25 was observed using his right index and middle fingers to remove his socks. Resident 25's left foot was observed with red colored skin tears to the top and left side of his foot, two horizontal marks to the top of his foot, scattered dryness and brown discoloration at the top of his foot, and brown discoloration to the side of his foot. Resident 25's right heel was observed with redness and the formation of a blister. In addition, Resident 25 was observed with yellow colored, long toenails extending beyond the edge of his toes. On 6/11/24 at 1050 hours, a concurrent observation, medical record review, and interview was conducted with CNA 4 and LVN 6. LVN 6 verified the above findings. When asked about assessing Resident 25's skin, LVN 6 stated last month was the last time Resident 25's head to toe skin inspection was completed. Review of Resident 25's weekly progress notes with LVN 6 failed to show documented evidence of any injuries or changes of skin integrity. On 6/11/24, at 1520 hours, an interview was conducted with Resident 25's assigned CNA (CNA 4). CNA 4 verified Resident 25's last shower was on 6/11/24. When asked about Resident 25's skin, CNA 4 stated she did not see any changes to Resident 25's skin integrity. Medical record review for Resident 25 was initiated on 6/11/24. Resident 25 was readmitted to the facility on [DATE]. Review of Resident 25's History and Physical examination dated 10/9/23, showed Resident 25 had no cognitive impairment. Further review of this examination form showed Resident 25's diagnoses included peripheral vascular disease for the bilateral lower extremities. Review of Resident 25's progress notes showed a medical specialist note dated 6/3/24, with Resident 25's diagnoses including left knee contracture, post status stroke with left side paralysis, tremors, and cellulitis of left lower extremity. Resident 25's plan of care included to perform daily skin checks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 1630 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the changes of Resident 25's skin were not documented to show they were observed and assessed and reported to Resident 25's physician for further follow up. There was no documented evidence a weekly skin head to toe assessment was completed for the resident and identified the impairment in the resident's skin integrity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of one resident (Resident 25) reviewed for accident hazards remained free from accident hazards. * The facility failed to ensure two persons transferred Resident 25 with the mechanical lift. This failure had the potential for injury to Resident 25. Findings: Review of the facility's P&P titled Lifting Machine, Using a Mechanical undated showed the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. At least two nursing assistants are needed to safely move a resident with a mechanical lift. Mechanical lifts may be used for tasks that require: transferring a resident from bed to chair and toileting or bathing. Medical record review for Resident 25 was initiated on 6/10/24. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 25's H&P examination dated 10/9/23, showed Resident 25 was alert and oriented and had independent decision-making capabilities. Review of Resident 25's MDS dated [DATE], showed Resident 25 was cognitively intact, had impairments to the bilateral lower extremities and was totally dependent on staff assistance for chair/bed to chair transfer. Review of Resident 25's Order Summary Report dated 6/12/24, showed a physician's order dated 4/16/20, for no weight bearing on the left lower extremity. Review of Resident 25's plan of care showed a care plan problem dated 4/21/17, addressing Resident 25's risk for decreased ability to perform ADL cares, including bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. Interventions showed to provide Resident 25 with extensive to total assist of two person for transfer. Review of Resident 25's Progress Notes showed a nursing entry dated 11/30/23 at 1940 hours, Resident 25 claimed he fell and his right shoulder was hit by the Hoyer lift (mechanical lift). Body check was done with no redness or marking noted. After telling him that, he wanted the supervisor. The RN supervisor was called and made aware of the residents' claim, but now he stated that he hit his forehead. The RN supervisor did another body check with no bruising, redness, scrape and swelling noted. The resident stated, I want the Hoyer lift and the CNA checked because they are not functioning right. Hoyer lift was checked and it is working fine. He got upset and asked the nurses to leave. The CNA was interviewed and stated, I would have called you if something had happened because if he fell while on the Hoyer lift that would be a serious scenario for one person to handle. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's eInteract Transfer Form dated 12/19/23, showed Resident 25's claimed of falling on 11/30/23, was offered several times by staff if he wanted to be transferred to the emergency room for evaluation and the resident had declined repeatedly. Resident 25 claimed of falling and hitting his left forehead and eye on the drawer. He was checked by two licensed nurses with no bruising, redness, or any marks noted. Today offered again and had finally agreed [to go to the ER]. On 6/10/24 at 1009 hours, an interview was conducted with Resident 25. Resident 25 stated he was transferred to the acute care hospital to be evaluated after an incident with the mechanical lift. Resident 25 stated the CNA was transferring him to the bed, after a shower, when Resident 25 hit the corner of the bedside drawer. When asked, Resident 25 stated there was only one CNA in the room during the transfer. On 6/13/24 at 0848 hours, an interview and concurrent medical record review for Resident 25 was conducted with RN 1. RN 1 was asked about the facility's policy for operating the mechanical lift. RN 1 stated mechanical lifts should be operated with two-people assistance. For transfers from bed to shower chair and back, there should be two-people to assist for resident safety and to prevent any injuries. RN 1 was asked about the incident surrounding Resident 25's acute care hospital transfer on 12/19/23. Concurrent record review of Resident 25's nursing documentation on 11/30/23 at 1940 hours, was conducted with RN 1. RN 1 reviewed the nurse's documentation and stated Resident 25 claimed he fell and was transferred for evaluation. RN 1 stated the nurse's documentation showed on the interview, the CNA stated only one person (the CNA) transferred Resident 25 using the mechanical lift. On 6/13/24 at 1032 hours, an interview and concurrent medical record review for Resident 25 was conducted with the DON. The DON verified the above findings. The DON further stated she expected there to always be two staff members present for transfers using a lift for the residents' safety. On 6/13/24 at 1130 hours, the DON and Administrator were informed and acknowledged the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 50787 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 8) reviewed for GT care received adequate care as evidenced by: * The facility failed to ensure the GT patency and placement were properly checked before the medication was administered for Resident 8. This failure had the potential for negative outcomes for the residents with GT. Findings: Review of the facility's P& P titled Administering Medications through Enteral Tube revised 11/2018 showed to verify the placement of the feeding tube. Review of the facility's document titled Gastrostomy and Jejunostomy Placement and Patency Check, dislodging: Pulling Out undated showed using a 60 ml syringe, pull syringe plunger back and fill with 10-20 ml of air, connect the syringe to the end of the feeding tube, put on the stethoscope and place bell or diaphragm of the stethoscope over the left upper quadrant of the abdomen while rapidly injecting the air. On 6/11/24 at 0943 hours, during the medication administration observation of LVN 3, LVN 3 was in the process of administering the GT medications and stated she was putting 10 ml of air to check for patency, then pushed the air to the GT without using the stethoscope (stethoscope was on her right shoulder). Thereafter, LVN 3 checked for residual feeding/gastric contents, none was noted. On 6/11/24 at 0958 hours, an interview was conducted with LVN 3. LVN 3 stated the process of checking the GT placement was to palpate the abdomen, inspect visually, listen with stethoscope for bowel sounds and palpate with hand for tenderness and then push air into GT to check for patency, auscultate to hear the air go in with or without stethoscope, would hear the swish once you input the air. LVN 3 clarified it was the facility's policy to use a stethoscope during auscultation to check for the GT placement. LVN 3 verified she did not use the stethoscope and acknowledged she failed to ensure Resident 8's GT placement was confirmed prior to its use.

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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. 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one sampled resident (Resident 93) reviewed for IV therapy was administered parenteral flushes in accordance with the physician's order. * The facility failed to flush Resident 93's IV every 12 hours as ordered by the physician. This failure posed the risk for complications related to the IV therapy. Findings: Review of the facility's P&P titled General Policies for IV Therapy dated 3/2023, showed the intermittent IV medications should be separated by saline flushes to avoid incompatibilities. Medical record review for Resident 93 was initiated on 6/10/24. Review of Resident 93's H&P examination dated 6/3/24 showed Resident 93 had capacity to understand and make decisions. Review of Resident 93's Physician Order Summary Report as of 6/10/24, showed the following physician orders: - On 6/3/24, Ertapenem Sodium (antibiotic) Injection Solution Reconstituted 1 gram intravenously one time a day for 10 Days. Flush IV with 10 ml Normal Saline (sodium chloride Flush) before and after giving meds. Change IV tubing daily. - On 6/4/24, Normal Saline Flush Solution 0.9 %, use 10 ml intravenously every 12 hours for minimum flush. Review of Resident 93's care plan focus problem titled Peripheral IV/ Midline IV initiated on 6/4/24, showed an intervention to flush the IV line per policy. Review of Resident 93's MAR for June 2024 showed no documented evidence for normal saline flush on the following dates and times: - On 6/4/24 at 2100 hours - On 6/5/24 at 0900 hours - On 6/9/24 at 0900 hours Further review of the MAR failed to show documentation the normal saline flush were held for any reason. On 6/10/24 at 0900 hours, Resident 93 was lying in bed with an IV locking device on the left hand. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 1600 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified the normal saline flush was not administered as ordered. On 6/13/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and medical record review, the facility failed to ensure the oxygen therapy equipment was stored in a sanitary manner for one of two sampled residents reviewed for oxygen therapy (Resident 393). * Resident 393's nasal cannula was observed lying on the floor. This failure posed the risk for equipment contamination and respiratory complications. Findings: Medical record review for Resident 393 was initiated on 6/10/24. Resident 393 was admitted to the facility on [DATE]. Review of Resident 393's Order Summary Report showed a physician's order dated 6/5/24, for oxygen to be administered at 2 to 3 liters per minute as needed to keep the resident's oxygen saturation levels above 90%. On 6/10/24 at 0922 hours, an observation was conducted of Resident 393. Resident 393 was observed lying in bed. Resident 393's nasal cannula was observed wrapped around the call light cord. On 6/10/24 at 0948 hours, an observation and concurrent interview was conducted with LVN 1. Resident 393's nasal cannula was observed lying on the floor. LVN 1 verified the findings and stated Resident 393's nasal cannula needed to be stored in a clean bag for infection control and not on the floor. Cross reference to F656.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the pharmaceutical services including accurate acquiring, receiving, dispensing, and record keeping were maintained to meet the needs of each resident as evidenced by: * The facility failed to ensure the medications removed from the emergency kit were replaced in a timely manner. * The facility failed to ensure the controlled drug count reconciliation logs were properly accounted for and documented. These failures had the potential for not having the medications available for use in case of emergency and drug diversion. Findings: Review of the facility's P&P titled Controlled Medication Storage effective 8/2014 showed at each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record. Any discrepancy in controlled substance medication count is reported to the Director of Nursing immediately. The Director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. 1. On 6/12/24 at 1049 hours, an inspection of the medication rooms for Stations 2 and 4 was conducted with LVN 4. An oral e-kit labeled 594 was observed with 2 yellow seals. LVN 4 stated the yellow seal meant the e-kit was opened. On 6/12/24 at 1107 hours, a concurrent interview and facility document review was conducted with LVN 4. LVN 4 showed the e-kit log's last entry was on 6/8/24 at 1544 hours. Percocet (pain reliever) 10/325 mg one tab every 8 hours was administered 6/8/24 at 1547 hours, by LVN 10. LVN 4 verified the findings and stated the medication should have been replaced within 24 hours. 2. Review of the facility's Controlled Medication Count Reconciliation Sheet showed multiple missing signatures on the following dates and times: - 4/3/24 1500-2300 hours, for incoming nurse - 5/8/24 2300 -0700 hours, for outgoing nurse - 5/31/24 0700 - 1500 hours, for incoming nurse - 6/6/24, 2300 -0700 hours, for outgoing nurse (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 1200 hours, an interview was conducted with LVN 4. LVN 4 stated the process of endorsing controlled medications between shifts included conducting a narcotic count, signing the Controlled Medication Reconciliation Count Sheet after counting, the outgoing nurse would inform the incoming nurse if an e-kit was opened, and checking the count sheet for completed signatures. LVN 4 verified and acknowledged the missing signatures.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, and medical record review, the facility failed to ensure one of 22 final sampled resident (Resident 25) was free from the unnecessary medications. * The facility failed to clarify Resident 25's physician's order for no other narcotics and muscle relaxants while on methadone (narcotic). Resident 25 was prescribed narcotics pain medications and muscle relaxant with methadone. This failure had the potential for Resident 25 to receive unnecessary medications and develop significant adverse effects, and risk adverse effects from prolonged use of medication. Findings: Medical record review for Resident 25 was initiated on 6/10/24. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 25's H&P examination dated 10/9/23, showed Resident 25 was alert and oriented and had independent decision-making capabilities. Review of Resident 25's Order Summary Report dated 6/12/24, showed the following physician's orders: - dated 4/15/20, no other narcotics and/or muscle relaxants while resident on methadone, - dated 10/1/22, to administer Dilaudid 2 mg by mouth every eight hours as needed for severe pain (level eight to ten out of ten), - dated 12/17/23, to administer Percocet 5-325 mg by mouth every four hours as needed for moderate pain (pain level five to seven out of ten), - dated 3/21/24, to administer methadone 5 mg by mouth two times a day for pain management, and - dated 4/4/24, to administer tizanidine 4 mg by mouth three times a day for muscle relaxant. Review of Resident 25's MAR for May and June 2024 showed Resident 25 was administered the following medications: - Dilaudid 2 mg every eight hours as needed for severe pain: on 5/2, 5/10, 5/20, and 6/11/24. - Percocet 5-325 mg every fours hours as needed for moderate pain on 5/4, 5/5, and 5/11/24. - methadone 5 mg two times a day for pain management: from 5/1/24 to 6/11/24 at 0600 and 1800 hours. - tizanidine 4 mg three times a day: from 5/1/24 to 6/11/24 at 0600, 1000, and 1900 hours. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's plan of care showed a care plan problem dated 6/23/23, addressing Resident 25's use of medications with black box warning, including Percocet, Dilaudid, and methadone. Interventions showed a warning that Dilaudid, methadone, and Percocet use exposed users to the risk of opioid addiction, abuse and misuse, which could lead to overdose and death. On 6/12/24 at 0830 hours, an interview was conducted with Resident 25. Resident 25 stated he took methadone, Dilaudid, Percocet, and Tylenol for pain. Resident 25 stated he had chronic pain throughout his body. On 6/12/24 at 1047 hours, an interview and concurrent medical record review for Resident 25 was conducted with LVN 2. LVN 2 verified the above findings and stated the physician's order should have been clarified with the physician. On 6/13/24 at 1054 hours, an interview and concurrent medical record review for Resident 25 was conducted with the DON. The DON acknowledged the above finding and stated the nurse should have clarified the orders with the physician. On 6/13/24 at 1130 hours, the DON and Administrator were informed and acknowledged the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50787 Based on interview, medical record review, and facility P& P review, the facility failed to ensure one of 22 final sampled residents (Resident 15) was free from the unnecessary psychotropic medications (medication that affects the brain activity). * The facility failed to ensure the Psychotropic Medication Administration Disclosure (informed consent) was completed prior to the administration of Resident 15's psychotropic medications. This failure posed the risk of not evaluating the need and effectiveness of Resident 15's psychotropic medications use, Findings: Review of the facility's P&P titled Informed Consent dated June 2021 showed the information to be included in obtaining consent for Psychotherapeutic Medications are as follows: the reason for the treatment and the nature and seriousness of the resident's illness, and the nature of the medication to be used including the dose, frequency, and duration. Prior to initiating the administration of a psychotherapeutic medication, the licensed nursing staff shall verify with the resident or the surrogate decision maker that he/she has been given the informed consent for the proposed psychotherapeutic medication by the prescriber. Psychotherapeutic medications may not be administered until informed consent has been verified. Review of the facility's P&P titled Psychotropic Medication Use dated June 2021 showed the facility shall verify informed consent prior to the administration of a psychotropic medication to a resident. Review of Resident 15's physician's orders dated 6/13/24, showed the following orders: - olanzapine (antipsychotic medication) oral tablet 5 mg two tablets by mouth two times a day for psychosis manifested by inconsolable screaming. - quetiapine fumarate (antipsychotic medication) oral tablet 50 mg one tablet by mouth at bedtime for psychosis manifested by sudden change in mood from pleasant to anger. Review of the Psychotropic Medication Administration Disclosure showed the physician's orders for the olanzepine and quetiapine fumarate. Under the Informed Consent section was the signature of the Health Care Decision Maker dated 4/20/24; however, the physician signature and date, including the Licensed Nurse and date for the verification section were left blank. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 0419 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked about the process for the use of psychotropic medications by the residents. RN 1 stated a consent would be obtained with the medication names, dosage, schedule, and the target behavior/s. The physician would sign and date and obtain the consent from the resident or the health care decision maker by having them sign and date the form as well after providing pertinent information about the psychotropic medication/s and its use. In addition, during the review of Resident 15's Psychotropic Medication Administration Disclosure with RN 1, RN 1 verified and acknowledged the form was not complete, it was missing the behavior, diagnosis for the use of the olanzapine, physician's signature and date, and licensed nurse's signature and date of verification. On 6/13/24 at 1454 hours, an interview was conducted with the DON. The DON was asked about the process for informed consent for the use of psychotropic medications, the DON stated it should be the physician who would obtain the consent from the resident and/or legal representative, then the nurse would verify. The DON verified and acknowledged Resident 15's Psychotropic Medication Administration Disclosure was not signed by the physician and not verified by the nurse.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the facility's medication error rate was below 5%. * The facility's medication error rate was 16.12%. One of three licensed nurses (LVN 3) was observed administering the medications to one of 22 final sampled residents (Resident 8) and was found to have errors. The facility failed to ensure Resident 8 received the prescribed medications as ordered. This failure had the potential for the resident to not receive the effective therapeutic effects of the medications and may negatively affect the resident's health. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed medications are administered in a safe and timely manner as prescribed. Medications are administered in accordance with the prescriber orders, including any required time. The medications are administered within one hour of their prescribed time, unless otherwise specified. Medication administration times are determined by the resident's need and benefit, and not for the staff's convenience. On 6/11/24 at 0914 hours, the medication administration observation was conducted with LVN 3 for Resident 8. LVN 3 prepared the following medications for Resident 8: - amoxicillin (antibiotic) oral capsule 500 mg give one capsule. - enoxaparin sodium (blood thinner medication) injection solution prefilled syringe 40 mg/0.4 ml inject 40 mg administered subcutaneously (under the layers of the skin). - multivitamin (vitamin supplement) oral liquid with minerals 5 ml. - glycolax powder (laxative) 17 gm to mix powder with four-eight ounces of liquid. However, LVN 3 was unable to locate these medications: amlodipine besylate oral tablet 5 mg, hydralazine hydrochloride oral tablet 25 mg, lisinopril oral tablet 20 mg, Enulose solution 10 gm/15 ml give 30 ml, and magnesium oxide 400 oral packet. On 6/11/24 at 0934 hours, LVN 3 administered the following medications: - amoxicillin oral cap 500 mg one capsule, - enoxaparin sodium injection solution prefilled syringe 40 mg/0.4 ml inject 40 mg injected subcutaneously, - multivitamin oral liquid with minerals 5 ml, and - glycolax powder 17 gm mixed with eight ounces of water. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for active orders as of 6/11/24, showed the following prescribed medication orders scheduled for 0900 hours: - amlodipine besylate oral tablet 5 mg one tablet by mouth one time a day for hypertension. - amoxicillin oral capsule 500 mg one capsule via GT three times a day for pneumonia. - enoxaparin sodium injection solution prefilled syringe 40 mg/0.4 ml inject 40 mg subcutaneous one time a day for DVT. - Enulose solution 10 gm/15 ml give 30 ml by mouth one time a day for constipation. - glycolax powder 17 gm give 17 gram by mouth two times a day for constipation, mix with powder with six-eight ounces of liquid. - hydralazine hydrochloride oral tablet 25 mg one tablet by mouth two times a day for hypertension. - lisinopril oral tablet 20 mg one tablet by mouth one time a day for hypertension. - magnesium oxide 400 oral packet one tablet give one tablet by mouth one time a day for supplement. - multivitamin oral liquid with minerals 5 ml by mouth one time a day for supplement. During the medication administration observation on 6/11/24, the following prescribed medications were not available for administration: amlodipine besylate, hydralazine hydrochloride, lisinopril, Enulose solution, and magnesium oxide. On 6/11/24 at 0918 hours, during an interview conducted with LVN 3, LVN 3 stated the medications were not available and stated she did not know why the above medications due to be administered at 0900 hours, were not available. On 6/11/24 at 1215 hours, interview conducted with the DON, the DON stated the delivery process for the medications for new admission and for IV medications and antibiotics, the medications should have been delivered within four hours, and for routine medications, they should have been delivered the following day. The DON was informed and acknowledged the above findings. The DON stated Resident 8's missed medications during the medication observation were stored in the bed hold medications bin inside the medication room and LVN 3 did not know because she worked part-time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 22 final sampled resident (Resident 8) was free from the significant medication errors. This failure placed Resident 8 at risk for medical complications. Findings: Medical record review for Resident 8 was initiated on 6/11/24. Resident 8 was admitted to the facility on [DATE], with diagnoses including essential (primary) hypertension and heart failure (unspecified). Review of Resident 8's Nursing Documentation Evaluation dated 6/10/24, showed weakness to both upper extremities in the musculoskeletal system review. Review of Resident 8's Order Summary Report as of: 6/11/24, showed the following orders: - amlodipine besylate (antihypertensive, medication to control blood pressure) oral tablet 5 mg one tablet daily - hydralazine hcl (antihypertensive) oral tablet 25 mg one tablet enterally two times a day - lisinopril (antihypertensive) oral tablet 20 mg enterally one time a day - enulose (laxative, medication to treat constipation) solution 10 gm/15 ml give 30 ml one time a day - magnesium oxide (supplement for bowel management) 400 oral packet 1 tablet enterally one time a day During the medication administration observation on 6/11/24 at 0914 hours, the above medications were not available for administration: amlodipine besylate, hydralazine hydrochloride, lisinopril, Enulose solution, and magnesium oxide. On 6/11/24 at 1215 hours, an interview was conducted with the DON. The DON stated Resident 8's medications were in the bed hold medication storage. On 6/11/24 at 1220 hours, an interview was conducted with LVN 3. LVN 3 showed Resident 8's bubble packed medications from the bed hold medication storage: lisinopril, amlodipine, hydralazine, and the enulose bottle. LVN 3 stated the magnesium oxide packet was not available. LVN 3 verified she had not given the prescribed medications to the resident that were identified earlier as not available. Cross reference to F759.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, medical record review, facility P&P review, the facility failed to ensure the medications were labeled and stored safely, securely, and properly. * The facility failed to ensure the medications were stored and labeled properly. * The facility failed to ensure the discontinued medications were removed from the medication cart. * The facility failed to ensure the oral medications were stored separate from externally used medications. These failures had the potential for medication errors. Findings: 1. Review of the facility's P&P titled Administering Medications revised ,d+[DATE] showed the individual administering the medications checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On [DATE] at 1449 hours, the treatment cart inspection was conducted with LVN 9. A triamcinolone acetonide cream 0.1% for Resident 85 did not have a clear label. LVN 9 stated she tried to save the label by putting a tape around it and acknowledged she would not be able to verify the information needed from the cream and the cream would be reordered from the pharmacy. 2. Review of the facility's P&P titled Disposal of Medications and Medication Related Supplies IE3: Discontinued Medications dated ,d+[DATE], showed if a medication expires, discontinued by a prescriber, the medications are marked as discontinued or stored in a separate location and later destroyed. a. On [DATE] at 1110 hours, the shared medication room for Stations 2 and 3 was inspected with LVN 4. The refrigerator contained pantoprazole (medication to treat acid reflux) 2 mg/ml date with an open date of [DATE], and an expiration date of [DATE], for Resident 79. LVN 4 verified the pantoprazole had expired. b. Medical record review for Resident 80 was conducted on [DATE]. Resident 80 was admitted to the facility on [DATE], with diagnoses including osteomylitis (swelling of bone). Review of Resident 80's physician's order showed an order dated [DATE], to administer ceftriaxone sodium solution 2 gm intravenously one time a day for right foot osteomyelitis. The order was discontinued on [DATE]. Review of Resident 80's MAR showed ceftriaxone sodium solution 2 gm was last given on [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1436 hours, an inspection of the IV Cart and concurrent interview was conducted with RN 1. The cart contained one bag of ceftriaxone (antibiotic) 2 gm/ns 100 cc with the filled date of [DATE], for Resident 80. RN 1 stated this medication was already given to Resident 80 from the e-kit and it was an extra dose. 3. Review of the facility's P&P titled Medication Storage in the Facility dated ,d+[DATE] showed orally administered medications are kept separate from the externally used medications. On [DATE] at 1415 hours, an inspection of Medication Cart 3 in Station 2 was conducted with LVN 4. Fluticasone (medication used to treat sneezing and other nasal symptoms) nasal spray was stored with ipratropium bromide inhalation solution. LVN 4 acknowledged the incorrect storage of the nasal spray with the inhalation solution.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 48882 Based on observation, interview, and facility document review, the facility failed to ensure the oversight of food service operations when the facility did not employ a full-time qualified individual, defined as 35 hours per week, to manage and oversee food operation services for the skilled nursing facility. This failure had the potential to jeopardize the health and well-being of the 82 residents who received food prepared in the kitchen. Findings: Review of the facility's matrix showed 82 of 87 residents who consumed food prepared in the kitchen. According to the California Code, Health, and Safety Code - HSC S 1265.4: A licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. Review of the untitled facility document provided by the Administrator showed the DSS's scheduled facility assignments for May 2024. The document showed the DSS was scheduled at the facility on the following dates: 5/8, 5/9, 5/15, 5/22, 5/23, 5/29, and 5/30/24. On 6/11/24 at 1018 hours, an interview was conducted with the DSS. The DSS stated she was scheduled at the facility two to three times a week. The DSS stated the RD worked at the facility once a week, on Fridays; and the Dietary Manager worked full-time, five days a week. The DSS further stated the Dietary Manager was not certified. On 6/12/24 at 1153 hours, an interview was conducted with the Administrator. The Administrator confirmed the RD and DSS worked part-time, and the Dietary Manager was not certified. The Administrator stated it was his understanding the Dietary Manager, although not certified, could be overseen by a DSS. The Administrator was informed of the Health and Safety Code requirement that the facility must employ a full-time qualified individual to oversee the dietetic service operations. On 6/12/24 at 1640 hours, the Administrator provided the schedule calendar for the DSS for the month of May 2024. The Administrator verified the DSS was not at the facility on a full-time basis. On 6/13/24 at 1130 hours, the DON and Administrator were informed and acknowledged the above findings.

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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. 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen when: * The facility failed to properly monitor for Time/Temperature Control for Safety (TCS) foods (food that require time and temperature controls to limit the growth of illness causing bacteria) to ensure proper cool down process was followed, as per the facility's P&P. * The facility failed to ensure the refrigerated pasta salad was labeled with a prepared date and a use by date, as per the facility's P&P. * The facility failed to label and properly cover the thawing meat in the refrigerator. * The facility failed to ensure the food past the use-by date was discarded. * The facility failed to properly air-dry the kitchen equipment. * The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions. * The facility failed to ensure the kitchen utensils were in good condition. * The facility failed to ensure the cutting boards were kept in sanitary condition and with cleanable surfaces. * The facility failed to ensure the employee beverages were kept separate from food prepared for resident consumption in the cook's refrigerator. These failures had the potential to cause foodborne illnesses in a highly susceptible resident population of 82 facility residents who consumed food prepared in the kitchen. Findings: Review of the facility's matrix showed 82 of 87 residents consumed food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 3-501.14 Cooling, showed (A) Cooked time/temperature control for safety food shall be cooled: (1) within two hours from 135 degrees Fahrenheit (F) to 70 degrees F; and (2) within a total of six hours from 135 degrees F to 41 degrees F or less, (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna. Review of the facility's P&P titled Food: Preparation revised 2/2023 showed prepared hot food items that are not intended for immediate service will be cooled using the following guidelines: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Place in shallow pans or cut/slice to promote rapid cooling, - TCS foods will be cooled from 135 degrees F to 70 degrees F within two hours, - TCS foods will be cooled from 70 degrees F to 41 degrees F within four hours. - total cooling time cannot exceed six hours. The clock starts at 135 degrees F. Review of the Cool Down Log for May 2024 showed to document the date, food, start time and temperature, time and temperature after two hours, and time and temperature after six total hours; and to indicate if the item was cooled from 70 degrees F to 41 degrees F in four hours, and if any corrective actions were needed. Further review of the Cool Down Log for May 2024 showed on 5/16/24, for potato salad, cooling started at 1100 hours, at 140 degrees; at 1400 hours (three hours later), the temperature was 58 degrees F; at 1700 hours, the temperature was 39 degrees F. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, an observation of the Cooks' Refrigerator was conducted with the DM. A covered metal container containing pasta salad was observed. The container of the pasta salad was labeled garden salad with the date of 6/8/24. The DM verified this finding and stated she did not know if the date of 6/8/24, was the prepared date or use-by date. Review of the Cool Down Log for June 2024 failed to show evidence of the cool down process for the garden salad, labeled 6/8/24. The Cool Down Log for June 2024 failed to show an entry for the initial date, time, and temperature and final time and temperature for the garden salad. Further review of the Cool Down Log showed the following entries: - on 6/10/24, for egg salad, cooling was started at 140 degrees F with no time documented; the next entry showed the temperature was 58 degrees F with no time documented; and at 1600 hours, the temperature was 40 degrees F. - on 6/11/24, for potato salad, cooling was started at 140 degrees F with no time documented; the next entry showed 68 degrees F with no time documented; the last entry showed the temperature was 40 degrees F with no time documented. - on 6/11/24, for g. pasta salad, cooling was started at 140 degrees F with no time documented; the next entry showed 68 degrees F with no time documented; the last entry showed the temperature was 40 degrees F with no time documented. - on 6/11/24, for tomato salad, cooling was started at 50 degrees F with no time documented and the next entry showed 40 degrees F with no time documented. On 6/11/24 at 0904 hours, an interview and concurrent review of the Cool Down Log for June 2024 was conducted with the DM. The DM verified the garden salad, labeled 6/8/24, in the Cook's Refrigerator, was not on the cool down log. The DM stated the garden salad should have been on the cooling log to monitor when it reached a certain temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 1545 hours, an interview was conducted with [NAME] 3. When asked how she prepared pasta salad, [NAME] 3 stated she boiled the pasta then drained the pasta water when the pasta was cooked. [NAME] 3 stated she then took the temperature of the pasta and put the cooked pasta in the refrigerator to cool. [NAME] 3 then stated she checked the temperature of the pasta after two hours. [NAME] 3 stated she put the pasta back in the refrigerator to cool; and after six hours, the temperature should be less than 40 degrees F. When asked where she documented the temperatures for the cool down process, [NAME] 3 stated she documented on the cooling log. Concurrent review of the Cool Down Log for June 2024 was conducted with [NAME] 3. [NAME] 3 stated she was responsible for the cool down for the items documented on the Cool Down Log. [NAME] 3 verified the above findings. [NAME] 3 stated she only recorded the temperatures on the cool down log and did not document the time. [NAME] 3 verified the Cool Down Log showed to document the time and temperature. 2. Review of the facility's P&P titled Food: Preparation revised 2/23 showed all refrigerated, ready to eat TCS prepared foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a prepared date and a use-by date. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, an observation of the Cooks' Refrigerator was conducted with the DM. A covered metal container containing pasta salad was observed. The container of the pasta salad was labeled garden salad with the date of 6/8/24. The DM verified the finding and stated she did not know if the date of 6/8/24, was the prepared date or use-by date and the pasta salad should have been discarded. 3. According to Food Code 2022, 3-501.13, Thawing, showed freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/ or produce toxins. Review of the facility's P&P titled Food: Preparation revised 2/2023 showed dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. The cook thaws frozen items that require defrosting prior to preparation using one of the following methods: thawing in the refrigerator, in a drip-proof container, and in a manner that prevents cross-contamination. Review of the P&P titled Receiving, revised 2/2023 showed all food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, an observation of the walk-in refrigerator was conducted with the DM. A steam pan containing raw chicken and covered with clear plastic wrap was observed. The plastic wrap was observed not fully covering the steam pan, with an opening exposed at one corner. The raw chicken was not labeled with the type of meat, date it entered the refrigerator, or a use-by date. When asked about the thawing process, the DM stated items that are put in the refrigerator for thawing should be covered and labeled with the date it was taken out of the freezer and entered the refrigerator. The DM verified the chicken was not labeled with a date and was not completely covered. On 6/11/24 at 0915 hours, an interview was conducted with [NAME] 1. [NAME] 1 was asked about the facility's thawing process. [NAME] 1 stated frozen meat are pulled from the freezer and put on the bottom shelf in the refrigerator. The frozen meat was labeled with the date it entered the refrigerator and was good in the refrigerator for three days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, an observation of the Cooks' Refrigerator was conducted with the DM. A container of diced red peppers labeled pimienton 6/2/24, use by 6/8/24 was observed. The DM verified the finding and stated the item should be discarded. 5. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air- Drying Required showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. Review of the facility P&P titled Warewashing, revised 2/2023 showed all dishware, serviceware, and utensils will be cleaned and sanitized after each use. All dishware will be air dried and properly stored. a. On 6/11/24 at 0807 hours, an observation of Dietary Aide (DA) 1 was conducted. DA 1 was observed unloading the dishwashing machine and removed a clear plastic bin. DA 1 was observed stacking the clear plastic bin upside down, on top of a stack of two clear plastic bins. On 6/11/24 at 0815 hours, DA 1 was observed taking the stack of three- clear plastic bins to store under the cabinet with other plastic bins. The clear plastic bins were observed still wet with water. On 6/11/24 at 0830 hours, an interview and concurrent observation was conducted with the DM. The DM stated the dietary aides are responsible for checking the items after the wash to ensure items are dry. If items are dry, then the dietary aide would move the dry items to the storage areas. Concurrent observation of the three clear plastic bins stacked upside down was conducted with the DM. The DM verified the three clear plastic bins were still wet. The DM stated the bins should have been washed and completely air dried prior to storage. The DM stated if items were stored wet, there may be potential risks of bacterial growth. b. On 6/11/24 at 1135 hours, during the puree preparation observation, [NAME] 2 was observed handing [NAME] 1 a wet rubber spatula. [NAME] 1 was then observed using the wet spatula to stir the beef in the blender. On 6/11/24 at 1138 hours, an interview was conducted with [NAME] 2. [NAME] 2 verified the rubber spatula she handed to [NAME] 1 was still wet. 6. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surfaces, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Non-Contact Surfaces, the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insect, rodents, and other pests. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Food: Preparation, revised 2/2023 showed all utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use. Review of the facility's P&P titled Equipment, revised 9/2017 showed all food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be clean and free of debris. Review of the facility P&P titled Warewashing, revised 2/2023 showed all dishware, serviceware, and utensils will be cleaned and sanitized after each use. The dining services staff will be knowledgeable in the proper technique in processing dirty dishware through the dish machine, and proper handling of sanitized dishware. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, a concurrent interview and observation was conducted with the DM. The following were observed: - dirty metal spatula with brownish stain; - three dirty scoopers containing food particles; - two steam pans storing clean cooking utensils were observed with food particles at the bottom of the pans; - the blender was observed with dry food particles on the inner wall; - the base of the blender blade was observed with blackish-brown residue; and - the bottom metal panel (where plates were stacked on) of the heated plate dispenser was observed with brownish stain and the bottom inner compartment of the plate dispenser was observed with black particles. The DM verified the above findings. The DM stated cooking utensils should be stored clean and the plate dispenser should be cleaned. 7. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, a concurrent interview and observation was conducted with the DM. The following were observed: - three portion servers with melted handles; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a purple scooper, observed chipped with multiple scratches on the handle; and - a can opener stored in the stand, observed with chipped stainless-steel coating, exposing the blade. The DM verified the above findings and stated the items should be replaced. 8. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. According to the 2022 FDA Food Code Section 4-202.11, multi-use food contact surfaces shall be smooth; free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; free of sharp internal angles, corners, and crevices; and finished to have smooth welds and joints. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, a concurrent interview and observation was conducted with the DM. Two green cutting boards were observed heavily marred and discolored. The DM verified the finding and stated the cutting boards should be replaced. The DM further stated cutting boards should be replaced as needed to prevent cross contamination. 9. On 6/10/24 at 0800 hours, during the initial tour of the kitchen, an observation of the cooks' refrigerator was conducted with the DM. A white bottle of caramel flavored coffee creamer and a bottle of pure leaf black tea were observed in the refrigerator with food used for resident consumption. The DM verified the above findings and stated the cook's fridge should only be used to store items for residents' consumption. The DM further stated the beverages were not for the residents and belonged to kitchen staff. On 6/13/24 at 1130 hours, the DM, DSS, DON and Administrator were informed and acknowledged all of the above findings.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 48882 Based on observation, interview, and facility P&P review, the facility failed to ensure two of four garbage dumpsters with lids were properly closed. This failure had the potential to attract pests/rodents that carry diseases. Findings: According to USDA Food Code 2022, Section 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (b) with tight-fitting lids or doors if kept outside the food establishment. Review of the facility's P&P titled Food-Related Garbage and Refuse Disposal (undated) showed all garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. On 6/10/24 at 0730 hours, an observation of the garbage disposal was conducted. One of four dumpster lid (Dumpster 1) was observed not completely covering the dumpster bin. On 6/10/24 at 1430 hours, a subsequent observation of the garbage disposal was conducted. Trash from inside Dumpster 1 was observed above the maximum loading level, and above the level of the dumpster bin. The dumpster lid (left side of the lid) was observed partially open and propped open by garbage inside Dumpster 1, preventing the lid from fully closing. On 6/11/24 at 0930 hours, an interview and concurrent observation of the dumpster was conducted with the Housekeeping Supervisor. The Housekeeping Supervisor stated dumpster lids should be closed to cover the trash inside the dumpster, to prevent animals/rodents from getting in. Concurrent observation of the dumper bins were conducted with the Housekeeping Supervisor. The Housekeeping Supervisor verified two of four dumper lids were not completely covering the dumpsters. The Housekeeping Supervisor stated he had informed the Maintenance Director on 6/10/24. On 6/11/24 at 1000 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated he was informed on 6/10/24, that two of four dumpster lids were not completely covering the dumpster bins. The Maintenance Director stated he had fixed the dumper lids on 6/10/24. Concurrent observation of the dumpster was conducted with the Maintenance Director. The Maintenance Director verified the lids of two dumpsters did not completely cover the dumpster bins and stated the lids should completely cover the dumpster bins with no openings. When asked, the Maintenance Director stated he had not contacted the dumpster company regarding a new lid. On 6/13/24 at 1130 hours, the DON and Administrator were informed and acknowledged the above findings.

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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** 50787 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to establish and maintain the infection control program and practices designed to help prevent the development and transmission of diseases and infections as evidenced by: * The facility failed to ensure the EBP (Enhanced Barrier Precautions) was practiced for Resident 71. * The facility failed to ensure hand hygiene was performed after adjusting the resident's bed control using a gloved hand and proceeding to perform care for Resident 8. * The licensed nurse failed to ensure a contaminated equipment was not disinfected prior to use on Resident 793. * The facility failed to ensure infection control was maintained in the laundry room. * The facility failed to ensure the staff and visitors followed the contact precautions before entering Resident 93's room. * The facility failed to ensure the trash can containing soiled PPE was closed and not overflowing. * The facility failed to show consistent and accurate documentation of its testing protocols for Legionella and other opportunistic pathogens in building water systems. * The facility failed to ensure CNA 1 wore appropriate PPE when assisting Resident 78 with transferring and toileting. Resident 78 was on enhanced barrier precautions. These failures had the potential risk for transmission of communicable diseases or organisms to residents in the facility. Findings: Review of the facility's P&P titled Enhanced Standard/ Barrier Precautions, undated, showed top wear gowns and gloves while performing the following tasks associated with the greatest risk for MDRO contamination of HCP hands, clothes and the environment: Any care activity where close contact with the resident is expected to occur such as bathing, peri- care, providing assistance with personal hygiene, assisting with toileting, changing incontinence briefs, respiratory care, wound care, etc. 1. On 6/10/24 at 0936 hours, CNA 8 was observed assisting Resident 71 in the bathroom. CNA 8 had gloves on and walked the resident back to her bed. CNA 8 was not wearing a gown. There was an Enhanced Standard Precautions sign posted outside the resident's door. CNA 8 stated she was assisting the resident in the bathroom and acknowledged she should have put a gown on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/24 at 0751 hours, an interview was conducted with the IP. The IP stated Resident 71 had a nephrostomy bag with a physician's order of EBP and the requirements included wearing a gown and gloves when performing care. The IP acknowledged CNA 8 should have worn a gown. 2. Review of the facility's P&P titled Handwashing/ Hand Hygiene revised 8/2019 showed: all personnel shall follow the hand washing/hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. Wash hands with soap and water for the following situations including after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. On 6/11/24 at 0934 hours, LVN 3 went inside Resident 8's room and put on gown and gloves, adjusted the resident's bed using bed remote control with her gloved hand, and proceeded to lift the resident's gown with the same gloves on. LVN 3 held the resident's hand and started to do palpation/abdominal assessment. On 6/11/24 at 0958 hours, during an interview with LVN 3, LVN 3 acknowledged she should have changed her gloves after touching Resident 8's bed control. When asked why she did not change her gloves, LVN 3 stated maybe she just got nervous. 3. Review of the facility's P&P titled Infection Prevention and Control revised 12/2023 showed the objectives of the infection prevention and control policies and procedures as follows: to maintain a safe, sanitary and comfortable environment for personnel, residents, visitors and the general public and provide evidenced based guidelines for infection prevention and control based on current best practices. On 6/11/24 at 0812 hours, a medication pass observation was conducted with LVN 2. LVN 2 picked the stethoscope from the medication cart and stethoscope fell to the floor. LVN 2 did not disinfect the stethoscope and instead placed it around her shoulder. LVN 2 went inside the Resident 793 room to check the resident's blood pressure. On 6/11/24 at 1438 hours, an interview was conducted with LVN 2. LVN 2 verified the stethoscope was on the floor and when she picked it up, she did not clean or disinfect prior to using it on Resident 793. 47474 4. Review of the facility's P&P titled Description of Steps in the Laundry Process revised 6/2016, showed soiled linen containers or barrels should be on each nursing unit stored in a soiled area so that nursing can deposit soiled linen. These containers should be checked at regular intervals to keep the soiled linen from over-flowing, which may cause odor and infection control problems. The P&P further showed it is very important to properly transport and store soiled linens to prevent the spread of infection. Laundry workers must always wear the proper personal protective equipment when handling soiled linen. On 6/12/24 at 1429 hours, a concurrent observation and interview was conducted with the Laundry Supervisor. The following was observed in the laundry room: - Three dirty barrels were overflowing with dirty linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Laundry Aide 1 did not don gown when handling the dirty barrels. - Laundry Aide 1 did not maintain infection control when the clean linens being transported were touching his shirt. - Laundry Aide 1 name badge stored on top of the clean linens. - Clean towels and linens were leaning against the walls. - Walls with gray dust particles. - One box of resident hangers was on the floor. The Laundry Supervisor verified the above findings and acknowledged infection control was not maintained. The Laundry Supervisor stated he expected his laundry staff to don a gown when handling dirty barrels, not to have personal belongings on top of the clean linens, and to carry clean linen away from their body. The Laundry Supervisor further stated the dirty barrels needed to be properly covered, items must be off the floor, and clean linens should not store against the walls. Moreover, the Laundry Supervisor stated the walls should be cleaned to ensure infection control was maintained. On 6/13/24 at 1131 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 48853 5. Review of the facility's P&P titled Isolation - Categories of Transmission-Based Precautions revised September 2022, showed under the section for Contact Precautions, the staff and visitors will wear gloves upon entering the room. The staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room. Medical record review for Resident 93 was initiated on 6/10/24. Review of Resident 93's H&P examination dated 6/3/24 showed the resident had capacity to understand and make decisions. Review of Resident 93's Physician Order Summary Report as of 6/10/24, showed a physician's order for Isolation Precautions for ESBL of urine. Review of Resident 93's care plan addressing ESBL UTI initiated on 6/4/24, showed an intervention for contact precautions. On 6/10/24 at 0900 hours, the Contact Precautions sign was observed posted outside of room [ROOM NUMBER], alerting anyone entering the room to perform hand hygiene and don gloves, and gown prior to entering the room. An over the door caddy containing gloves and gowns was observed hanging on the door. Resident 93's responsible party was sitting by the resident's bedside inside room [ROOM NUMBER] not wearing gown and gloves. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/24 at 0901 hours, Resident 93's responsible party went out of room [ROOM NUMBER] to the hallway. On 6/10/24 at 0904 hours, Resident 93's responsible party went back to room [ROOM NUMBER] without performing hand hygiene and did not wear gloves and disposable gown. On 6/10/24 at 0905 hours, an interview was conducted with CNA 9. CNA 9 verified Resident's 93 was on contact isolation precaution. CNA 9 verified a visitor was inside room [ROOM NUMBER] not wearing gloves and gown. On 6/10/24 at 0907 hours, the Activity Assistant entered room [ROOM NUMBER] without wearing gloves and gown to visit the resident. On 6/10/24 at 0915 hours, an interview was conducted with the Activity Assistant. The Activity Assistant verified she failed to wear gloves and gown before entering room [ROOM NUMBER]. The Activity Assistant verified room [ROOM NUMBER] had signage for Contact Precaution, and stated she did not notice as the sign was in a different color. On 6/10/24 at 0920 hours, an interview was conducted with the IP. The IP verified Resident 93 was on contact precautions. The IP stated anyone coming in the resident's room should practice hand hygiene and wear gloves and gown. 6. On 6/10/24 at 0945 hours, the Contact Precautions sign was observed posted outside of room [ROOM NUMBER], alerting anyone entering the room to perform hand hygiene and don gloves, and gown prior to entering the room. An over the door caddy containing gloves and gowns was observed hanging on the door. The trash can prior to exiting room [ROOM NUMBER] was observed overflowing with soiled PPE and open. On 6/10/24 at 0945 hours, the MDS Coordinator verified Resident 93 was on contact precautions and the trash can in the room was overflowing with soiled PPE and open. 7. According to the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's Water Management Program, undated, showed Section IV for control measures and monitoring for daily water temperature reading. The facility failed to show consistent and accurate documentation of its testing protocols for Legionella and other opportunistic pathogens in the building water systems. On 6/13/24 at 0815 hours, an interview and concurrent facility record review was conducted with the Maintenance Director. The Maintenance Director verified the above findings. (continued on next page)

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	056076	A. Building B. Wing	06/13/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/24 at 1023 hours, an interview was conducted with the Administrator. The Administrator verified the above findings. 48882 8. Medical record review for Resident 78 was initiated on 6/10/24. Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's H&P examination dated 3/14/24, showed Resident 78 had the capacity to understand and make decisions. Review of Resident 78's Order Summary Report showed the following physician's orders: - dated 6/10/24, for an indwelling urinary catheter 16 Fr with 30 cc balloon to drainage bag for obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), - dated 6/12/24, for Enhanced Barrier Precautions every shift for an indwelling urinary catheter and history of ESBL (bacteria that produces enzymes called extended-spectrum beta-lactamase which is resistant to many types of antibiotics). Review of Resident 78's plan of care showed a care plan problem dated 4/8/24, addressing Resident 78's risk for MDRO colonization/infection due to Resident 78's indwelling device and actual colonization/infection with MDRO ESBL. Interventions showed to implement enhanced barrier precautions: to use gown and gloves when performing high-contact activities: dressing, bathing and showering, transferring, and changing briefs or assisting with toileting. On 6/12/24 at 0838 hours an observation was conducted outside of Resident 78's room. A sign posted outside or Resident 78's room showed Enhanced Barrier Precautions: everyone must clean their hands before entering and leaving the room. Providers and staff must also wear gloves and gown for following high contact Resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. On 6/12/24 at 1620 hours, CNA 1 was observed inside Resident 78's room assisting Resident 78 to the toilet. CNA 1 was observed wearing gloves and was not wearing a gown. CNA 1 stated Resident 78 was currently on the toilet. On 6/12/24 at 1625 hours, Resident 78 was standing over the restroom sink. CNA 1 was observed putting a diaper on Resident 78. Resident 78's catheter tubing and drainage bag was observed. On 6/12/24 at 1630 hours, an interview and concurrent observation was conducted with the DSD. The DSD verified CNA 1 was not wearing a gown. The DSD stated, per the Enhanced Barrier Precaution sign on the wall, the staff are expected to don gloves and gown when assisting the residents with transfers and toileting to prevent/minimize the spread of organisms. On 6/12/24 at 1632 hours, an interview was conducted with CNA 1. CNA 1 verified she assisted Resident 78 to transfer out of bed and to the restroom, to put on his diaper, and transfer back to bed. CNA 1 verified she did not don a gown and stated she should have worn a gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/24 at 1054 hours, an interview was conducted with the DON. The DON stated Enhanced Standard Precautions was implemented to protect the residents, visitors and staff from the transmission of multi drug resistant organism. The DON stated she expected the staff to don PPE when going into resident rooms to provide care and when assisting the residents with transfers. On 6/13/24 at 1130 hours, the DON and Administrator were informed and acknowledged the above findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 46787 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the antibiotics were prescribed and administered to the residents under the guidance of their antibiotic stewardship program. * The facility failed to monitor and address the use of antibiotics when the resident's condition did not meet the McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) for six nonsampled residents (Residents 38, 63, 71, 593, 594, and 595). * The facility failed to ensure their antibiotic surveillance tracking forms included outcome and adverse events during the months of January 2024 through May 2024. These failures had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria. Findings: According to the CDC's guidances, an estimated 70% of nursing home residents receive one or more courses of antibiotics during a year. Studies have shown that 40% to 75% of the antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Frail and older adults are at significant risk of harm from antibiotic overuse including increased adverse drug events, increased drug interactions and infection with antibiotic-resistant organisms. The World Health Organization (WHO) cites antibiotic resistance as one of the three biggest threats to human health. Review of the facility's P&P titled Antibiotic Stewardship dated 9/18/23, showed antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. All clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. At the conclusion of the review, the provider will be notified of the findings. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: . outcome and adverse events. On 6/12/24 at 1102 hours, a concurrent interview, medical record review, and facility document review was conducted with the IP. The IP stated within her role as the facility's infection preventionist, she was responsible for the oversight of the facility's antibiotic stewardship program. The IP stated a component of the facility's antibiotic stewardship program consisted of conducting a review of residents prescribed antibiotics and determining whether those residents had met McGeer's criteria of a true infection. The IP stated when a resident was prescribed antibiotics and failed to meet McGeer's criteria, the resident's physician would then be notified the resident had not met McGeer's criteria. The IP stated the rationale for notifying the physician when a resident was prescribed antibiotics had not met McGeer's criteria, was to provide the physician with the opportunity to discontinue unnecessary antibiotics. The IP stated the unnecessary use of antibiotics was associated with resident adverse events and the development of MDROs. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's monthly Infection Prevention and Control Surveillance Logs for January 2024 through May 2024 was conducted with the IP and showed the following residents were prescribed antibiotics: -Resident 593 (January 2024) -Resident 63 (January 2024) -Resident 38 (January 2024) -Resident 594 (March 2024) -Resident 71 (March 2024) -Resident 595 (March 2024) a. Review of the facility's Antibiotic Surveillance Data Collection forms (which contained the McGeer's criteria) for Residents 38 and 595 was conducted with the IP. The IP verified Residents 38 and 595 were prescribed antibiotics; however, they did not meet McGeer's criteria for a true infection. Further review of Residents 38 and 595's medical records failed to show documented evidence the residents' physicians were notified that these residents did not meet the McGeer's criteria (thus potentially preventing the physicians from discontinuing the antibiotics for these residents). Review of Residents 63, 71, 593, and 594's medical records was conducted with the IP. The IP verified Residents 63, 71, 593, and 594 were prescribed antibiotics; however, antibiotic surveillance information was not collected. b. Further review of the facility's monthly Infection Prevention and Control Surveillance Logs failed to show documented evidence of outcomes and any adverse events from antibiotic use for January 2024 through May 2024. The IP verified and acknowledged the above findings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer and provide education for COVID-19, influenza, and pneumococcal immunizations for three of 22 final sampled residents (Resident 2, 15, and 75). * The facility failed to provide education and offer the COVID-19 and influenza immunizations to Resident 75. * The facility failed to offer and provide education for PCV 15/20 (PCV 15 protects against two additional serotypes and PCV 20 protects against seven additional serotypes involved in cases of invasive pneumococcal disease (IPD) and pneumonia) for Residents 2, 15, and 75. These failures increased the risk for residents to be inadequately vaccinated for COVID-19, influenza, and pneumococcal disease and not be informed of its associated complications. Findings: Review of the new CDC guidelines titled Morbidity and Mortality Weekly Report (MMWR) dated 1/28/22, for the use of 15-Valent Pneumococcal Conjugate Vaccine (PCV15) and 20-Valent Pneumococcal Conjugate Vaccine (PCV20) among U.S. Adults: Updated Recommendations of the Advisory Committee on Immunization Practices (APIC) in the United States as of 2022 showed the ACIP recommended PCV15 or PCV20 for adults who are either aged [AGE] years and older or aged 19-[AGE] years with certain underlying conditions. When PCV15 is used, it should be followed by a dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23), typically one year later. The previous CDC's Pneumococcal Vaccine guidelines, prior to 1/2022 update, showed the recommendations for pneumococcal vaccination (PCV13 or Prevnar13(R), and PPSV23 or Pneumovax23(R)) for all adults [AGE] years or older. For adults [AGE] years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23. Review of the CDC's guidelines for Pneumococcal Vaccination reviewed 9/22/23, showed the following: - for adults [AGE] years or older who had never received any pneumococcal vaccine regardless of risk conditions, give one dose of PCV 15 or PCV 20 (PCV 15 protects against two additional serotypes and PCV 20 protects against seven additional serotypes involved in cases of invasive pneumococcal disease (IPD) and pneumonia). When PCV 15 is used, it should be followed by a dose of PPSV 23 (pneumococcal polysaccharide vaccine, use for protected adults and children older than 2 years of age against invasive disease caused by the 23 capsular serotypes contained in the vaccine) at least one year later. The minimum interval (eight weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete. When PCV 20 is used, it does not need to be followed by a dose of PPSV 23. Their vaccines are then completed. For adults [AGE] years or older who had only received PPSV 23 regardless of risk condition, give one dose of PCV 15 or PCV 20 at least one year after the most recent PPSV 23 vaccination. Regardless of vaccine given, an additional dose of PPSV 23 is not recommended since they already received it. Their vaccines are then completed. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Coronavirus Disease (COVID-19) Vaccination of Residents revised June 2022 showed each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. The resident's medical record includes documentation that indicates, at a minimum, the following: that the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine, including: samples of the educational materials used, the date the education took place, and the name of the individual who received the education. Review of the facility's P&P titled Influenza Vaccine revised March 2022 showed all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents. Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's medical record. Review of the facility's P&P titled Pneumococcal Vaccine revised October 2023 showed all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 1. Medical record review for Resident 75 was initiated on 6/10/24. Resident 75 was admitted to the facility on [DATE], and readmitted on [DATE]. Further review of Resident 75's medical record failed to show documented evidence Resident 75 was offered the COVID-19 and influenza immunizations or provided with education regarding the benefits and potential risks associated with COVID-19 and influenza vaccine, including: samples of the educational materials used, the date the education took place, and the name of the individual who received the education. 2. Review of Residents 2, 15, and 75's Pneumococcal Immunization Records were conducted on 6/10/24. a. Medical record review for Resident 2 was initiated on 6/10/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's Pneumococcal Vaccine Informed Consent form (undated) failed to show Resident 2 was offered or provided education for the PCV 15 or PCV20 vaccines as per the CDC's guidelines. b. Medical record review for Resident 15 was initiated on 6/10/24. Resident 15 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 15's Pneumococcal Vaccine Informed Consent dated 4/20/24, showed blank entries under the following sections: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- PCV 15 or PCV20 vaccine history - Information provided to patient/representative and questions answered - Potential side effects - Benefits and risks of vaccine - Reason for declination Further review of Resident 15's medical record failed to show documented evidence PCV 15 or PCV20 was given or offered. c. Medical record review for Resident 75 was initiated on 6/10/24. Resident 75 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 75's Order Summary Report dated 6/11/24, showed a physician's order dated 6/4/24, may have Prevnar 20 (PCV20) for prophylaxis. Review of Resident 75's Immunization Record showed Resident 75 received the PCV 20 vaccine at the facility on 6/5/24. However, review of Resident 75's Pneumococcal Vaccine Informed Consent form dated 6/4/24, showed the following sections were left blank: - PCV 15 or PCV20 vaccine history - Information provided to patient/representative and questions answered - Potential side effects - Benefits and risks of vaccine On 6/12/24 at 0948 hours, a concurrent interview and resident medical record review was conducted with the Infection Preventionist. The IP stated within her role as the facility's infection preventionist, she was responsible for the immunizations of the residents. The IP verified and acknowledged the above findings.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 46787 Based on interview, facility document review, and facility P&P review, the facility failed to maintain the documentation if the staff received the COVID-19 vaccinations, were provided the education regarding the benefits and risks of COVID-19 vaccines, and were offered to receive the COVID-19 vaccine. This failure placed the staff and residents at risk of COVID-19. Findings: Review of the facility's P&P titled Coronavirus Disease (COVID-19) Vaccination of Staff revised June 2022 showed all staff are required to be fully vaccinated for COVID-19. Under the section for Documentation and Reporting showed the Infection Preventionist maintains a tracking worksheet of staff members and their vaccination status. The tracking worksheet provides the most current vaccination status of all staff who provide any care, treatment, or other services for the facility and/or its residents. The worksheet includes: staff name (and/or employee ID), initial start of employment or service, termination of employment or service, job title, work area, brief description of how they interact with residents, and vaccination status. On 6/12/24 at 0948 hours, a concurrent interview and facility document review was conducted with the IP. The IP stated within her role as the facility's infection preventionist, she was responsible for the tracking of the facility staff's vaccination status for COVID-19. The IP stated the facility staff vaccination status was tracked on a worksheet. However, review of the facility's document titled Staff 2023-2024 Vaccination failed to show the COVID-19 vaccination status worksheet to track all working staff members was complete. The tracking sheet had multiple missing information regarding the staff COVID-19 vaccination status. The IP verified and acknowledged the findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 48882 Based on observation, interview, equipment instruction manual review, and facility P&P review, the facility failed to maintain the essential equipment in safe operating condition. * The facility failed to ensure the ice machine was cleaned and sanitized according to the manufacturer's specification. This failure had the potential for the equipment to not function in the way it was intended, which could cause food-borne illnesses for the residents. Findings: Review of the facility's Matrix showed 83 of 87 residents who consumed food prepared in the kitchen. According to USDA Food Code 2022, Section 4-501.11, Good Repair and Proper Adjustment, showed the proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. Review of the facility's P&P titled Equipment revised 9/2017 showed all food service equipment will be clean, sanitary, and in proper working condition. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. Review of the Scotsman Ice Systems Installation and User's Manual for Air and Water Cooled Modular Cuber Prodigy Elite Series Models MC0322 through MC1030 dated 6/2022, showed the ice system requires three types of maintenance: removed the build up of mineral scale from the ice machine's water system and sensors, sanitize the ice machine's water system and the ice storage bin or dispenser, and clean or replace the air filter and clean the air cooled condenser. Ice machines also require occasional cleaning of their water systems with a specifically designed chemical. This chemical dissolves mineral build up that forms during the ice making process. The User Manual's section for the Scale Removal, Cleaning Internal Parts, and Sanitizing showed the following: - pour the specified amount of Scotsman Clear 1 ice machine scale remover into the reservoir. The unit will circulate the scale remover, then drain and flush it. The Note indicated using chemicals or dilution ratios other than what is specified will damage the ice machine and significantly affect the performance and life of the ice machine. - to mix a cleaning solution of 6 ounces(oz) of Scotsman Clear 1 scale remover with 9 cups (72 oz) of 105 to 115 degrees F potable water, - in a separate bucket, mix a sanitizing solution of 1.6 oz of Nu-Calgon IMS Sanitizer with 1 gallon of 105 to 115 degree F potable water, (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- remove air filters (if applicable), water level sensor and housing, water distributor(s), curtain(s), ice thickness sensor, and splash panel for additional cleaning, - soak and scrub each part using the previously prepared solution of Scotsman Clear 1 scale remover and a nylon brush and then rinse with water, - soak and scrub each part using the previously prepared sanitizing solution. - pour the previously prepared sanitizing solution into the reservoir until it is full. The unit will circulate the sanitizer, then drain and flush it, and to removed all ice from storage bin or dispenser and sanitize bin or dispenser with remaining sanitizer solution while machine completes sanitizing cycle. On 6/11/24 at 0845 hours, an interview was conducted with the Maintenance Director regarding cleaning and sanitizing of the ice machine. The Maintenance Director stated he followed the manufacturer's guidelines to clean and sanitize the ice machine monthly. On 6/11/24 at 0911 hours, an interview and concurrent observation was conducted of the ice machine cleaner and sanitizer used by the Maintenance Director. The Maintenance Director stated he used Manitowoc Ice Machine Cleaner and Manitowoc Ice Machine Sanitizer to clean and sanitize the ice machine. On 6/12/24 at 0944 hours, an interview and concurrent review of the Scotsman Ice Systems Installation and User's Manual was conducted with the Maintenance Director. The Maintenance Director verified the instructions showed to use Scotsman Clear 1 Scale Remover to clean and de-scale, and Nu-calgon Sanitizer to sanitize the ice machine. The Maintenance Director further stated he had always used the Manitowoc Ice Machine Cleaner and Sanitizer. On 6/13/24 at 1130 hours, the DON and Administrator were informed and acknowledged the above findings.