STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Post-Acute	678 3rd Street Woodland, CA 95695

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 41838 Based on observation, interview, and record review, the facility failed to protect resident privacy when tray tickets were thrown into the trash for a census of 87 who were eating facility prepared meals This failure had the potential for 87 residents' personal and health information unprotected form unintended access. Findings: During the initial kitchen tour on 1/6/25 at 9:49 a.m., the Dietary Supervisor (DS) showed the path taken of kitchen trash to the outside dumpsters in the parking lot. The parking lot was not gated or secured from the public. During a return visit on 1/7/25 at 8:46 a.m., Diet Aide 1 (DA 1) was washing the breakfast dishes. She removed the trays from the cart, dumped leftover food and paper products (including at least 12 tray tickets) into the garbage can, before separating like items for wash. When questioned, DA 1 stated this was her usual process. During a subsequent interview on 1/7/25 at 8:58 a.m., with the DS, the DS stated the tray tickets should be placed in a bin (found in the dry storage) that collected paper for shredding. The DS further stated that this step was necessary as otherwise this would be a violation of HIPPA (Health Insurance Portability and Accountability Act, a federal law that sets a national standard to protect medical records and other personal health information). Review of tray tickets for 1/7/25 included the following information: name, ID number, dining location, unit/room/bed, diet order, food and beverage texture requirements, notes such as need for assistive devices and portion sizes, allergies, standing orders and dislikes. Review of facility provided policy titled Protected Health Information (PHI), Management and Protection of (Med-Pass Inc., Revised April 2014) indicated that Protected Health Information (PHI) shall not be used or disclosed except as permitted by current federal and state laws. In bullet 1 it further indicated that It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46995 Based on interview and record review, the facility failed to follow physician orders for one of 24 sampled residents (Resident 41) when Resident 41's medication to treat high blood sugars was not given as ordered by the physician. This failure had the potential for Resident 41 to have unmanaged blood sugars. Findings: Resident 41 readmitted to the facility late 2023 with diagnoses which included trouble controlling his blood sugars. During a review of Resident 41's Order Summary Report [OSR], order start date of 12/4/23, the OSR indicated, HumaLOG [fast acting insulin that is used to lower blood sugar] Inject as per sliding scale: if 70-150=NONE; 151-200=NONE; 201-250=1; 251-300=2 NOTIFY MD [medical doctor] if BS [blood sugar] is < [less than] 70 or > [greater than] 301, intramuscularly at bedtime . During a review of Resident 41's Medication Administration Record [MAR], dated 11/1/24-12/31/24, the MAR indicated Resident 41 had a BS of 340 on 11/3/24, a BS of 320 on 11/6/24 and a BS of 304 on 12/2/24. The MAR indicated Humalog was not administered on any of these dates with a corresponding code of No Insulin Required. During a review of Resident 41's progress notes, there were no documented physician notification for BS greater than 301 for 11/3/24, 11/6/24, or 12/2/24. During an interview on 1/8/25 at 9:44 a.m. with Licensed Nurse (LN 2), LN2 stated she would follow the physician orders for insulin administration. During a concurrent interview and record review on 1/8/25 at 3:02 p.m. with the Assistant Director of Nursing (ADON) of Resident 41's MAR, the ADON confirmed Humalog was not administered and the physician was not notified on three separate dates when Resident 41's BS was greater than 300. The ADON stated, You would expect to see a note . During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 2/12, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed . During a review of the facility's P&P titled, Insulin Administration, dated 9/14, the P&P indicated, To provide guidelines for the safe administration of insulin to residents with diabetes .The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies before giving the insulin .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46995 Based on observation, interview, and record review, the facility failed to identify and provide care for one of 24 sampled residents (Resident 1) when no wound care orders, monitoring, or care plans were created for Resident 1's left great toe wound. This failure placed Resident 1 at increased risk for wound deterioration and infection. Findings: Resident 1 was readmitted to the facility 12/13/24 with diagnoses which included hardening of left leg arteries, diabetes (a condition in which the body has trouble controlling blood sugar), vascular disease that occurs when diabetes damages blood vessels, reducing blood flow to organs, and gangrene (dead tissue caused by an infection or lack of blood flow). During a review of Resident 1's SKILLED NURSING FACILITY ADMISSION ORDERS dated 12/13/24, the orders indicated, Diagnosis .GANGRENE OF LEFT TOE .wound .Anterior Left Toe. During a review of Resident 1's ADMISSION NURSING ASSESSMENT, undated (uploaded into electronic record 12/17/24), the assessment indicated, Left Great Toe Meta [illegible] Joint Black Toe Nail (sic). During a review of Resident 1's Order Summary Report [OSR], dated 12/1/24-12/31/24, the OSR does not include any treatment orders or monitoring of Resident 1's left or right toes. During a review of Resident 1's skin integrity care plans (CP) dated 12/18/24, the CP's do not include any right or left foot toe wounds. During a review of Resident 1's Wound Physician Consultation Notes dated 12/17/24 and 12/30/24, the notes do not indicate any wound assessments or measurements to Resident 1's right or left foot. During an observation on 1/9/25 at 8:46 a.m. with Licensed Nurse (LN 5) of Resident 1's wound care, LN5 removed the blankets from Resident 1's legs which revealed his bare feet. The upper half of Resident 1's left foot great toe was dry, shriveled, and brown/black in color with a hard dry black protrusion exiting from the tip of toe. On the side of his toe was a dry black circle area surrounded by thick flakes of skin. The entire toe had orange discoloration over dry flakes of skin. During an interview on 1/9/25 at 9:02 a.m. with LN5, LN5 was asked what treatment was performed on Resident 1's left great toe. LN 5 reviewed the electronic health record and stated were no treatment orders for Resident 1's toe. During an interview on 1/9/25 at 9:08 a.m. with LN 6, LN 6 stated, I would expect to see treatment orders for his toes. I don't see any monitoring orders for his toes or treatments .I do not see any care plans for his feet . LN 6 stated it was important to have treatment orders for observe for signs and symptoms of infection or worsening of the wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 9:50 a.m. with the Nurse Consultant (NC), the NC stated, I would expect all wounds to be monitored and have a care plan .it is important to prevent patient decline and promote healing. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, dated 4/18, the P&P indicated, .The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions .The physician will order pertinent wound treatments .The physician will evaluate and document the progress of wound healing .The physician will guide the care plan as appropriate . During a review of the facility's P&P titled, Wound Care, dated 10/10, the P&P indicated, The purpose of this procedure is to provide guidelines for the car of wounds to promote healing .Verify that there is a physician's order for this procedure .Review the resident's care plan .The following information should be recorded in the residents medical record .All assessment data .obtained when inspecting the wound weekly .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49814 Based on observation, interview, and record review, the facility failed to implement wound prevention measures for one of 24 sampled residents (Resident 65) when Resident 65's heel foam protectors were not put on per physician order. This failure had the potential to worsen or complicate Resident 65's wound. Findings: Resident 65 was admitted to the facility in October of 2024 with diagnoses that included diabetes (disorder causing blood sugar to be high) and non-pressure open wound to heels. A review of Resident 65's, Wound Physician Consultation Note [WPCN], dated 12/30/24, indicated Resident 65 had a stage three pressure ulcer (damage to the skin from prolonged pressure ranging from stage one to stage four with four being the most severe) to his left heel and a stage two pressure ulcer to his right heel. The WPCN indicated there was no change in the wound status since the last visit. A review of Resident 65's Order Details (OD), dated 1/2/25, indicated, TX [treatment]- Apply foam booties [foam placed on heels to prevent wound or wound progression] as tolerated when in bed. Three times a day. A review of Resident 65's Care Plan (CP), dated 8/13/24, indicated, Risk for skin breakdown/pressure ulcer formation will be minimized with interventions through the next review date .Float heels when in bed. During an observation on 1/7/2025 at 8:08 a.m., in Resident 65's room, Resident 65 was lying in bed supine. Resident 65 did not have his foam heel protectors on. During a concurrent observation and interview on 1/7/25 at 9:56 a.m. with Licensed Nurse (LN) 3 who was the wound nurse in the Resident 65's room, LN 3 confirmed Resident 65 did not have his foam heel protectors on and were placed in the corner of the room. Resident 65 stated, I haven't worn those in a while. Resident 65 also indicated staff don't offer to put the foam heel protectors on for him. LN 3 indicated facility staff should be putting on the foam heel protectors and floating his heels. LN 3 indicated not doing so could cause Resident 65's wounds to worsen and prevent healing. During an observation on 1/8/25 at 3:06 p.m., outside Resident 65's room, Resident 65 was lying in bed without his heel protectors on and his heels were in contact with the bed surface. Between 3:06 p.m. and 3:55 p.m., CNA 4 entered Resident 65's room and did not encourage or offer to put on the heel protectors for Resident 65.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41838 Based on observation, interview, and record review the facility failed to maintain Resident 14's weight when resident 14 lost 14.5% of his body weight in a 6-month period. This failure had the potential of leading to malnutrition and increased mortality. Findings: During the initial dining observation on 1/7/25 at 12:04 p.m., in the dining room, resident 14 was observed eating his meal. Resident 14 was noted to eat independently but was easily distracted and needed to be redirected to eat twice. Resident 14 left the dining room with approximately 50% of his meal consumed. During an observation on 1/8/25 at 12:03 p.m. in the dining room, Resident 14 had finished eating his lunch meal having eaten most of the hamburger but no other tray items. During an observation on 01/09/25 at 11:48, in the dining room, Resident 14 ate 1 (4 ounce) ice cream container, drank 100% of an 8 ounce milk carton, and few bites of the pasta entree. During a review of resident 14's electronic record on 1/7/25 at 3:04 p.m., Resident 14 was noted to be [AGE] year-old male admitted to the facility in the early winter of 2012. Diagnosis for resident 14 included reflux, depression, dysphagia (difficulty swallowing), failure to thrive, anxiety disorder, and dementia (condition of impaired brain function). Orders for resident 14 included a regular diet, vitamins with minerals, a high calorie nutrition supplement (240 milliliters [8 ounces], offered three times per day). Weight history as follows: 1/2/24=144# (pounds) 2/1/24=143# 3/1/24=145# 4/29/24=136# 5/14/24=135# 6/4/24=133# 7/3/24=129# 8/2/24=127# (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/1/24=124# 10/1/24=126# 11/4/24=127# 12/4/24=127# 1/2/25=128# Resident had lost of 9#/6.2% of his body weight from 3/1/24 to 4/29/24 which is considered significant. Review of weight from 8/2/24 showed a decrease of 16#/11.2% of body weight from the previous 6 months. Review of weight from 9/1/24 showed a decrease of 21#/14.5% of body weight from the previous 6 months. Both 6-month losses were considered severe (being greater than 10% over 6 months). Review of Interdisciplinary Team (IDT) note from 4/4/24, after a 5# weight loss over a month, indicated that resident had a dislike of facility foods. Under the nutritional diagnosis it indicated that the resident had unintentional weight loss r/t (related to) unknown etiology . Review of IDT notes from on 6/14/24, 7/5/24, 8/23/24, 9/6/24, and 10/16/24 indicated that resident had Unintentional weight loss r/t inadequate energy intake . Review of Registered Dietitian note from 4/4/24 indicated an average intake of 66% for the previous 2 weeks. Review of nutrition assessment done on 12/4/24 indicated that Resident 14 had an average meal intake of 66%. Review of Dietary Profile notes from 10/22/24 indicated that Resident 14 had a poor appetite and meal intake was between 25-50% of meals. Review of Dietary Profile notes from 12/4/24 indicated that resident was eating an average of 66% of meals. Estimated caloric intake was between 1000-1499 calories per day, while estimated need was between 1730-1900 calories per day. Review of care plan from 9/16/24 included goals for Resident 14: 1) weight being between 145#-155#, and 2) consumption of 70% of meals. Interventions listed providing a fortified, mechanical soft diet, providing snacks, and addressing GERD (acid reflux) discomfort. During an interview on 1/8/25 at 9:18 a.m. with the Speech Therapist (ST), the ST stated that Resident 14 was on caseload in late October of 2024. This was to determine if Resident 14 could advance his diet as he had expressed unhappiness with soft foods. The ST further stated that the interdisciplinary team (of which she is a part of) had discussed Resident 14's weight loss in the past. The ST did not remember an identified reason for resident 14's weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 11:07 a.m., with the Registered Dietitian (RD, who had worked at the facility for 1 week), the RD discussed the process used to prevent weight loss in prior facilities of employment. The RD discussed working with the interdisciplinary team (often composed of representatives from nursing, dietary, therapy and social services, who then share concerns with the health care provider) to conduct a root cause analysis to identify the cause of the weight loss. The RD stated in most cases interventions may start with a food first approach such as updating the food preferences and adding snacks. The RD stated if that was not successful, she would consider adding supplemental nutrition, an appetite stimulant, and/or consider artificial nutrition. If these interventions didn't show progress the team would discuss end of life care. During a review of resident 14's electronic medical record with the RD, the RD concurred that Resident 14's weight decreased from 144# to 128# over the past year. The RD stated that Resident 14's intake had been variable, and the average was approximately 60%. The RD concurred that a cause for the weight loss had not been identified. During a phone interview with Resident 14's Medical Doctor (MD) on 1/9/25 at 1:50 p.m., stated I do not have a medical reason that is associated with his trend in weight loss. Review of facility provided policy titled Weight Monitoring and Management (company not listed, revised 2019) indicated that one of the purposes of the policy was To be able to provide appropriate interventions in a timely manner to residents with unplanned and significant weight variance. The policy further indicated under the procedures in bullet 8. indicated that Any resident weight that varies from the previous reporting period by 5% in 30 day, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of weight loss. Assessment of risk factors for weight change and intervention required.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50619 Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 87 residents when: 1. An unsealed e-kit (emergency supply kit) was found in the medication storage room, which resulted in prescription medications being at risk for diversion and use without a prescription. 2. An e-kit was previously accessed multiple times without medications being replaced by the pharmacy which had a potential to cause harm by not having enough emergency medication for the residents. These failures had the potential for drug diversion, medication errors, and not having medications readily available in emergency situations. Findings: 1. During the medication storage room observation on 1/6/25 at 12:05 p.m. in the first-floor medication storage room with Licensed Nurse (LN) 8, an IV (Intravenous, medications given through the veins) e-kit #368 was observed unlocked. Inside e-kit, there was a bag of yellow zip-ties in a bag sitting on top of multiple prescription medications and medical supplies. During an interview on 1/6/25 at 12:05 p.m. with LN 8 in the first-floor medication storage room, LN 8 stated that having an unlocked e-kit could result in medications being given to the wrong person or getting into the wrong hands. During an interview on 1/7/25 at 1:14 p.m. with CP (Consultant Pharmacist) in the conference room, CP, CP stated that all e-kits came sealed with red zip ties and should have been re-sealed after opening with yellow zip ties. During an interview on 1/8/25 at 10:48 a.m. with the Interim Director of Nursing (DON 1), DON 1 stated that the e-kits could not be accessed without pharmacy's approval and the e-kits should have been sealed after use. During a review of the facility policy titled Medication Ordering and Receiving from Pharmacy: IC5: Emergency Pharmacy Service and Emergency Kits, dated 8/14, the policy indicated, .An Emergency supply of medications including emergency drugs, antibiotics, controlled substances, and products for infusion is supplied by the provider pharmacy in limited quantities in portable, sealed containers .h. When an emergency or stat dose of a medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication .reseal the emergency supply .n. If exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening . 2. During a medication storage room observation on 1/6/25 at 12:05 p.m. in the first-floor medication room with LN 8, e-kit 1120 was observed to be previously accessed four times without medications being replaced by the pharmacy as follows: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/24/24: azithromycin (an antibiotic used to treat infections) 250 mg (milligram, a unit of measure), two tablets removed, 12/29/24: azithromycin 250 mg, one tablets removed, 1/2/25: ciprofloxcin (an antibiotic used to treat infections) 250 mg, two tablets removed, 1/4/25: metoprolol tartrate (a medication used to lower high blood pressure) 50 mg, 1 tablet removed. During an interview on 1/6/25 at 12:05 p.m. with LN 8 in the first-floor medication storage room, LN 8 stated that nurses did not fax for an e-kit refill and that they got a code from pharmacy to access e-kits, so pharmacy knew the e-kit was accessed when pharmacy gave out the code and knew to come and replaced the e-kits. During an interview on 1/7/25 at 1:14 p.m. with CP in the conference room, CP, CP stated that e-kits should have been replaced within 3 days and whoever opened the e-kit first should have contacted the pharmacy to replace by faxing in the e-kit refill sticker or calling pharmacy directly. CP confirmed that when pharmacy gave an access code, the access code did not alert pharmacy to replace the e-kit and that staff had to alert pharmacy separately from receiving an access code. During an interview on 1/8/25 at 10:48 a.m. with DON 1, DON 1 stated that it was the nurse's responsibility to fax the form indicating the e-kit was accessed and should have requested the e-kit to be filled within 72 hours of opening the e-kit. During a review of the facility policy titled Medication Ordering and Receiving from Pharmacy: IC5: Emergency Pharmacy Service and Emergency Kits, dated 08/14, the policy indicated, Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy .a. Telephone/fax numbers for emergency pharmacy service are posted at nursing stations .i. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the emergency drug supply .n. If exchanging kits, the used sealed kits are replaced with new sealed kits within 72 hours of opening.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50619 Based on observation, interview, and record review, the facility failed to ensure three of 87 sampled Residents (Resident 10, Resident 30 and Resident 25) were free from unnecessary antipsychotic medications (drugs that alter a person's thoughts, feelings, moods, awareness, and behaviors used to treat mental health conditions) when: 1. An Antipsychotic was prescribed for treatment of schizoaffective disorder (a condition that affects a person's ability to think, feel, and behave clearly with mood symptoms) in a dosage indicative for treatment of sleep disturbance without an FDA approved diagnosis for Resident 10. 2. An Antipsychotic was prescribed for Resident 30 with no previous documented serious mental health diagnosis prior to admission. 3. Resident 25 received an as needed antianxiety medication without a 14 day stop date. These failures placed Resident 10 and Resident 30 at an increased risk for adverse drug effects and Resident 25 for receiving psychotropic medication without proper evaluation. Findings: 1. Resident 10 was admitted to the facility in 01/2017 with diagnoses that included schizoaffective disorder and major depressive disorder (a mental health condition characterized by persistent sad mood or loss in interest in activities that causes significant impairment in daily life). Review of the MDS (Minimum Data Set, an assessment tool), dated 8/24, indicated the resident had severe cognitive impairment with a score of 7/15 in the Brief Interview for Mental Status Assessment (BIMS) (a tool used by facilities to screen and identify memory, orientation, and judgement status of the resident). Review of Resident 10's clinical records indicated that there were physician orders for the following medications to treat schizoaffective disorder: 4/2/24: divalproex sodium delayed release (a medication used to treat seizures or mental disorders) 250 mg (milligram, a unit of measure), 2 tablets by mouth two times a day for AEB (as evidenced by) Aggressive behaviors towards staff related to schizoaffective disorder. 11/12/24: quetiapine (antipsychotic medication) 25 mg, 1 tablet by mouth at bedtime for AEB Auditory hallucination related to schizoaffective disorder. 12/4/24: risperidone (antipsychotic medication) 2 mg, 1 tablet by mouth two times per day for AEB Auditory hallucinations related to schizoaffective disorder. (continued on next page)

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Woodland Post-Acute	678 3rd Street Woodland, CA 95695

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the online Food and Drug Administration (FDA) website, quetiapine is an antipsychotic that is not FDA approved to help with sleep. The initial dosage for treating schizophrenia or bipolar is 25-50 mg twice daily with recommended total dosage between 150mg-750 mg per day. According to the online medical reference site, FDA, divalproex sodium is not indicated for use for schizophrenia or schizoaffective disorder. According to the online medical reference site, FDA, risperidone is an antipsychotic approved to treat schizophrenia with target dose of 4-8mg daily. In a telephone interview on 1/9/24 at 11:00 a.m. with CP (Consultant Pharmacist), CP stated that 25mg of quetiapine was not FDA approved for treating shizoaffective disorder. CP also stated that divalproex Sodium 250 mg twice daily was being used off-label for schizoaffective disorder and confirmed divalproex sodium was not FDA approved for schizoaffective disorder. CP also indicated that if CP tells doctor a medication is used inappropriately, If I don't get a response, I cannot change it. CP also confirmed that there was no FDA indication for risperidone use with schizoaffective disorder and that it was being used for Resident 10 off-label. When requested from CP, supporting literature was not provided to support off-label use of divalproex sodium, risperidone, or using less than FDA approved dosing of 25mg of quetiapine for schizoaffective disorder. In an interview on 1/9/25 at 11:55 a.m. with Director of Nursing 1 (DON 1)in the DON office, DON 1 stated that quetiapine 25 mg is for sleep rather than treating a psychiatric disorder and divalproex sodium is not FDA approved for schizoaffective disorder. DON 1 stated that antipsychotics are not appropriate to use if no FDA approval or if no previous studies to indicate use and if prescribing for sleep, the order should say for sleep and not to treat schizoaffective disorder. In an observation in the third-floor elevator lobby area on 1/9/25 at 1:01 p.m., Resident 10 confirmed her identity and was in wheelchair, smiling, asking Department for their names and to shake hands. Resident 10 stated, Stay with me so I can get to know you better. No aggressive behaviors were observed. In an interview on 1/9/25 with LN 9, LN 9 stated that Resident 10 is not a threat to caregivers .Not violent or aggressive and that she can tell Resident 10 hallucinates from Resident 10's verbal language. LN 9 stated that RES 10's Peers are safe as well and that Resident 10 has conversations alone asking questions . but talks normal to other patients. In a telephone interview on 1/9/25 at 1:37 p.m. with MD 2, MD 2 stated that divalproex sodium was not for schizophrenia but was for bipolar and that quetiapine was not a great medication for schizophrenia. MD 2 stated that divalproex sodium was for the affective component of schizoaffective disorder which was the bipolar (a disorder associated with episodes with mood swings ranging from depressive lows to manic highs) and that quetiapine 25 mg dosage is indicated for sleep. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on 1/9/25 at 3:01 p.m. with a family member of Resident 10 (a family member), the family member indicated that quetiapine was started to help Resident 10 sleep and was not sure if quetiapine is helping. During a review of facility's policy titled, Antipsychotic Medication Use. Dated 12/16, the policy indicated that, .1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective . 2. Resident 30 was admitted in October of 2024 with cognitive communication deficit, and failure to thrive. Upon readmission, on 11/13/24, schizophrenia and alcohol abuse were added to the diagnoses. Review of the admission MDS indicated the resident had moderate cognitive impairment with a score of 8/15 in the BIM assessment. Review of the Resident 30's clinical record indicated the resident had the Physician Orders for the following antipsychotics to treat paranoid schizophrenia: 11/29/24: olanzapine (a drug used to treat mental health disorders) 5 mg, 1 tablet by mouth at bedtime for AEB anger outburst. 11/29/24: olanzapine 2.5 mg, 1 tablet by mouth one time a day for AEB anger outburst 12/2/24: divalproex delayed release 250mg, 1 tablet by mouth three times per day for M/B (manifested by) yells out. Review of Resident 30's clinical records indicated that Resident 30 had no documented history of schizophrenia in previous hospitalization records and that the diagnosis was newly added while at the facility. Olanzapine was started during most recent hospital admitted d 11/13/14 and continued at the facility upon admission. No psychiatric evaluations were found in medical records indicating new diagnosis of schizophrenia. During a review of Resident 30's California Department of Healthcare Services-Notice of attempted evaluation, (DHS Notice) dated 11/13/24, the DHS Notice indicated that a level II evaluation for serious mental illness (SMI) was unable to be completed due to The individual has no serious mental illness. No functional limitations in last six months. During a review of Resident 30's Note to Attending Physician/Prescriber, dated 11/25/24, the Note to Attending/Physician Prescriber indicated, .The attending physician in collaboration with the consultant pharmacist must reevaluate the use of the psychotropic medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission. No signature or response noted in the physician response section. During a review of Resident 30's Consultant Pharmacist's Medication Regimen Review (MRR), dated 12/19/2024, the MRR indicated that the CP sent recommendations to MD 1 regarding Resident 30 who was receiving divalproex for schizophrenia and that while divalproex is widely used to manage behavior and that the Resident did not have an FDA approved medical diagnosis for use. CP requested to Please either clarify the diagnosis or have MD (Medical Doctor) document risk vs (versus) benefits for using divalproex for any other off-label diagnosis. Review of records indicated no action was taken from recommendations to clarify diagnosis or document risk versus benefits. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on 1/9/25 at 11:00 a.m. with CP, CP stated, that Resident 30 should have been taken off olanzapine and divalproex sodium and that indication for use needs to be more specific than just that the Resident was yelling out. In an interview on 1/9/25 at 11:55 a.m. with DON 1 in the DON office, DON 1 stated, .I cannot find anything with schizophrenia prior to admit . and the expectation is to refer to psychiatrist to manage psychiatric medications. DON 1 further stated that there was no referral to psych in chart . In an interview on 1/9/25 at 12:54 p.m. at the first-floor nurse's station with LN 10, LN 10 stated that Resident 30 Does not attack me. Not danger to self or roommates. Cannot walk . Not physically combative. Yells when sleeping . In an observation on 1/9/25 at 12:58 p.m. at the first-floor nurse's station, RES 30's identity was confirmed, and Resident 30 was sitting in a wheelchair in the hallway with calm demeanor with no screaming or yelling noted. In a telephone interview on 1/9/25 at 2:14 p.m. with MD 1, MD 1 stated, .Can't confirm schizophrenia prior to admit .[RES 30] has some sort of mental disorder because he had alcoholism. Maybe depression or something. According to the online medical reference site, National Institute of Mental Health (NIMH), retrieved on 1/15/25, indicated, .Schizophrenia is .diagnosed in the late teen years to early thirties, and tends to merge earlier in males . During a review of the facility's policy titled Antipsychotic Medication Use, dated 12/16, the policy indicated, 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective .2. The Attending Physician and other staff with gather and document information to clarify a resident's .medical condition .and risk to the resident and others 5. Residents who are .transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use .18. The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. 46995 3. Resident 25 admitted to the facility mid 2017 with diagnoses which included memory problems and anxiety disorder. During a review of Resident 25's Minimum Data Set (MDS, an assessment tool) dated 12/10/24, the MDS indicated a Brief Interview for Mental Status (BIMS, a standardized test that screens for cognitive impairment) score of 1/15, which indicated severe cognitive impairment. During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated 12/16, the P&P indicated, .The need to continue PRN [as needed] orders for psychotropic medications beyond the 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order . The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review Resident 25's Order Summary Report [OSR], dated 1/8/24, the OSR indicated, LORazepam (sic) [a medication to treat anxiety] .Give 1 tablet by mouth every 4 hours as needed For (sic) repetitive pacing related to ANXIETY DISORDER .order date 12/10/24 . The OSR did not indicate any stop date, or date reviewed by physician. During a review of Resident 25's MEDICATION ADMINISTRATION RECORD [MAR], dated 12/1/24-12/31/24, the MAR indicated the resident had received the as needed Lorazepam eight times after the 14th day. During an interview on 1/8/24 at 3:38 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, There should be a 14 day stop date for anti-anxiety medications . The ADON confirmed Resident 25's Lorazepam was started on 12/10/24, with no stop dated, It's indefinite .it should have a 14 day stop date .it's [stop date] important so we can revisit to determine if behaviors are still there or increased .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50619 Based on observation, interview, and record review, the facility failed to ensure the medication rate did not exceed 5% for three of four sampled residents (Resident 16, 486, and 55) for a census of 87 when five medication errors occurred out of 29 opportunities that resulted in 17.2% medication error rates. 1. For Resident 16, a Licensed Nurse 2 (LN 2) administered Resident's calcium and vitamin D (a supplement used to raise calcium and vitamin D levels), not in accordance with Physician Orders when one tablet of calcium 600mg (milligram, unit of measurement) + 400 units (unit, a measurement) vitamin D was administered when the physician ordered calcium-vitamin D tablet 600-200mg/unit, give 2 tablets by mouth one time a day. 2. For Resident 486, a Licensed Nurse 7 (LN 7) did not administer hydroxyzine (a medication used to treat anxiety and tension caused by nervous and emotional conditions) when hydroxyzine was not stocked on the medication cart nor available for administration. 3. For Resident 55, LN 2: a. did not administer buspirone (a medication that treats anxiety) when it was unavailable to administer, b. administered sucralfate after breakfast and not on an empty stomach per pharmacy and manufacturer's recommendations, and c. did not give famotidine (a medication given to treat heartburn by reducing stomach acid), but marked famotadine as given in the e-MAR (electronic health record). These failures resulted in Resident 16 not getting the appropriate dose of medication which could delay stabilizing low calcium levels, Resident 486 having potential unescessary negative mood changes, and Resident 55 having potential for alteration in behavior and mood as well as increase in stomach discomfort due to not receiving morning medications as prescribed. Findings: 1. During an observation of medication administration on 1/7/25 at 8:16 a.m. on the second floor with Licensed Nurse 2 (LN 2), LN 2 was observed preparing to administer Resident 16's morning medications, removed 1 pill from the calcium-vitamin 600mg-400mg-units container and administered medication to Resident 16. During an interview on 1/7/25 at 8:35 a.m., LN 2 confirmed that all medications needed to perform medication pass for Resident 16 were available and given and that Resident 16 was done with medication pass. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication reconciliation record review of Resident 16's Orders, dated 12/14/24, the Orders indicated that 2 tablets of calcium-vitamin d 600-200mg-units are to be given once per day for a total dose of 1200-400mg-units per day. During a record review of Resident 16's Labs, dated 12/12/24, the Labs indicated that Resident 16 had a low calcium level of 5.6mg/dl (milligrams pe deciliter, a measurement) with the normal range being 8.4-10.6mg/dl. During an interview on 1/7/25 at 1:49 p.m. with LN 2 at the nurse's station, LN 2 stated that Resident 16 got 1 tab of calcium-vitamin D instead of 2 and stated that the doctor will be notified, and another pill will be given. LN 2 stated Resident 16 had low calcium and that is why 2 pills was needed and then confirmed that the dose available on the medication cart did not match the doctor's order and that she had to contact the physician for clarification. During an interview on 1/8/25 at 10:48 a.m. with Director of Nursing 1 (DON 1), DON1 stated that the calcium and vitamin d .should be given as ordered. During a review of the facility's policy titled Administering Medications, dated 12/12, the policy indicated, Medications shall be administered in a safe and timely manner, and as prescribed .3. Medications must be administered in accordance to orders .5. If a dosage is believed to be inappropriate or excessive for a resident .the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns .7. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage .of administration before giving the medication . 2. During an observation of medication administration on 1/7/25 at 8:43 a.m. on the first floor with (LN 7), LN 7 was observed preparing to administer Resident 486's morning medications by taking a blood pressure of Resident 486 and gave four out of five medications ordered. LN 7 was observed asking an unknown CNA (Certified Nursing Assistant) if Resident 486 was agitated and the CNA stated that Resident 486 was agitated. LN 7 then opened the drawer of the medication cart to give hydroxyzine solution 25 mg/ml as needed for anxiety but was unable to give due to not being available on the medication cart to administer to the resident. During a record review of Resident 486's Orders, dated 12/26/24, the Orders indicated that hydroxazine solution 25 mg/ml, give 25 mg by mouth every 8 hours as needed for anxiety for two weeks. During a medication reconciliation of Resident 486's e-MAR (Electronic Medication Administration Record), dated 01/2025, the MAR indicated that the hydroxyzine was given after the morning medication pass. During an interview on 1/7/25 at 1:42 p.m., LN 7 confirmed that hydroxyzine was not given during the morning medication pass and stated that it was in the system as house stock, but there was no house stock, so LN 7 found a bottle in another medication cart, took 1 pill from the bottle, and gave it later after the morning medication pass was observed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/25 at 10:498 a.m. with DON 1 in the first floor waiting room, DON 1 stated that that medications should have been readily available to administer, reordered ahead of time if running low, the doctor called for an alternative, or accessed the e-kit if no medication left. DON 1 further stated that borrowing from another cart is not allowed for prescription medications. During a review of the facility's policy titled Administering Medications, dated 12/12, the policy indicated, Medications shall be administered in a safe and timely manner, and as prescribed .23 . Medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing Services. 3. a. During a medication administration observation on 1/8/25 at 8:32 a.m. with LN 2 on the second floor, LN 2 did not administer buspirone as ordered because no pills were available on the medication cart to be administered. During an interview on 1/8/25 at 10:37 a.m. with LN 2, LN 2 confirmed that buspirone was not given, but would be delivered around 10 or 11 a.m. During a record review of Orders, dated 1/7/25, the Orders indicated that buspirone 5 mg tablet, give 1 tablet by mouth every 12 hours for anxiety as evidence by pacing in hallway. During an interview on 1/8/25 at 10:48 a.m. with (DON 1), DON1 stated that medications should be readily available to give, reordered ahead of time if running low, should be given when ordered to be given. During a review of the facility's policy titled Administering Medications, dated 12/12, the policy indicated, Medications shall be administered in a safe and timely manner, and as prescribed .3. Medications must be administered in accordance to orders, including any required timeframe. 3. Medications must be administered within one (1) hour of their prescribed timeframe, unless otherwise specified (for example, before and after meal orders) . b. During a medication administration observation on 1/8/25 at 8:32 a.m. on the second floor with LN 2. LN 2 was observed administering sucralfate to Resident 55 after breakfast was served. During an interview on 1/8/25 at 8:47 a.m., LN 2 at the second-floor medication cart , LN 2 stated that sucralfate is ordered to be given after food since it was scheduled with the morning medication pass at 9 a. m. and that it was given for acid reflux. During a record review of Orders, dated 10/24/24, the Orders indicated that sucralfate oral solution 10 ml to be given by mouth two times a day for GI (gastrointestinal) distress. During an observation on 1/8/25 at 8:45 a.m. of the sucralfate medication bottle, the bottle contained a pharmacy label indicating to take medication on an empty stomach 1 hour prior or 2-3 hours after a meal. During an observation on 1/8/25 at 8:46 a.m. of the sucralfate manufacturer's label attached to the bottle, the manufacturer's label indicated that sucralfate should be given on an empty stomach. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/25 at 10:48 a.m. with (DON 1), DON1 stated that nurses should follow manufacturer's recommendations because medication for acid reflux would be more effective if taken as prescribed before meals. During a review of the facility's policy titled Administering Medications, dated 12/12, the policy indicated, Medications shall be administered .as prescribed .3. Medications must be administered in accordance to orders, including any required timeframe. 3. Medications must be administered within one (1) hour of their prescribed timeframe, unless otherwise specified (for example, before and after meal orders) . c. During a medication administration observation on 1/8/25 at 8:32 a.m. on the second floor with LN 2. LN 2 was observed administering morning medications for Resident 55, but did not administer famotidine as ordered. During an interview on 1/8/25 at 10:37 a.m. with LN 2 at the second-floor nurse's station, LN 2 stated famotidine was marked as given in the e-MAR, but was not given, I guess and that she will give it right away and let the doctor know. During a record review of Orders, dated 9/15/24, the Orders indicated that famotidine 20 mg tablet, 1 tablet to be given by mouth two times per day. During an interview on 1/8/25 at 10:48 a.m. with (DON 1), DON 1 stated that medications should be given when ordered to be given. During a review of the facility's policy titled Administering Medications, dated 12/12, the policy indicated, Medications shall be administered in a safe and timely manner, and as prescribed .3. Medications must be administered in accordance to orders, including any required timeframe. 3. Medications must be administered within one (1) hour of their prescribed timeframe, unless otherwise specified (for example, before and after meal orders) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50619 Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled correctly, when: 1. Unopened insulin pens were not kept refrigerated, 2. Opened multidose inhalers did not have open dates to determine expiration dates, 3. Personal items and non-pharmaceutical items were stored in a medication cart and a medication room, 4. Expired insulin pens were not discarded and still available for use, 5. Loose pills were found in a medication carts and a medication room, 6. Prescription pharmaceutical products did not have patient specific labels, and 7. A prescription blister pack and a prescription eye drop were dropped in the back of a medication cart and not accessible to be used for Resident's needs. These failures had the potential for accidental use of expired medications, drug diversion, infection control risk, and safety risk for a census of 87. Findings: 1. a. During a medication cart check of medication cart #1 on 1/6/25 starting at 11:17 a.m. at the first-floor nurse's station with LN 4, a Basaglar Kwikpen (an insulin pen used to lower blood sugar level) 100 u/ml (unit per mililiter, unit of measurement) was found unopened and undated inside medication cart 1, stored at room temperature with a label indicating to refrigerate. b. During a medication cart check of medication cart #1 on 1/6/25 starting at 11:17 a.m. at the first-floor nurse's station with LN 4, a Humalog Kwikpen (an insulin pen used to lower blood sugar level) 100 unit/ml was observed unopened, undated, and stored at room temperature with a label indicating to refrigerate. c. During a medication cart check of medication cart #1 on 1/6/25 starting at 11:17 a.m. at the first-floor nurse's station with LN 4, a Basaglar Kwikpen 100 unit/ml was found unopened and undated inside medication cart 1, and stored at room temperature with a label indicating, Refrigerate until used**Once in use, store at room temperature*. In an interview on 1/6/25 at 11:46 a.m. at the first floor nurse's station, LN 1 stated, that she was unsure of the open dates was unsure if the insulin pens could be used or not, and that and that the insulin pens may have been ineffective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/7/25 at 1:15 p.m. with Facility Pharmacist (FP) in the conference room, FP indicated that an open date was needed for insulin pens when removed from the refrigerator or when opened. In an interview on 1/8/25 at 10:48 a.m. in the 1st floor waiting room with the Interim Director of Nursing (IDON), the IDON indicated that insulin pens should be kept in refrigerator until ready for use, and that storing at room temperature without an open date or removed from refrigeration date can cause alteration in efficacy. During a review of the facility's policy titled, Storage of Medications, dated 04/07, the policy indicated, .4. The facility shall not use .deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location . 2. a. During a medication cart check of medication cart 1 on 1/6/25 starting at 11:17 a.m. at the first-floor nurse's station with LN 4, an opened umeclidinium inhalation powder (combination of two medications used for breathing issues) multi-dose Inhaler was used and had no open date. The manufacturer expiration date was 06/2026 and the manufacturer's label stated, Discard the inhaler six weeks after opening the moisture-protective foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first. b.During a medication cart check of medication cart 1 on 1/6/25 starting at 11:17 a.m. at the first-floor nurse's station with LN 4, an opened Levalbuterol Inhalation Solution multi-dose inhaler was observed with no open date. The manufacturer expiration date indicated 12/25 and that, .Once the foil pouch is opened, the vials should be used within two weeks . In an interview on 1/6/25 at 11:46 a.m. with LN 4, LN 4 stated that the umeclidinium inhaler instructions say to Discard six weeks after opening and stated, .I'm unsure of expiration date because I do not know the open date. In an interview on 1/7/25 at 1:15 p.m. with CP in the conference room, CP confirmed that opened inhalers should have open dates on them. In an interview on 1/ 8/25 at 10:48 a.m. in the first floor waiting room with DON 1, DON 1 confirmed that not dating opened inhalers could change the efficacy of med[ication]s if not properly stored, [and] expired med[ication]s could be given. During a review of the facility's policy titled, Labeling of Medication Containers, the policy indicated, All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations .2. Any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy . 3. Labels for individual drug containers shall include all necessary information such as .h. The expiration date when applicable . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Storage of Medications, the policy indicated, The facility shall store all drugs and biologicals in a safe .manner .4. The facility shall not use .outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed . 3. a. During a first-floor medication cart check of medication cart #1 on 1/6/25 starting at 11:10 a.m. with LN 4, non-pharmaceutical items such as two CDs, a clear bag with money in it, and a lighter were stored in the controlled drug lock box. b. During a second-floor medication room check on 1/7/25 starting at 9:31 a.m. with LN 2, a paring knife with a 3-4-inch blade, measuring about 8 inches total length was found in a drawer on top of medical supplies with an exposed blade. During an interview on 1/6/25 at 11:48 a.m. with LN 4, LN 4 stated that, Non-pharmacological items stored in the medication cart could cause infection control issues. During an interview on 1/7/25 at 9:33 a.m. in the second-floor medication room with LN 2, LN 2 stated, [The] knife is about a foot long. That patient has been discharged for a long time, not here anymore. In an interview on 1/7/25 at 1:15 a.m. in the conference room with the CP, the CP agreed that non-pharmaceutical items such as cash, lighters, and CDs, and knives should not be stored in medication carts or medication storage rooms. In an interview on 1/8/25 at 10:48 a.m. in the first floor waiting room with DON 1, DON 1 indicated that non-pharmacological items stored in the medication cart lock box posed an infection control and contamination risk, personal items and utensils should not have been stored in medication storage areas, and that the knife could be used as a weapon. During a review of facility policy titled, Storage of Medications, dated 07/27, the policy indicated, The facility shall store all drugs and biologicals in a safe, secure . manner. 4. a. During a medication cart check of medication cart 2 on the second floor with LN 2 on 1/7/25 starting at 9:07 a.m., a Lispro pen (medication pen used to reduce blood sugar levels) 100 unit/ml was found with an opened date of 11/28/24 and an expiration date of 12/26/24. b. During a medication cart check of medication cart 1 on the second floor with Licensed Nurse (LN) MS on 1/7/25 starting at 9:07 a.m., a Humalog pen (Medication pen used to reduce blood sugar levels) 100 unit/ml was found with opened date of 12/3/24 and expiration date of 12/31/24. In an interview on 1/7/25 at 9:09 a.m. at the second-floor medication cart in front of the nurse's station with LN 2, LN 2 agreed that insulin was expired and could be ineffective. In an interview on 1/8/25 at 10:48 a.m. in the first floor waiting room with DON 1, DON 1 indicated that, Nurses are responsible for checking expiration date[s]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Storage of Medications, dated 04/07, the policy indicated, .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed . 5. a. During a medication cart check on 1/6/25 starting at 9:07 a.m. with LN 4, two loose pills were found in the top drawer of medication cart 1 of the first floor's medication cart. b. During a first-floor medication room check on 1/6/25 starting at 12:05 p.m. with LN8, three loose pills were found on the medication storage room counter top, and c. During a medication cart check of the second-floor medication cart on 1/7/25 with LN 2, two loose pills were visualized in the bottom rear side of the medication cart. During an interview on 1/6/25 at 11:47 a.m. with LN 4, LN 4 stated that that the two loose pills meant that patient didn't get their medications and that there is risk of diversion. In an interview on 1/6/25 at 12:05 p.m. with LN 8 in the first-floor medication room, LN 8 confirmed that there were three loose pills in the medication storage room and stated that loose pills was a potential consumption hazard and could get into the wrong hands. In an interview on 1/7/25 at 9:19 a.m. with LN 2, LN 2 confirmed two loose pills and stated that loose pills posed risk of diversion and that the resident may not have gotten their medication due to it not being available. In an interview on 1/8/25 at 10:48 a.m. in the first floor waiting room with DON 1, DON 1 stated it is the nurses' responsibility to check medication carts and maintaining the medication room in a nice, clean, and organized manner. During a review of the facility's policy titled, Storage of Medications, dated 04/07, the policy indicated, The facility shall store all drugs an biologicals in a safe, secure .manner .1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received .8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 6. a. In an observation of the first-floor medication storage room on 1/6/25 at 12:05 p.m. with LN 8, nine 5% Lidocaine patches marked as Rx (prescription) only did not have patient-specific labels on them and two Glucagon pens were found without patient-specific labels on them. In an interview on 1/6/25 at 12:05 p.m. in the first-floor medication room with LN 8, LN 8 confirmed there were no patient labels on the Lidocaine patches or glucagon pens and stated that the Lidocaine patches and glucagon pens were house supply, but after LN 8 read the label showing Rx only, agreed that the medications should have been prescribed to a resident. In an interview on 1/7/25 at 1:14 p.m. in the conference room with CP, CP agreed that any medication with the Rx only label needs to be labeled and if no label, staff should have called pharmacist to replace. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/8/25 at 10:48 a.m. in the first-floor hallway with DON 1, DON 1 stated, that maybe the nurses weren't able to differentiate between 4% and 5% lidocaine patches and that It is not safe to use without an appropriate label. During a review of the facility's policy titled, Storage of Medications, dated 04/07, the policy indicated, .3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing .

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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. 50633 Based on observation, interview, and record review the facility failed to provide food storage and preparation in accordance with professional standards for food service safety when: 1. Kitchen containers and steam table pans were found stored wet, 2. Several food items in freezer and refrigerator were not securely closed, 3. A stored steam table pans found to have food residue in the pan, 4. Red cutting board for meat found with deep grooves, 5. Shelf under cook's food preparation table was found with rust and white discoloring, and 6. Floor drain near cook's station had green-colored build up around drain along with chipped and worn flooring. Theses failures had the potential of leading to food borne illness for 87 residents out of a census of 87 who are eating facility prepared foods. Findings: 1. During the initial kitchen tour on 1/6/25 at 9 a.m., 2 kitchen containers and container lids, 2 carafes, and 4 steam table pans were observed stored wet. During a concurrent interview on 1/6/25 with Dietary Supervisor (DS), DS stated, The kitchen equipment should be clean and dry before storing as it can lead to bacterial growth and make residents sick. During a review of the facility's policy and procedure (P&P) titled, Dish Washing, (RDs for Healthcare, Inc. 2018), indicated, Dishes are to be air dried in racks before stacking and storing. A review of the US Food and Drug Administration's (FDA) 2022 Food Code, section 4-901.11, titled, Equipment, Utensils, Air-Drying Required, indicated, After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining . and (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry. 2. During the initial kitchen tour on 1/6/25 at 9:18 a.m., freezer # 1 was observed with a box of frozen bacon with the plastic packaging opened and unsealed. The freezer also contained a box of garden nuggets in a plastic bag that was not closed. Freezer #2 was observed with a box of sausage patties that the plastic packaging had not been closed, as well as a box of frozen hamburger patties not tightly sealed and was exposed to air. Refrigerator #2 had a package of sliced turkey not closed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 1/6/2025 with DS, DS stated she expected staff to ensure frozen food items were tightly sealed and stored in freezer to prevent freezer burn of food items and that food items not tightly sealed could result in cross contamination of food items. During a review of the facility's P&P) titled, Procedure for Freezer Storage, (RDs for Healthcare, Inc. 2018), indicated, Store frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn. 3. During initial kitchen tour on 1/6/25 at 11:17 a.m., one medium sized steam table pan was observed to have food residue on the pan's cooking surface while stored in the ready to use pan area of the cook's area. During concurrent interview with DS on 1/6/25, DS stated she expected her staff to thoroughly clean dirty containers. During a review of the facility's P&P titled, Dish Washing, (RDs for Healthcare, Inc. 2018), indicated, Gross food particles shall be removed by carefully scraping and pre-rinsing in running water, and Appropriate chemicals will be used to wash, de-stain and rinse dishes. A review of the US FDA 2022 Food Code, section 4-602.11 titled, Equipment Food-Contact Surfaces and Utensils, indicated, (A) Equipment food-contact surfaces and utensils shall be cleaned . (4) Before using or storing . 4. During initial kitchen tour on 1/6/25 at 11:17 a.m., 1 red cutting board (out of 3, which was used for red meat) was observed with multiple deep cut marks on both sides of the cutting board. During concurrent interview with DS on 1/6/25, DS stated the cutting board should be replaced as the deep grooves in the cutting board were a concern for bacterial growth. A review of the US FDA 2022 Food Code, section 4-501.12 titled, Cutting Surfaces, indicated, Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED, or discarded if they are not capable of being resurfaced. 5. During the initial kitchen tour on 1/6/25at 11:17 a.m., storage shelf under cook's food preparation table was observed to have rust and white discoloring on surface of shelf. During concurrent interview with DS on 1/6/25, DS stated she expected the storage shelf to be smooth and without rust and not have white discoloring on the surface of the shelf as that area on the shelf can breed bacterial growth and lead to cross contamination. A review of the US FDA 2022 Food Code, section 3-304.12 titled, In-Use Utensils, Between-Use Storage, indicated, During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: .(C) On a clean portion of the food preparation table or cooking equipment only if the in-use utensil and the food-contact surface of the food preparation table or cooking equipment are cleaned and sanitized at a frequency . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the US FDA 2022 Food Code, section 4-202.11 titled, Food-Contact Surfaces, indicated, (A) Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections . 6. During the initial kitchen tour on 1/6/25 at 11:17 a.m., the floor drain near cook's station had turned a green color around the drain and the flooring around the drain was observed to be chipped and worn areas. During concurrent interview with DS and Maintenance Supervisor (MS) on 1/6/2025, DS stated the metal had reacted with the bleach used during cleaning. MS assessed the drain area and confirmed it was discolored and worn. A review of the US FDA 2022 Food Code, section 4-202.16 titled, Nonfood-Contact Surfaces, indicated, Nonfood-CONTACT SURFACES shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 41838 Based on observation, interview, and record review, the facility failed to provide a resident refrigerator and microwave for staff to store and heat residents' food. This failure had the potential of leading to poor food intake, weight loss, and food borne illness for the 87 residents eating meals. Findings: During the initial kitchen tour on 1/6/25 at 9:09 a.m., the Dietary Supervisor (DS) stated that resident food was not kept in the kitchen and that residents did not have a place to store food in the facility. During an interview on 1/8/25 at 9:12 a.m. on the first floor with Licensed Nurse 4 (LN 4), the handling of food from outside sources was discussed. LN 4 stated residents were allowed food from outside, and staff would check the food against the diet order to see if the food was appropriate before giving to the resident. When the resident had finished eating, the food would not be kept as the facility had no refrigerator or microwave for resident food. During an interview on 1/8/25 at 9:28 a.m., on the second floor with Certified Nursing Assistant 5 (CNA 5), CNA 5 explained that residents could have outside food brought in. Once the resident was finished with the meal, CNA 5 would chart the amount eaten. When asked about food storage, CNA 5 stated he would have it stored in the kitchen. During an interview on 1/8/25 at 9:33 a.m., on the third floor, LN 1 stated outside food would be checked against the diet order before it would be given to the resident. When the resident was finished eating, staff would discard the leftover food. LN 1 further stated that residents did not have refrigerator or microwave available to them as they were removed a few years ago. During an interview on 1/8/25 at 9:43 a.m., with the Director of Staff Development (DSD), the DSD stated that her expectation was that perishable foods be date checked to ensure it was safe for the resident to eat. Perishable food could be left out for 1 hour but after that it needed to be discarded. If storage of perishable food was desired, it could be kept in the activity refrigerator. During an interview on 1/8/25 at 9:51 a.m., with the Activity Assistant (AA), the AA stated they only store items for activities such as sodas in the refrigerator in the social dining/activities room. During an interview on 1/8/25 at 12:23 p.m. with the Assistant Director of Nursing (ADON), the ADON stated that leftover food could be taken home by the family, otherwise it would be disposed of. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility provided policy titled Foods Brought by Family/Visitors (Med-Pass, Inc., Revised March 2022) indicated that Food brought to the facility by visitors and family is permitted. Facility staff will stive to balance resident choice .with the nutritional and safety needs of residents. It further indicated in bullet 5 that Food brought by family/visitors that is left with the resident to consume later is .b. stored in re-sealable containers with tightly fitting lids in a refrigerator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46995 Based on interview and record review, the facility failed to maintain accurate and consistent medical records for two of 24 sampled residents (Resident 1 and Resident 41) when: 1. Resident 1's progress notes (PN) did not include any reason medications were not administered; and 2. Resident 41's insulin (a medication to treat high blood sugars) administration documentation was inconsistent. These failures created inaccurate health records which increased the potential for incorrect assessment of the residents and for creating miscommunication among healthcare professionals regarding the residents health status. Findings: Resident 1 was readmitted to the facility in late 2024 with diagnoses which included a condition in which the heart does not pump adequately, progressive damage and loss of kidney function, high blood pressure, and irregular rapid heart rate that causes poor blood flow. During a review of Resident 1's Order Summary Report [OSR], dated 1/7/24, the OSR indicated, Metoprolol Tartrate [medication to treat high blood pressure and heart failure] .two times a day for htn [hypertension, high blood pressure] .Isosorbide Dinitrate [medication used to treat heart failure] .one time a day for heart failure .Furosemide [medication to treat fluid retention caused by heart failure, kidney failure, and high blood pressure] .one time a day for chf [congestive heart failure] . During a review of Resident 1's Medication Administration Record [MAR], dated 12/1/24-12/31/24, the MAR indicated, Metoprolol was not administered eight times. The Isosorbide was not administered five times, and the Furosemide was not administered four times. The MAR box for administration had and X and an administration code of, Held/ Other Reason/See Progress Notes. During an interview on 1/8/24 at 9:44 a.m. with Licensed Nurse (LN 2), LN 2 stated an X in the MAR means a medication was not given. If [medications] not given .go to the progress nots to write a note. Every time a medication is not given it [MAR] pulls you to the progress notes. During a concurrent interview and record review on 1/8/24 at 3:31 p.m. with the Assistant Director of Nursing (ADON) of Resident 1's MAR. The ADON confirmed Resident 1's MAR indicated multiple medications charted as not administered without any corresponding progress note to explain why. The ADON stated she would expect to see a note why the medications were not given, I would expect blood pressure entered, would expect a progress note to determine if given .It's important .meds to keep the blood pressure low so the heart is not working too hard. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Documentation of Medication Administration, dated 4/07, the P&P indicated, The facility shall maintain a medication administration record to document all medications administered .Documentation must include, as a minimum .Reason(s) why a medication was withheld, not administered, or refused . Resident 41 readmitted to the facility late 2023 with diagnoses which included trouble controlling his blood sugars. During a review of Resident 41's OSR, order start date of 12/4/23, the OSR indicated, HumaLOG [fast acting insulin that is used to lower blood sugar] Inject as per sliding scale: if 70-150=NONE; 151-200=NONE; 201-250=1; 251-300=2 NOTIFY MD [medical doctor] if BS [blood sugar] is < [less than] 70 or > [greater than] 301, intramuscularly at bedtime . During a review of Resident 41's MAR, dated 11/1/24-12/31/24, the MAR indicated Resident 41 had a BS of 150 on 11/4/24, a BS of 120 on 11/14/24, and a BS of 186 on 12/12/24. The MAR Indicated NONE in addition to a check mark on the dates with a corresponding code of Administered. During a review of Resident 41's Location of Administration Report, dated 11/1/24-12/31/24, the report indicated Humalog was administered on 11/4/24, 11/14/24 and 12/12/24. All entries included the route and location of administration. During a concurrent interview and record review on 1/8/24 at 3:02 p.m. with the ADON of Resident 41's MAR, the ADON confirmed the Humalog was documented as administered on three separate dates when Resident 41's BS was less than 200. The ADON stated, You would expect to see a note. It would be best practice to write a progress note .It's not consistent documentation .the expectation is that is it accurately documented .keeps the patients safe . During a review of the facility's policy and procedure (P&P) titled, Documentation of Medication Administration, dated 7/07, the P&P indicated, The facility shall maintain a medication administration record to document all medications administered .Documentation must include .method of administration .reason(s) why a medication was withheld, or not administered .

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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** 29825 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program to prevent the development and transmission of communicable diseases and infections for 4 residents (Residents 32, 53, 61 and 57) in a census of 87 when: 1. Resident 32's nebulizer (machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) and Resident 53 and Resident 61's oxygen tubings were not covered or labeled, and when 2. Resident 57's urinary catheter (a thin tube used to drain urine from the bladder to an outside collection bag) was found touching the floor multiple times during the survey period. These failures increased the potential for infection for the residents . Findings: 1. Resident 32 was admitted to the facility in the fall of 2024 with diagnoses which included irregular heartbeat and not having enough healthy red blood cells. During a review of Resident 32's Minimum Data Set (MDS, an assessment tool), dated 10/24/24, the MDS indicated Resident 32 was alert and oriented and able to make her needs known. During a review of Resident 32's Order Summary Report (physician orders, PO), dated 12/22/24, the PO indicated, Ipratropium-Albuterol Solution [a medication to help breathing] .inhale orally via nebulizer every 8 hours as needed for SOB [shortness of breath] or Wheezing . During a concurrent observation and interview on 1/6/25 at 8:51 a.m. with Resident 32, Resident 32's nebulizer was uncovered and unlabeled. Resident 32 indicated she used the nebulizer, Day before yesterday. I don't use it all the time . During a concurrent observation and interview on 1/06/25 at 8:55 a.m. with Certified Nurses Assistant (CNA) 3, CNA 3 verified the observation and said, I'm not sure if the respiratory device is supposed to be covered. During an concurrent observation and interview on 1/6/25 at 8:56 a.m. with Licensed Nurse (LN) 1, LN 1 was asked about covering and labeling the oxygen equipment and said, It should be covered, clean and not plugged in, if not in use. She [Resident 32] used it a couple days ago. It's the [licensed] nurse's responsibility to make sure it's covered. They never told us to date it . Resident 53 was admitted to the facility in the fall of 2023 with diagnoses which included heart problem, insufficient red blood cells and severe memory loss. During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 had severe memory loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Post-Acute	678 3rd Street Woodland, CA 95695

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's PO, dated 12/13/24, the PO indicated OXYGEN @ [at] 1-5 L/MIN [liters, a volume of measurement, per minute] VIA NASAL CANNULA [thin tube leading from oxygen source to the nasal passages to deliver oxygen] AS NEEDED FOR SOB [shortness of breath] . During a concurrent observation and interview with Resident 53 on 1/6/25 at 9:33 a.m., Resident 53 did not answer questions except with a nod of the head or a one word answer. His oxygen cannula was uncovered and draped over the oxygen condenser (a medical device that takes in regular air, removes the nitrogen from it, and delivers a stream of air that is significantly higher in oxygen concentration). During a concurrent observation and interview on 1/6/25 at 9:35 a.m. with CNA 3, CNA 3 verified the observation of Resident 53's unlabeled, uncovered oxygen tubing. During a concurrent observation and interview on 1/6/25 at 9:36 a.m. with LN 1, LN 1verified Resident 53's nasal cannula was uncovered and said, It should be covered. It's only PRN [as needed]. He's done with it. During an interview on 1/8/25 at 1:02 p.m. with the Interim Director of Nurses (DON 1), the DON 1 was asked his expectations for the covering and labeling of oxygen and respiratory equipment and said, They [oxygen equipment] should be placed in a bag. The bag or tubing should be dated . Resident 61 was admitted to the facility in the fall of 2024 with diagnoses which included lung problem. During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61 was alert and oriented and able to make her needs known. During a review of Resident 61's CP titled Impaired Gas Exchange .Hypoxia [low oxygen level], dated 12/4/24, the CP indicated Administered (sic) prescribed oxygen .Provide respiratory treatment as ordered . During a review of Resident 61's PO, dated 12/5/24, the PO indicated Oxygen @ 2-3L/min via nasal cannula routinely . During an observation on 1/7/25 at 7:06 a.m., Resident 61's nasal cannula was draped over the oxygen tank without a date or cover. During a concurrent observation and interview on 1/7/25 at 7:12 a.m. with CNA 3, CNA 3 verified Resident 61's nasal cannula and oxygen tubing were draped over the oxygen cannister without a cover or date. The facility P&P for covering and dating of resident oxygen equipment was requested but not provided. 2. Resident 57 was admitted to the facility in the spring of 2024 with diagnoses which included a urinary problem. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 57's PO, dated 10/16/24, the PO indicated [Name of] Catheter connected to drainage bag. Catheter in place d/t [due to] urinary retention . During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had moderate memory impairment. During an observation on 01/06/25 at 9:30 a.m. of Resident 57, there was an Enhanced Barrier Precaution (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms) sign on his door, his bed was in the lowest position and his catheter bag was touching the floor. During a concurrent observation and interview on 1/6/25 at 9:36 a.m. with LN 1, LN 1 verified his catheter bag was on the floor and said, It should not be on the ground. He's high risk for a fall so we put the bed down . It should not be touching the floor . During a second observation on 1/7/25 at 6:52 a.m., Resident 57's catheter was touching the floor. During a concurrent observation and interview on 1/7/25 at 6:54 a.m. with CNA 3, CNA 3 verified the observation and said, He [Resident 57] has control of the bed and keeps putting it down. We tell him not to. Sometimes he yells at us if we tell him he's supposed to keep the catheter bag off the floor. During a review of the facility P&P titled Catheter Care, Urinary, revised 9/24, the P&P indicated The purpose of this procedure is to prevent catheter-associated urinary tract infections .Be sure the catheter tubing and drainage bag are kept off the floor . During an interview on 1/8/25 at 1:02 p.m. with the DON 1, the DON 1 was asked his expectations for catheter bags touching the floor and said, The bag should not be touching the floor.