

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER North Bay Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Douglas Street Petaluma, CA 94952	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident hand-outs (weekly menu, activities calendar, guide for translation services) were provided in Resident's preferred language for two of 23 sampled residents (Resident 342 and Resident 8). This failure resulted in Resident 342 and Resident 8 being uninformed on menu options, activities, and how to obtain a translator.</p> <p>Findings:</p> <p>a. During a concurrent observation and interview on 1/13/25 at 3:22 p.m. with Resident 342, through the translation services provided from the facility, in Resident 342's room , posted on the walls were the weekly menu, activity calendar, interpretive services-reference guide and instructions for accessing interpreter, all written in English. Resident 342 stated he did not understand the signage because it was written in English. Resident 46 further stated he only spoke and read in Spanish.</p> <p>During an interview on 1/14/25 at 10:48 a.m. with Registered Nurse (RN) 2, RN 2 stated she has not seen any papers or forms in other languages. The forms were all written in English. RN 2 further stated, Doesn't make sense why it's in English when he can't read it, and it was important for signage to be in Resident's primary language so he could be informed.</p> <p>During an interview on 1/14/25 at 10:59 a.m. with the Registered Dietician (RD), the RD stated the facility did not offer menus in different languages. RD stated it would be important to have the menu in different languages so the Resident knew what they were eating and if they wanted to request a food alternative.</p> <p>During an interview on 1/14/25 at 11:03 a.m. with the Activities Director (AD), the AD stated the facility did not offer activity calendars in a different language.</p> <p>During a review of Resident 342's Minimum Data Set (MDS-an assessment tool), dated 12/26/24, the MDS indicated, Resident 342's preferred language was Spanish, and an interpreter was needed for communication.</p> <p>During a review of [facility name] Facility Assessment, dated 1/6/25, the Facility Assessment indicated, .The facility can provide or accommodate most activities, food and nutrition services, languages . according to resident preference .</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Translation and/or Interpretation of Facility Services, dated November 2020, the P&P indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information .</p> <p>b. During an observation on 01/14/25 at 3:58 p.m. in Resident 8's Room, the weekly menu for January 13-19, 2025, and the facility monthly activity schedule for January 2025 posted on Resident 8's wall was in English only. Translation services posted on the wall next to bed was in English only.</p> <p>During an interview on 01/14/25 at 03:43 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that Resident 8 spoke only Chinese.</p> <p>During an interview on 01/14/25 at 03:52 p.m. with Certified Nurse Assistant (CNA) 8, CNA 8 stated that Resident 8 only spoke Mandarin. CNA 8 stated, I haven't seen the menu or activity paper in other languages.</p> <p>During a review of Resident 8's Face Sheet (demographics), dated 2/29/24, the Face Sheet indicated Chinese was listed as Resident 8's primary language.</p> <p>During a review of Resident 8's Minimum Data Set (MDS-an assessment tool), dated 11/15/24, the MDS indicated, Resident 8's preferred language was Mandarin, and an interpreter was needed for communication.</p> <p>During a review of [facility name] Facility Assessment, dated 1/6/25, the Facility Assessment indicated, .The facility can provide or accommodate most activities, food and nutrition services, languages . according to resident preference .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Translation and/or Interpretation of Facility Services, dated November 2020, the P&P indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information .</p> <p>50933</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for Resident 46. This failure resulted in Resident 46 being unable to contact staff for assistance.</p> <p>Findings:</p> <p>During a review of Resident 46's Face Sheet (demographics) dated 1/16/25, the Face Sheet indicated Resident 46 was admitted to the facility on [DATE] with diagnoses of hemiplegia (complete paralysis to one side of the body) following cerebral infarction (stroke- serious condition that occurs when blood flow to the brain is blocked) affecting right dominant side, aphasia (unable to communicate verbally) and weakness.</p> <p>During an observation on 1/14/25 at 4:02 p.m. in Resident 46's room, Resident 46 was reclined in a geriatric chair (padded chair that is designed to help seniors with limited mobility) in the middle of the room without a call light. Resident 46 threw one pillowcase, in the direction of the door, and waved multiple times. Resident 46 grunted and pointed at the call light, on the floor.</p> <p>During an interview on 1/14/25 at 4:05 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 46 was non-verbal and required maximum assistance for all Activities of Daily Living (ADL). CNA 2 stated Resident 46 call light was not within resident's reach.</p> <p>During an interview on 1/16/25 at 11:25 a.m. with the Director of Nursing (DON), the DON stated that the call light should have been within Resident 46's reach at all times. It is important for all the residents to be able to use the call light for assistance.</p> <p>During a review of Resident 46's Minimum Data Set (MDS-an assessment tool), dated 4/29/24, MDS indicated Resident 46 had absence of spoken words and rarely/never understood for ability to verbally express ideas or wants.</p> <p>During a review of Resident 46's Care Plans, dated 10/31/24, the Care Plans indicated, [Resident 46] has a communication problem r/t [related to] Expressive Aphasia (unable to communicate verbally) . Ensure/provide a safe environment: Call light in reach .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Call Light, Answering, dated 4/1/19, the P&P indicated, .Make sure call cords are placed within the resident's reach at all times .</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119</p> <p>Based on interview and record review, the facility failed to ensure one of 23 sampled residents (Resident 83) and/or their legal representatives were informed and/or provided written information about Advance Directives (AD, legal document that provides instructions regarding medical care according to the resident's wishes and only goes into effect if the resident can no longer communicate their wishes).</p> <p>This failure had the potential to result in lack of knowledge regarding care and treatment decision making for Resident 83.</p> <p>Findings:</p> <p>During a review of Resident 83's Admission Record (AR), the AR indicated the facility admitted Resident 83 on 11/12/2024 with multiple diagnoses including hypertension (high blood pressure) and muscle weakness. The AR indicated Resident 83 had a Responsible Party 1 (RP) 1 as the emergency contact.</p> <p>During a review of Resident 83's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 83's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 12 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment, 99 severely impaired). The BIMS assessment indicated Resident 83 had moderate cognitive impairment.</p> <p>During a concurrent interview and record review on 1/14/25 at 3:57 p.m. with Minimum Data Set Coordinator (MDSC), Resident 83's Physician Orders for Life-Sustaining Treatment (POLST), dated 11/12/24 was reviewed. The POLST indicated Section D, Information and Signatures was incomplete. MDSC stated RP 1 did not sign the Advance Directive Acknowledgment form. MDSC stated there was no documented evidence RP 1 was provided information regarding AD and written information on AD formulation.</p> <p>During a concurrent interview and record review on 1/16/25 at 10:32 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Residents' Rights Regarding Treatment and Advance Directives dated February 2023 was reviewed. The P&P indicated, .Advance Directive is a written instruction, such as a living will or durable power of attorney .On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advance directive . Any decision making regarding the residence choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care . The DON stated it was the physician's and the nurses' responsibility to ensure that information regarding the advanced directive was discussed and documented. The DON stated the purpose of the advanced directive was to meet the wishes and desires of the individuals living will.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49936</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary (clean manner that prevents the spread of diseases), safe, and comfortable environment when:</p> <ol style="list-style-type: none"> All 21 residents' bathrooms were in disrepair. Resident 54's privacy curtain (curtain used as divided between residents' beds) was not kept in a sanitary manner. Comfortable water temperatures were not maintained in the bathrooms for 5 Residents' rooms (room [ROOM NUMBER], 114, 141, 143 and 146). <p>These failures violated the residents' rights to live in a sanitary, safe, comfortable, homelike environment and had the potential to result in injury and illness in a medically compromised population. The facility census was 94.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 1/13/25 at 12:46 p.m. with Resident 23 in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], the flooring going into the shower had an uneven surface with multiple large multilayer cracks, exposing old cement and flooring underneath. The cracks had lifted sharp jagged edges and were covered in rough and grimy dark black brownish moist substances. Resident 23 stated that he did not like using the bathroom because of the black stuff on the floor that looks like mold. Resident 23 stated he felt like the bathroom was not cleaned enough and not cleaned properly.</p> <p>During an interview on 1/14/2025 at 10:15 a.m. with Resident 56, Resident 56 stated she purchased her own disinfectant because the showers were not being cleaned regularly. Resident 56 stated, in the past, she slipped going into the shower due to the flooring condition. Resident 56 stated the bathrooms looked and felt dirty and unsafe so she had to put towels down on the floor everywhere so that her bare feet would not touch the floor.</p> <p>During an interview on 1/14/25 at 10:41 a.m. with Resident Council (gathering of residents who work together to improve their living conditions) Members, a consensus of six out of 11 Resident Council Members (Residents 23, 56, 83, 84, 341, and 343) stated that the bathrooms did not feel or look clean. A consensus of nine out of 11 Resident Council Members (Residents 6, 21, 23, 56, 79, 83, 84, 341, and 343) stated that the bathrooms did not feel safe to use.</p> <p>During a concurrent observation and interview on 1/14/25 at 4:30 p.m. with the Housekeeping Manager (HKM) in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were black, gunky, moist substances in the cracks, on the baseboards on the shower, and around the toilet. HKM stated that she thought the substance was mold, and that it would not come off even after deep cleaning. HKM stated, the black substance looks dirty, like [the staff] aren't cleaning.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/15/25 on 8:23 a.m. with the HKM, the HKM stated that housekeeping staff were reporting the poor state of the bathrooms to the previous Director of Maintenance (DOM), but the previous DOM never addressed the issues.</p> <p>During an observation on 1/15/25 at 8:29 a.m. in the bathroom for room [ROOM NUMBER], there were cracks at the edges of the shower and between the shower ramp and the tiles. The cracks had jagged uneven edges and a grimy black and gray substances. There was a gap on floor between the toilet and the tiles that was filled in with gunky black substances.</p> <p>During a concurrent observation and interview on 1/15/25 at 8:31 a.m. with the HKM in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], the flooring going into the shower had multilayered cracks exposing black grimy fuzzy substances. The cracks had sharp uneven edges. There was a gap between the toilet and the linoleum flooring covered with moist fuzzy gunky dark brown substances. There were multiple cracks along the baseboards and the linoleum flooring with uneven sharp edges. HKM stated the cleaning solution that housekeeping staff used could not remove the substances and discolorations.</p> <p>During an observation on 1/15/25 at 8:31 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were big dark black fuzzy stains around and behind the toilet. There were cracks between the shower ramp and the flooring. The cracks had jagged edges and exposed a rough black grainy surface. On the doorway between the bathroom and into room [ROOM NUMBER], the whole flooring was missing, exposing an uneven, rough surface with a brown and gray grimy substance.</p> <p>During an observation on 1/15/25 at 8:36 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were long gray discolorations under the sink and by the toilet. On the flooring going into the shower, there were large multilayer cracks with ragged, uneven edges, The cracks exposed a rough and grainy surface with black and gray grimy substances.</p> <p>During an observation on 1/15/25 at 8:38 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were scratched, silver discolorations on the rim of the toilet bowl. There was a gap between the linoleum floor and the toilet covered in a black grimy substance. There were cracks with jagged sharp edges on the linoleum floor by the toilet. There was a large deep crack on the flooring going into the shower. The crack had sharp jagged edges and exposed a hard gray grimy substance. There were gaps along the edges of the flooring going into the shower. The gaps were filled with black and gray gunky substances.</p> <p>During an observation on 1/15/25 at 8:41 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were cracks with jagged uneven edges on the flooring going into the shower. The cracks exposed a grimy rough black surface. There was a gap between the toilet and the flooring that was covered with a gunky moist black substance.</p> <p>During an observation on 1/15/25 at 8:43 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were cracks with jagged edges all over the floor, exposing a black grimy rough surface. There was a gap between the flooring and the toilet which was covered with a dark brown gunky substance.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 1/15/25 at 8:52 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were gaps between flooring and the toilet covered with black, dark brown gunky substances and surrounded by large black fuzzy discolorations on the floor. There was a large crack on the flooring by the doorway to room [ROOM NUMBER]. The crack had jagged sharp edges and moist thick grimy black substances.</p> <p>During an observation on 1/15/25 at 8:55 a.m. in the bathroom for room [ROOM NUMBER], there were peeling paint on and above the baseboards by the shower. There were long dark cracks on the wall above the showerhead. The baseboard next to the toilet was peeling off.</p> <p>During an observation on 1/15/25 at 8:58 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were cracks on the shower flooring with uneven edges and exposed dark grimy substances. There were gaps on the baseboards along the shower walls. The gaps had black and dark gray grimy substances. There were gaps between the toilet and the flooring covered in dark brown and fuzzy moist gunky black substances, surrounded by a thin layer of dark gray stains.</p> <p>During an observation on 1/15/25 at 9:00 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were multiple cracks with uneven edges on the shower ramp with black and gray grimy substances. There was a gap between the flooring and the toilet which was covered with a dark brown gunky substance. There was a multilayer crack on the flooring by the doorway to room [ROOM NUMBER]. The crack had jagged sharp edges and thick gunky black substances.</p> <p>During an observation on 1/15/25 at 9:04 a.m. in the bathroom for room [ROOM NUMBER], there were cracks on the shower flooring covered with black and dark gray grimy substances. There was a long crack running along the edge of flooring going into the shower covered with a black gunky substance.</p> <p>During an observation on 1/15/25 at 9:05 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there was multiple cracks with ragged, uneven edges on the flooring going into the shower. The cracks had black and gray grimy substances. There were cracks with jagged and uneven edged on the linoleum flooring by the toilet.</p> <p>During an observation on 1/15/25 at 9:08 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were cracks with jagged uneven edges on the flooring going into the shower. The cracks exposed a grimy rough black surface. There was a gap between the flooring and the toilet which was filled with a dark brown gunky substance. There were cracks with jagged and uneven edged on the linoleum flooring by the toilet.</p> <p>There were dark gray and black stains on the doorway leading into room [ROOM NUMBER].</p> <p>During an observation on 1/15/25 at 9:12 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were cracks on the shower flooring with uneven edges and exposed dark grimy substances. There were long dark gray stains across the floor and around the toilet.</p> <p>During an observation on 1/15/25 at 9:14 a.m. in the bathroom for room [ROOM NUMBER], there were cracks with jagged edges on the linoleum flooring next to toilet. There were multiple cracks with uneven edges on the shower ramp with black and gray grimy substances.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 1/15/25 at 9:15 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were cracks with jagged sharp edges on the linoleum floor behind the toilet. There were multiple cracks with ragged, uneven edges on the flooring going into the shower. The cracks had black and gray grimy substances.</p> <p>During an observation on 1/15/25 at 9:29 a.m. in the bathroom for room [ROOM NUMBER], there was a gap between the flooring and the toilet which was filled with a dark brown gunky substance. There were cracks with ragged, uneven lifted edges on the flooring going into the shower. The cracks had multiple gray grimy substances.</p> <p>During an observation on 1/15/25 at 9:43 a.m. in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were cracks on the shower flooring with uneven edges and exposed dark grimy substances. There were gaps on the baseboards along the shower walls. The gaps were filled with a black and dark gray grimy substance. There were gaps between the toilet and the flooring were filled with dark brown and fuzzy moist gunky black substances.</p> <p>During an interview on 1/15/24 at 9:56 a.m. with the Administrator (Admin), the Admin confirmed the poor condition of the flooring in the bathrooms, and it needed to be replaced.</p> <p>During an interview on 1/15/24 at 3:49 p.m. with Resident 83, Resident 83 stated the bathrooms sucked and looked like a mess. Resident 83 stated the bathrooms were scummy and uncomfortable to be in.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated February 2021, the P&P indicated, residents are provided with a safe, clean, comfortable and home like environment .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated December 2009, the P&P indicated, Functions of maintenance personnel include . Maintaining the building in good repair.</p> <p>50669</p> <p>2. During a concurrent observation and interview on 1/16/25 at 9:30 a.m. with Resident 54 in room [ROOM NUMBER], a dark brown substance was observed smeared on the curtain divider between bed B and bed C, facing bed C. Resident 54 stated, It looks like poop and it has been there for a while.</p> <p>During an interview on 1/16/25 at 9:32 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, I don't know what that is. It's dirty for sure. LVN 1 stated maintenance only changes the curtains after a request is put in and no request had been put in.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated February 2021, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment .</p> <p>3. During an interview on 1/13/25 at 10:53 a.m. with Resident 33, Resident 33 stated, The showers are always cold.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent observation and interview on 1/16/25 at 12:17 p.m. with Maintenance (MAIN) in room [ROOM NUMBER]'s bathroom, MAIN checked the shower's hot water temperature with a digital thermometer and it read 97.3 degrees Fahrenheit after waiting six minutes. MAIN stated the digital thermometer was calibrated on 1/16/25. MAIN stated, It feels cold, it's supposed to be at least 109.</p> <p>During a concurrent observation and interview on 1/16/25 at 12:27 p.m. with MAIN in room [ROOM NUMBER]'s bathroom, MAIN checked the shower's hot water temperature with a digital thermometer and it read 95.6 degrees Fahrenheit after waiting six minutes. MAIN stated the digital thermometer was calibrated on 1/16/25. MAIN checked the sink's hot water temperature and it read 106.3 degrees Fahrenheit after waiting six minutes. MAIN stated it was too cold to shower in and the sink temperature should have been at least 109 degrees Fahrenheit.</p> <p>During a concurrent observation and interview on 1/16/25 at 12:32 p.m. with MAIN in room [ROOM NUMBER]'s bathroom, MAIN checked the shower's hot water temperature with a digital thermometer and it read 95.3 degrees Fahrenheit after waiting six minutes. MAIN stated the digital thermometer was calibrated on 1/16/25. MAIN checked the sink's hot water temperature, it read 91.7 degrees Fahrenheit after waiting six minutes. MAIN stated, Yeah, that's not right. A temperature log was requested, and MAIN stated, There were no temperature logs.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safe Water Temperatures, undated, the P&P indicated, .maintain appropriate water temperatures in resident care areas . Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits monthly and as needed.</p>		

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<p>F 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>49936</p> <p>Based on interview and record review, the facility failed to ensure proper screening and follow-up for Registered Nurse (RN) 3 who had been found guilty of neglect by a court of law.</p> <p>This finding had the potential to compromise the safety of all residents, staff, and visitors. The facility census was 94.</p> <p>Findings:</p> <p>During a review of RN 3's employee files titled, CALIFORNIA BOARD OF REGISTERED NURSING- BRN (Board of Registered Nursing) LICENSING DETAILS, dated 1/16/25 and 12/19/23, the documents indicated RN 3 had an administrative disciplinary action against RN 3's license posted on 12/12/23.</p> <p>During a review of a public court document (legal document available to the public and is part of the court record) titled, BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA, dated 11/30/23, the document indicated, [RN 3] was convicted by a plea of guilty to: (1) child endangerment . felony .</p> <p>During an interview on 1/17/25 at 8:31 a.m. with the Administrator (ADMIN), the ADMIN identified himself as the facility's abuse coordinator (designated staff member within a nursing home responsible for overseeing and coordinating the facility's efforts to prevent resident abuse). The ADMIN stated it was the responsibility of the facility to check a registered nurse's license when up for renewal for the expiration date and if anything was added to the license, like a DUI. The ADMIN stated an employee with a disciplinary action against their nursing license meant the facility had to investigate the issue and go from there.</p> <p>The facility was unable to provide documentation that the administrative disciplinary action against RN 3's license was investigated and addressed by the facility.</p> <p>During a review of Registered Nurse (RN) 3's Job Description, dated 1/25/24, the document indicated, . Specific Requirements- Must possess a current, unencumbered (a license that's free of disciplinary limitation), active license to practice as an RN .</p> <p>During a review of the California Penal Code (a legal document that compiles a jurisdiction's criminal laws, defining various crimes), dated 1/1/23, the PENAL CODE Section 11165.2 indicated, 'Severe neglect' also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that their person or health is endangered .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, the P&P indicated, .Conduct employee background checks and not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law . a disciplinary action in effect against his or her professional license by a state licensure body as a result of finding of abuse, neglect, exploitation .</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>50669</p> <p>Based on interview and record review, the facility's abuse program failed to protect the residents when:</p> <ol style="list-style-type: none"> 1. Resident 54's transfer request after a resident-to-resident altercation was not completed. (Cross Reference F745) 2. Reports of abuse were not reviewed and analyzed by QAPI (QAPI, data-driven approach to improving quality in healthcare facilities) per the facility's policy ad procedure. 3. There was no policy and procedure developed to prohibit and prevent retaliation (act of revenge that causes harassment or harm) against residents, families, and visitors who report incidents of abuse, neglect, or other similar violations. <p>These failures had the potential to compromise the safety of all residents, staff, and visitors. The facility census was 94.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an interview on 1/13/25 at 9:03 a.m. with Resident 54, Resident 54 stated she was involved in a resident-to-resident altercation on 12/13/24 and has been trying to leave the facility. Resident 54 stated, I don't feel safe here. <p>During an interview on 1/16/25 at 9:26 a.m. with Resident 54, Resident 54 stated she did not feel safe at the facility and still wanted to transfer to a different facility. Resident 54 stated she had not heard any update in a month.</p> <p>During an interview on 1/16/25 at 10:01 a.m. with the Social Services Director (SSD), the SSD stated she did not call any facilities to follow-up on transferring Resident 54 since 12/18/24. The SSD stated it was very important for residents to feel safe at the facility, and she should have seen her more frequently and followed up with transferring Resident 54 to a different facility.</p> <p>During an interview on 1/16/25 at 11:06 a.m. with the Director of Nursing (DON), the DON stated after Resident 54 stated she did not feel safe, the SSD should have followed up daily to address any psychosocial needs.</p> <p>During a review of Resident 54's Summary- Resident-to-Resident Incident, dated 12/13/24, Resident 54's Summary- Resident-to-Resident Incident indicated, When asked if [Resident 54] feels safe in the facility, [Resident 54] stated, 'No.' .When asked if [Resident 54] would like to be place in another facility . [Resident 54] stated, 'Yes.'</p> <p>During a review of Resident 54's Social Services Note, dated 12/17/24, the note indicated Resident 54 did not feel safe at the facility and discussed other facility options with the SSD. The note indicated the SSD faxed a referral.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 54's Social Services Note, dated 12/18/24, the note indicated, [facility name 1] has been called to see if they have reviewed referral have called and have asked for them to call back awaiting response, [facility name 2] was called to see if they have reviewed referral they have not called back at this time.</p> <p>During a review of Resident 54's Social Services Note, dated 12/19/24, the note indicated, [facility name 1] have called have not been able to speak with admission. Will f/u (follow up) as needed.</p> <p>During a review of Resident 54's Psychiatric Visit Progress Report, dated 12/23/24, the Psychiatric Visit Progress Report indicated, Patient reports feeling depressed because of this place and how they're running this place.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated April 2021, was reviewed. The P&P indicated, Protect residents from any further harm .</p> <p>49936</p> <p>2. During a review of the facility's QAPI Minutes (a written record of a QAPI meeting that documents topics discussed, decisions made, and actions taken), dated January to December 2024, the minutes indicated there was no analysis of data regarding abuse allegations and no discussion of possible trends regarding abuse occurrence in the facility.</p> <p>During an interview on 1/17/25 at 9:17 a.m. with the Administrator (ADMIN), the ADMIN identified himself as the facility's abuse coordinator (designated staff member within a nursing home responsible for overseeing and coordinating the facility's efforts to prevent resident abuse). The ADMIN stated he reported abuse allegations to QAPI but did not keep a log to track trends regarding abuse. The ADMIN stated, It's not QAPI's job to track abuse.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated April 2021, the P&P indicated, Establish and implement a QAPI review and analysis of reports, allegations or findings of abuse, neglect, mistreatment, misappropriation of property.</p> <p>3. During an interview on 1/14/25 at 10:14 a.m. with Resident 84, Resident 84 stated she sometimes felt like she should not report incidents or concerns to staff because she was afraid of staff retaliation.</p> <p>During an interview on 1/16/25 at 5:56 p.m. with the Administrator (ADMIN), the ADMIN identified himself as the facility's abuse coordinator (designated staff member within a nursing home responsible for overseeing and coordinating the facility's efforts to prevent resident abuse). The ADMIN stated retaliation only occurred against staff who reported abuse. The ADMIN stated retaliation against residents who reported abuse was not possible; it's not a thing.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated April 2021, the P&P did not include prohibiting and preventing retaliation against residents, families, or visitors that reported abuse. The facility was unable to provide a policy or procedure regarding how the facility would ensure residents would not be subjected to acts of retaliation during and after an abuse investigation.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119</p> <p>Based on interview and record review, the facility failed to send a copy of the resident's transfer notification to the Office of the State Long-Term Care Ombudsman (resident advocacy agency) for two of 23 sampled residents (Resident 77 and 84) when:</p> <ol style="list-style-type: none"> 1. Resident 77 was transferred to General Acute Care Hospital (GACH) on 11/10/24, and a transfer notification was not sent to the Ombudsman. 2. Resident 84 was transferred to General Acute Care Hospital (GACH) on 11/15/24, and a transfer notification was not sent to the Ombudsman. <p>These failure resulted in the Office of the State Long-Term Care Ombudsman not being aware of Resident 77 and 84's transfers to GACH.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 77's Face Sheet (demographics), the Face Sheet indicated Resident 77 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe). <p>During a review of Resident 77's Progress Notes, dated 11/10/24, the notes indicated .running high temp (temperature) with irregular HR (heart rate). MD (medical doctor) notified of the vitals and was recommended to send him to the hospital .</p> <p>During a concurrent interview and record review on 1/15/25 at 12:28 p.m. with the Medical Records Director (MRD), Resident 77's Medical Record was reviewed. The MRD stated Resident 77 was sent to the hospital on 11/10/24, and that the Notice of Transfer or Discharge was not sent to the Office of the State Long-Term Care Ombudsman.</p> <p>During an interview on 1/15/25 at 2:28 p.m. with Registered Nurse (RN) 6, RN 6 stated the purpose of the notice of transfer and discharge was to notify the Office of the State Long-Term Care Ombudsman of the transfer or discharge of resident. RN 6 stated it was the licensed nurse's responsibility to complete and send the notice of transfer or discharge form.</p> <p>During a concurrent interview and record review on 1/16/25 at 10:30 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Transfer or Discharge, Facility-Initiated, dated October 2022, was reviewed. The P&P indicated, .The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge, including the basis .A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer is provided to the resident and representative . The DON stated it was the licensed nurses' responsibility to send the notice of transfer or discharge at the time it was initiated. The DON stated the notice of transfer or discharge should be sent to the Office of the State Long-Term Care Ombudsman.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50933</p> <p>2. During a review of the Resident 84's provider note from [hospital name], dated 11/15/24, the note indicated Resident 84 was admitted to the hospital for osteomyelitis of great left toe (swelling that occurs in the bone).</p> <p>During a review of the Resident 84's [hospital name] History and Physical (H&P), dated 11/15/24, the H&P indicated Admit [Resident 84] to hospital service.</p> <p>During a concurrent interview and record review on 1/15/25 at 2:44 p.m. with the Medical Records Director (MDR), Resident 84's Medical Record was reviewed. The MRD stated Resident 84 was sent to the hospital on 11/15/24, and that the Notice of Transfer or Discharge to the Office of the State Long-Term Care Ombudsman was not in Resident 84's Medical Record.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, Facility-Initiated, dated October 2022, the P&P indicated .The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge, including the basis . A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer is provided to the resident and representative .</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50933</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Sets (MDS- a standardized assessment and care planning tool) were accurate for two of 23 sampled residents (Residents 25 and Resident 391). This failure had the potential to adversely affect the provision of care for Residents 25 and Resident 391.</p> <p>Findings:</p> <p>1. During an interview on 01/15/25 at 3:26 p.m. the Medical Record Director (MRD), MRD stated Resident 391 was discharged home.</p> <p>During a concurrent interview and record review on 01/16/25 at 9:25 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 391's MDS, dated [DATE], was reviewed. Resident 391's quarterly MDS Section A2105 indicated Resident 391 was discharged to a Short-Term General Hospital. MDSC stated Resident 391's MDS was inaccurate because she went home, not to the hospital.</p> <p>During a review of Resident 391's Discharge Summary, dated 11/27/24, the Discharge Summary indicated Resident 391 was to be discharged to home on 11/29/24.</p> <p>During a review of Resident 391's Nursing Progress Note, dated 11/29/24, the Nursing Progress Note indicated, On 11/29/2024, the patient was successfully discharged from the skilled nursing facility . is expected to continue at her new setting, home .</p> <p>During a review of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Manual Version 3.0, dated October 2024, the RAI Manual indicated, The assessment accurately reflects the resident's status .</p> <p>52029</p> <p>2. During a review of Resident 25's Face Sheet (demographics), the Face Sheet indicated Resident 25 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of the temporal lobe (brain tumor), iron deficiency anemia (a condition in which blood lacks healthy red blood cells), type 2 diabetes mellitus (a disease resulting in body's inability to regulate blood sugar), and dysphasia (difficulty swallowing).</p> <p>During a concurrent interview and record review on 1/14/25 at 4:00 p.m. with Director of Nursing (DON), Resident 25's Weight Measurements was reviewed. Resident 25's weights were documented as:</p> <p>9/23/24- 153 lbs. (pounds)</p> <p>10/7/24- 148 lbs.</p> <p>11/2/24- 144 lbs.</p> <p>11/26/24- 139 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/10/24- 135 lbs.</p> <p>12/24/24- 120 lbs.</p> <p>12/30/24- 120 lbs.</p> <p>12/31/24- 113 lbs.</p> <p>1/2/25- 120 lbs.</p> <p>1/6/25- 119 lbs.</p> <p>DON confirmed Resident 25 lost 34 pounds which was a 22.22% weight loss since his admission.</p> <p>During an interview on 1/14/25 at 2:14 p.m. with Registered Dietitian (RD), RD confirmed Resident 25 had a 22.22% weight loss since admission.</p> <p>During a concurrent interview and record review on 1/15/25 at 11:14 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 25's MDS, dated [DATE], was reviewed. Under Section K 300, Weight Loss of 5% or more in the last month or loss of 10% or more in the last 6 months, MDSC coded a response of no. MDSC confirmed she did not code the MDS accurately. MDSC stated it was important to code the MDS correctly because the MDS triggered the resident's plan of care.</p> <p>During a review of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Manual Version 3.0, dated October 2024, the RAI Manual indicated, The assessment accurately reflects the resident's status .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated March 2022, the P&P indicated, A comprehensive assessment of every resident's needs . which includes admission assessments, quarterly assessment, annual assessment, Significant change in status assessments, and completion of the MDS .</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>50669</p> <p>Based on interview and record review, the facility failed to identify a mental illness (MI- medical disorder that affects a person's thinking, emotions, or behavior) and subsequently failed to refer one of 23 sampled residents (Resident 71) for a Level II PASRR (Preadmission Screening and Resident Review- used to ensure individuals are placed in an appropriate setting and receive needed mental health services) screening. This failure resulted in Resident 71 not receiving specialized mental health services to meet her needs.</p> <p>Findings:</p> <p>During a review of Resident 71's PASRR, dated 7/14/23, the PASRR indicated Level 1 screening was negative. PASRR indicated Resident 71 was not diagnosed with a mental disorder such as anxiety disorder (mental health condition that involves excessive and persistent feelings of fear, worry, dread and uneasiness that can cause physical symptoms) and panic disorder (mental health condition that experiences unexpected and repeated episodes of intense fear accompanied by physical symptoms like chest pain), and not prescribed psychotropic (a drug that affects how the brain works and causes changes in mood, thoughts, feelings and behaviors) medications for mental illness.</p> <p>During a review of Resident 71's Minimum Data Set (MDS-an assessment tool), dated 7/20/23, the MDS indicated Resident 71's active diagnoses were anxiety disorder and post-traumatic stress disorder (a condition of persistent mental and emotion stress occurring because of injury or severe psychological shock). The MDS indicated Resident 71's Level II PASRR Conditions were not checked.</p> <p>During a review of Resident 71's CAA [Care Area Assessment] Worksheet (a tool used to further investigate specific areas of concern identified during MDS assessment), dated 7/20/23, the CAA Worksheet indicated Resident has had thoughts that she would be better off dead, or thoughts of hurting herself, and she was on medication for PTSD and psychosis (symptoms that can cause a person to lose touch with reality such as hallucinations). The CAA Worksheet further indicated Resident 71 had severe depression and was recommended for a Referral . PsyD (doctor of psychology) .</p> <p>During a concurrent interview and record review on 1/16/25 at 9:52 a.m. with Social Services Director (SSD), Resident 71's Medication Administration Record (MAR), dated 1/16/25 was reviewed. Resident 71's MAR indicated Resident received three different medications for post-traumatic stress disorder, panic disorder and depression. SSD stated it was her responsibility to arrange the referral for a PASRR evaluation. SSD stated if a resident had psychosis, depression, anxiety or other mental health related diagnoses, the resident would be referred for clarification for PASRR evaluation. SSD stated Resident 71 was never evaluated or referred for PASRR clarification, but she should have been.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Preadmission Screen and Resident Review (PASRR), dated July 2016, the P&P indicated, It is the policy of this facility to complete and submit a PASRR screening . If facility is dissatisfied with the recommendations in the PASRR determination letter, they can request a reconsideration . the facility will update the existing PASRR on file for either of the following reasons . there is a significant change in a resident's physical or mental condition .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52029</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to reduce the risk of injuries from falls for one of 23 sampled residents (Resident 25). This failure resulted in the potential for the resident to suffer an injury during a fall.</p> <p>Findings:</p> <p>Review of Resident 25's Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the temporal lobe (brain tumor).</p> <p>During an interview on 1/13/25 at 10:50 a.m. with Resident 25's Responsible Party (RP) 1, RP 1 stated facility staff called her on 1/12/25 and informed her that Resident 25 had rolled out of his bed.</p> <p>During an observation on 1/13/25 at 9:00 a.m. in Resident 25's room, Resident 25 was in bed asleep. No fall mat was observed on the floor at his bedside.</p> <p>During an observation 1/13/25 11:58 a.m. in Resident 25's room, Resident 25 was in bed asleep. No fall mat observed at bedside.</p> <p>During an interview on 1/15/25 at 8:45 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 25 required assistance to get out of bed. CNA 1 stated he was aware that the resident was found on the floor. CNA 1 confirmed there was not a fall mat at Resident 25's bedside.</p> <p>During an interview on 1/14/25 at 9:11 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 25 fell on [DATE] and was found crawling on the floor. RN 1 stated that a fall mat should have been placed next to Resident 25's bed.</p> <p>During an interview on 1/15/25 at 9:15 a.m. with Charge Registered Nurse (CRN) 1, CRN 1 stated that Resident 25 recently had a fall on 1/12/25. CRN 1 stated that Resident 25 becomes agitated and scoots around in bed. CRN 1 stated that Resident 25 required a fall mat and that it may have been removed for cleaning.</p> <p>During an interview on 1/15/25 at 12:30 p.m. with the Director of Nursing (DON) 1, DON 1 stated that the fall mat should be used as an intervention for Resident 25 because he was prone to crawling or rolling out of bed.</p> <p>During a review of Resident 25's Care Plan, dated 10/15/24, the Care Plan indicated, Resident 25 had been found crawling out of bed and interventions included keep floor mat at bedside.</p> <p>During a review of the facility's policy titled, Falls and Fall Risk, managing, dated March 2018, the policy indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119</p> <p>Based on observation, interview, and record review, the facility failed to revise and implement a person centered comprehensive care plan for one of 23 sampled residents (Resident 28), when Resident 28 fell on [DATE] and care plan interventions were not revised and updated.</p> <p>This failure placed Resident 28's health and safety at risk when fall care plan interventions were not revised.</p> <p>Findings:</p> <p>During a review of Resident 28's Face Sheet (demographics), the Face Sheet indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including repeated falls, muscle weakness and dementia (impaired ability to remember, think, or make decisions).</p> <p>During an observation on 1/14/25 at 8:56 a.m. in Resident 28's room, Resident 28 was observed seated in his wheelchair self-propelling himself out of his room.</p> <p>During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) Assessment, dated 12/19/24, the MDS indicated Resident 28's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 3 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment, 99 severely impaired). The BIMS assessment indicated Resident 28 had severe cognitive impairment.</p> <p>During a review of Resident 28's Progress Notes, dated 1/12/25, the notes indicated, . Resident had unwitnessed fall and sustained on left elbow skin tear on upper extremities . Resident found on lying position by a [Certified Nurse Assistant] CNA .confusion as baseline .</p> <p>During a concurrent interview and record review on 1/14/25 at 3:40 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 28's Care Plan (CP), dated 9/7/24 was reviewed. The CP indicated, .is at risk for falls R/T [related to] deconditioning, gait/balance problems . LVN 4 reviewed Resident 28's CP and stated there were no updated interventions after the fall on 1/12/25. LVN 4 stated care plan interventions should be updated after a fall, but was not. LVN 4 stated the fall care plan should have been updated and that it was the nurses' responsibility to update it. LVN 4 stated the purpose of the CP was to implement interventions and measure what was working or not.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/16/25 at 10:26 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated March 2018 was reviewed. The P&P indicated, .Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . In conjunction with the attending physician, staff will identify and implement relevant interventions . to try to minimize serious consequences of falling . The DON stated the CP should be updated after a fall to prevent a serious injury. The DON stated the purpose of the care plan was to identify problems and implement interventions to maintain or improve conditions.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50669</p> <p>Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice when Licensed Vocational Nurse (LVN) 2 prepared two unsampled residents' (Resident 39 and Resident 193) medications and did not observe Resident 39 and Resident 193 ingest medications. This failure had the potential to result in Resident 39 and Resident 193 receiving the wrong medications.</p> <p>Findings:</p> <p>During an observation on 1/15/25 at 12:35 p.m. in the hallway of Station 1, LVN 2 was standing in front of the medication cart. LVN 2 had two medicine cups on top of the medication cart with unidentified pills: the first medicine cup, labeled 22A in black marker, had one long yellow pill. The second medicine cup, labeled 22C in black marker, had one round blue pill and one round white pill. LVN 2 went into the medication cart and dispensed a third pill into the medicine cup labeled 22C. LVN 2 then walked down the hallway, approximately 65 feet, holding the two medicine cups. LVN 2 entered Resident 39 and 193's room and placed the medicine cup labeled 22A on the bedside table for Resident 39. LVN 2 then walked over and placed the medicine cup labeled 22C on the bedside table for Resident 193. LVN 2 did not observe Resident 39 and Resident 193 ingest the medications that were placed on their bedside tables, and did not inform the residents of what medications were in the cups .</p> <p>During an interview on 1/15/25 at 12:41 p.m. with LVN 2, LVN 2 stated she was supposed to push the medication cart to the resident's room and prepare medications one resident at a time. LVN 2 confirmed she did not follow expectations. LVN 2 further stated she did not observe Resident 39 and Resident 193 ingest the medications because They always take those meds [medications].</p> <p>During an interview on 1/15/25 at 12:47 p.m. with the Director of Nursing (DON), the DON stated the expectation was the medication cart goes to each room with the nurse during medication administration. DON stated nurses should not prepare multiple residents' medications at one time to avoid the possibility of medication error. DON further stated residents should be observed while taking medications by the nurse.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, .Medications are administered at the time they are prepared. Medications are not pre-poured . The resident is always observed after administration to ensure that the dose was completely ingested .</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49936</p> <p>Based on observation, interview, and record review, the facility failed to ensure that Resident 290 received an assistive device for his vision needs when Resident 290 did not receive assistance with making an appointment to get new eyeglasses.</p> <p>This failure resulted in negatively affecting Resident 290's ability to enjoy his favorite hobbies such as crossword puzzles.</p> <p>Findings:</p> <p>During a review of Resident 290's Face Sheet (demographics), the Face Sheet indicated Resident 290 was admitted on [DATE] with diagnoses including diabetic retinopathy (eye condition that damages the eye's blood vessels due to high blood sugar). The Face Sheet included a picture of Resident 290 wearing eyeglasses.</p> <p>During a concurrent observation and interview on 1/14/25 at 4:25 p.m. with Resident 290 in his room, Resident 290 was holding up the crossword puzzle very close to his face. Resident 290 stated that he has been unable to do his crossword puzzles which he loved to do because he did not have eyeglasses for more than two weeks. Resident 290 stated that he reported his eyeglasses missing and requested getting new eyeglasses from the Social Services Director (SSD).</p> <p>During an interview on 1/14/25 at 4:32 p.m. with the SSD, the SSD stated that she remembered talking to Resident 290 about needing to send him out for a consultation if he needed help with getting eyeglasses, but she did not document the interaction or follow-up afterwards. The SSD stated that if residents brought up issues to her when she was not in the office, she would sometimes forget to chart them. The SSD stated that she was responsible for helping residents with setting up an appointment to get new eyeglasses. The SSD stated that Resident 290 not having his glasses would negatively affect his quality of life by a lot.</p> <p>During a review of Resident 290's Nursing Admission Screening, dated 12/27/24, the document indicated, Resident 290 wears glasses.</p> <p>The facility was unable to provide a policy and procedure regarding ensuring that residents received the proper assistive devices, such as eyeglasses, to maintain vision abilities.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52029</p> <p>Based on interview, and record review, the facility failed to ensure physician visits were conducted once every thirty days for Resident 25. This failure had the potential to result in an undetected decline in Resident 25's health and/or potential delays in treatment or services.</p> <p>Findings:</p> <p>During a review of Resident 25's Face Sheet (demographics), the Face Sheet indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the temporal lobe (brain tumor), iron deficiency anemia (fewer red blood cells in the body due to a lack of iron), type 2 diabetes mellitus (condition that causes the level of sugar in the blood to become too high), and dysphasia (difficulty swallowing).</p> <p>During an interview on 1/15/25 at 3:20 p.m. with Medical Director (MD), MD stated she visited the facility daily and saw the residents who need medication changes. MD stated she was unaware of the requirements for physician's visits, but she tried to see all residents monthly. MD stated, Sometimes I just pop in and see how they are doing and I don't document that. When I do an examination, I document it.</p> <p>During a concurrent interview and record review of Resident 25's Medical Record on 1/15/25 at 4:00 p.m. with the Director of Nursing (DON), DON stated he was unsure how often the MD visited Resident 25. DON confirmed there was no documentation in the record which indicated that Resident 25 was seen by MD between 9/20/24 and 11/28/24 (58 days). DON stated, [MD] must not have visited Resident 25 during that timeframe.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Physician Visits, dated April 2013, the P&P indicated, The Attending Physician must visit his/her patients at least once every thirty days for the first ninety days . physician must perform relevant tasks at the time of each visit including a review of the resident's total program of care and appropriate documentation.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure five out of five licensed nurses (Registered Nurse 3, 4, 5, 6 and Licensed Vocational Nurse 2) were competent (having the necessary ability, knowledge, or skill to do something successfully) in medication administration. This failure resulted in a medication error rate of 24% and had the potential to result in significant adverse events (any undesirable or harmful effects that occur as a result of medical treatment including medications) to a medically compromised population. The facility census was 94. (Cross-reference F759)</p> <p>Findings:</p> <p>During multiple observations on 1/15/25 at various times with Registered Nurse (RN) 3, RN 4, RN 5, RN 6, and Licensed Vocational Nurse (LVN) 2, medications were administered to Resident 36, 39, 71, 81, 193, and 291. The medication error rate was 24%.</p> <p>During an interview on 1/15/25 at 12:55 p.m. with the Director of Nursing (DON), the DON stated nurses were evaluated for medication administration competency upon hire and if there were any errors with competency during medication administration audits (observations to help identify potential and actual medication errors at different stages). The DON further stated medication administration audits were completed by the Pharmacist (PHARM).</p> <p>During an interview on 1/16/25 at 3:26 p.m. with the PHARM, the PHARM stated he has not completed medication administration audits and that was not his responsibility.</p> <p>During a review of Duties and Responsibilities (job description), for RN 3, 4, 5, 6 and LVN 2, the Duties and Responsibilities indicated, Implement and maintain established nursing objectives and standards . Ensure that established departmental policies and procedures are followed . Prepare and administer medications as ordered by the physician .</p> <p>During a review of [facility name] Facility Assessment, dated 1/6/25, the Facility Assessment indicated, .Staff Training/Education & Competencies . Upon hire skills checks are completed through competency evaluations and are reviewed annually thereafter or as needed. Performance evaluations are performed annually to ensure staff are meeting the facility standards of performance and conduct .</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices . Medications are administered in accordance with written orders .</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to provide mental health services to Resident 71. This failure had the potential to negatively affect Resident 71's psychosocial (the mental, emotional, social and spiritual effects of a disease) well-being.</p> <p>Findings:</p> <p>During a review of Resident 71's Face Sheet (demographics) dated 1/16/25, the Face Sheet indicated Resident 71 was admitted to the facility on [DATE], with diagnoses of depression, panic disorder (mental health condition that experiences unexpected and repeated episodes of intense fear accompanied by physical symptoms like chest pain), generalized anxiety disorder (mental health condition that involves excessive and persistent feelings of fear, worry, dread and uneasiness that can cause physical symptoms), and chronic post-traumatic stress disorder (a condition of persistent mental and emotion stress occurring because of injury or severe psychological shock).</p> <p>During a review of Resident 71's Minimum Data Set (MDS-an assessment tool), dated 7/20/23, the MDS indicated, Resident 71's active diagnoses are anxiety disorder and post-traumatic stress disorder.</p> <p>During multiple observations on 1/13/25 to 1/17/25 at various times in room [ROOM NUMBER], Resident 71 was always in her room isolated and lying in bed most of the day.</p> <p>During an interview on 1/14/25 at 10:39 a.m. with Registered Nurse (RN) 2, RN 2 stated Resident 71 had depression, and she was sad often because her son passed away. RN 2 stated since admission, Resident 71 has laid in bed and rarely left her room.</p> <p>During an interview on 1/15/25 at 5:14 p.m. with the Medical Director (MD), the MD stated, Resident 71 definitely had depression and sometimes aggression.</p> <p>During an interview on 1/16/25 at 9:16 a.m. with Resident 71, Resident 71 stated the facility had not provided behavioral health services. Resident 71 further stated she had informed the Social Services Director (SSD) that she wanted counseling. Resident 71 stated she had been dealing with so much mentally for [AGE] years, I'm sad mostly all day.</p> <p>During an interview on 1/16/25 at 9:52 a.m. with the SSD, the SSD stated Resident 71 had not been evaluated or seen by any mental health professional.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/16/25 at 4:02 p.m. with the Administrator (ADMIN), Resident 71's CAA [Care Area Assessment] Worksheet (a tool used to further investigate specific areas of concern identified during MDS assessment), dated 7/20/23 was reviewed. The CAA Worksheet indicated Resident has had thoughts that she would be better off dead, or thoughts of hurting herself, and she was on medication for PTSD and psychosis (symptoms that can cause a person to lose touch with reality such as hallucinations). The CAA Worksheet further indicated Resident 71 had severe depression and was recommended for a Referral . PsyD (doctor of psychology) . The ADMIN confirmed Resident 71 did not have any mental health services and stated, I'm very surprised, she should have had help.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Behavioral Health Services,' undated, the P&P indicated, The facility will provide, and residents will receive behavioral health services .</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. follow up on facility transfer for one of 23 sampled residents (Resident 54) 2. properly screen for Preadmission Screening and Resident Review (PASARR- used to ensure individuals are placed in an appropriate setting and receive needed mental health services) for one of 23 sampled residents (Resident 71) 3. arrange and provide mental/psychosocial counseling services for one of 23 sampled residents (Resident 71) <p>These failures resulted in the delay of Resident 54 and Resident 71's care to maintain their well-being.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 1/13/25 at 9:03 a.m. with Resident 54 in room [ROOM NUMBER], Resident 54's privacy curtain was drawn, Resident 54 was sitting on edge of the bed, and watching television. Resident 54 stated she was involved in a resident-to-resident altercation on 12/13/24 and had been trying to leave the facility and stated, I don't feel safe here.</p> <p>During an interview on 1/16/25 at 9:26 a.m. with Resident 54, Resident 54 stated she did not feel safe at the facility and still wanted to transfer to a different facility. Resident stated she had not heard any update in a month.</p> <p>During an interview on 1/16/25 at 10:01 a.m. with the Social Services Director (SSD), the SSD stated she did not call any facilities to follow up on transferring Resident 54 since 12/18/24. The SSD stated it was very important for residents to feel safe at the facility and she should have seen here more frequently and followed up with transferring Resident 54 to a different facility.</p> <p>During an interview on 1/16/25 at 11:06 a.m. with the Director of Nursing (DON), the DON stated after Resident 54 stated she did not feel safe, Social Services should have followed up daily to address any psychosocial needs.</p> <p>During a review of Resident 54's Summary- Resident-to-Resident Incident, dated 12/13/24, Resident 54's Summary- Resident-to-Resident Incident indicated, When asked if she feels safe in the facility, [Resident name] stated, No. When asked if she would like to be place in another facility . [Resident name] stated, yes.</p> <p>During a review of Resident 54's Social Services Note, dated 12/17/24, the Social Services Note indicated, she said she was doing well but did not fell safe . when she was asked if she felt safe here she replay no was and discus other placement options and she said to was okay, Referral was fax .</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 54's Social Services Note, dated 12/18/24, the Social Service Note indicated, . [facility name 1] has been called to see if they have reviewed referral have called and have asked for them to call back awaiting response, [facility name 2] was called to see if they have reviewed referral they have not called back at this time.</p> <p>During a review of Resident 54's Social Services Note, dated 12/19/24, the Social Service Note indicated, [facility name 1] have called have not been able to speech with admission. Will f/u (follow up) as needed.</p> <p>During a review of Resident 54's Psychiatric Visit Progress Report, dated 12/23/24, the Psychiatric Visit Progress Report indicated, Patient reports feeling depressed because of this place and how they're running this place.</p> <p>Facility was unable to provide policy and procedure for Social Services.</p> <p>2. During a review of Resident 71's PASRR, dated 7/14/23, the PASRR indicated Level 1 screening was negative. PASRR indicated Resident 71 was not diagnosed with a mental disorder such as anxiety disorder (mental health condition that involves excessive and persistent feelings of fear, worry, dread and uneasiness that can cause physical symptoms) and panic disorder (mental health condition that experiences unexpected and repeated episodes of intense fear accompanied by physical symptoms like chest pain), and not prescribed psychotropic (a drug that affects how the brain works and causes changes in mood, thoughts, feelings and behaviors) medications for mental illness.</p> <p>During a review of Resident 71's Minimum Data Set (MDS-an assessment tool), dated 7/20/23, the MDS indicated, Resident 71's active diagnoses are anxiety disorder and post-traumatic stress disorder (a condition of persistent mental and emotion stress occurring because of injury or severe psychological shock). The MDS indicated, Resident 71's Level II Preadmission Screening and Resident Review (PASRR) Conditions were not checked.</p> <p>During a review of Resident 71's CAA [Care Area Assessment] Worksheet (a tool used to further investigate specific areas of concern identified during MDS assessment), dated 7/20/23, the CAA Worksheet indicated Resident has had thoughts that she would be better off dead, or thoughts of hurting herself, and she was on medication for PTSD and psychosis (symptoms that can cause a person to lose touch with reality such as hallucinations). The CAA Worksheet further indicated Resident 71 had severe depression and was recommended for a Referral . PsyD (doctor of psychology) .</p> <p>During a concurrent interview and record review on 1/16/25 at 9:52 a.m. with Social Services Director (SSD), Resident 71's Medication Administration Record (MAR), date 1/16/25 was reviewed. Resident 71's MAR indicated Resident received three different medications for post-traumatic stress disorder, panic disorder and depression. SSD stated if a resident had psychosis, depression, anxiety or other mental health related diagnoses, the resident would be referred for clarification for PASRR evaluation. SSD stated Resident 71 was never evaluated or referred for PASRR clarification and she should have been.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Preadmission Screen and Resident Review (PASRR), dated July 2016, the P&P indicated, It is the policy of this facility to complete and submit a PASRR screening . If facility is dissatisfied with the recommendations in the PASRR determination letter, they can request a reconsideration . the facility will update the existing PASRR on file for either of the following reasons . there is a significant change in a resident's physical or mental condition .</p> <p>3. During multiple observations on 1/13/25 to 1/17/25 at various times in room [ROOM NUMBER], Resident 71 was always in her room isolated and lying in bed mostly all day.</p> <p>During an interview on 1/14/25 at 10:39 a.m. with Registered Nurse (RN) 2, RN 2 stated Resident 71 had depression, and she was sad often because her son passed away. RN 2 stated since admission, Resident 71 has laid in bed and rarely left her room.</p> <p>During an interview on 1/15/25 at 5:14 p.m. with the Medical Director (MD), the MD stated Resident 71 definitely had depression and sometimes aggression.</p> <p>During an interview on 1/16/25 at 9:16 a.m. with Resident 71, Resident 71 stated the facility had not provided behavioral health services and she further stated she had informed the Social Services Director that she wanted counseling. Resident 71 stated she had been dealing with so much mentally for [AGE] years, I'm sad mostly all day.</p> <p>During an interview on 1/16/25 at 9:52 a.m. with the Social Services Director (SSD), the SSD stated Resident 71 had not been evaluated or seen by any mental health professional.</p> <p>During a concurrent interview and record review on 1/16/25 at 4:02 p.m. with the Administrator (ADMIN), Resident 71's CAA [Care Area Assessment] Worksheet (a tool used to further investigate specific areas of concern identified during MDS assessment), dated 7/20/23 was reviewed. The CAA Worksheet indicated Resident has had thoughts that she would be better off dead, or thoughts of hurting herself, and she was on medication for PTSD and psychosis (symptoms that can cause a person to lose touch with reality such as hallucinations). The CAA Worksheet further indicated Resident 71 had severe depression and was recommended for a Referral . PsyD (doctor of psychology) . The ADMIN confirmed Resident 71 did not have any mental health services and stated, I'm very surprised, she should have had help.</p> <p>During a review of Resident 71's Admission Record, dated 1/16/25, the Admission Record indicated, Resident 71 was admitted to the facility on [DATE], with diagnoses of depression, panic disorder (mental health condition that experiences unexpected and repeated episodes of intense fear accompanied by physical symptoms like chest pain), generalized anxiety disorder (mental health condition that involves excessive and persistent feelings of fear, worry, dread and uneasiness that can cause physical symptoms), and chronic post-traumatic stress disorder (a condition of persistent mental and emotion stress occurring because of injury or severe psychological shock).</p> <p>During a review of Resident 71's Minimum Data Set (MDS-an assessment tool), dated 7/20/23, the MDS indicated, Resident 71's active diagnoses are anxiety disorder and post-traumatic stress disorder.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Behavioral Health Services,' undated, the P&P indicated, The facility will provide, and residents will receive behavioral health services .</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52029</p> <p>Based on interview and record review, the facility failed to ensure Monthly Medication Reviews (MMR- a comprehensive review of all medications a resident receives) were conducted for Resident 61. This failure resulted in the potential for Resident 61 to receive unnecessary medications.</p> <p>Findings:</p> <p>During a review of Resident 61's Face Sheet (demographics), the Face Sheet indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including Lewy body dementia (brain disease that causes a gradual decline in thinking, movement, and behavior) and major depressive disorder (a mental disorder causing low mood, lack of interest and feelings of hopelessness).</p> <p>During an interview on 1/16/25 at 3:14 p.m. with Pharmacist (PHARM), PHARM stated that he should conduct a MMR every month to look for any medication concerns such as duplicate therapy or medication interactions and email the results to the Director of Nursing (DON) so that any issues with the resident's medications could be addressed.</p> <p>During a concurrent interview and record review of Resident 61's MMRs on 1/16/25 at 3:50 p.m. with DON, there were no documentation of MMRs found in Resident 61's Medical Record for the months of January and August 2024. DON confirmed MMRs were not conducted.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Consultant Pharmacist Reports, dated December 2016, the P&P indicated, The consultant pharmacist performs a comprehensive medication regimen review at least monthly . to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy . the findings are documented and stored within 72 hours.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52029</p> <p>Based on interview and record review, the facility failed to attempt a Gradual Dose Reduction (GDR- an attempt to reduce the dose of medications which affect the nervous system to treat mental illness to achieve the lowest dose possible) for one of 23 sampled residents (Resident 61). This failure had the potential to result in Resident 61 receiving psychotropic medications which were unnecessary and in excessive dose.</p> <p>Findings:</p> <p>During a review of Resident 61's Face Sheet (demographics), the Face Sheet indicated Resident 61 was admitted to the facility on [DATE] with diagnoses which included Lewy body dementia (brain disease that causes a gradual decline in thinking, movement, and behavior) and major depressive disorder (a mental disorder causing low mood, lack of interest and feelings of hopelessness).</p> <p>During an interview on 1/15/25 at 8:45 a.m. with Certified Nurse Assistant (CNA) 6, CNA 6 stated Resident 61 has shown no aggression to staff or other residents.</p> <p>During an interview on 1/15/25 at 9:00 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 61 was very polite and calm and did not have any issues with the staff or cause trouble with the other residents. LVN 2 confirmed Resident 61 did not have any aggressive behaviors.</p> <p>During a review of Resident 61's Medical Record on 1/15/25 at 3:53 p.m., the Medical Record indicated:</p> <p>On 4/13/24, Medical Director (MD) renewed the order for, escitalopram oxalate (Medication used to treat depression [Mood disorder that causes a persistent feeling of sadness and loss of interest] and anxiety [Intense, excessive, and persistent worry and fear about everyday situations]) 20 milligrams (mg, measurement of weight) once daily for anxiety and pacing. MD ordered staff to monitor Resident 61 for signs of depression and excessive pacing every shift.</p> <p>On 5/24/24, the MD renewed the order for quetiapine (medication used to treat mental disorders and regulate mood, thought, and behaviors) 50 mg every night and quetiapine 25 mg twice a day, at 8 a.m. and 1 p.m. for angry outbursts, aggressive behavior, and striking out. MD ordered staff to monitor Resident 61 for aggressive behavior and striking out every shift.</p> <p>Resident 61's Medication Administration Records (MAR), dated April 2024 through 1/13/25, indicated Resident 61 had no documented aggressive behaviors, striking out, depression, or excessive pacing during the timeframe (9 1/2 months).</p> <p>Resident 61's Minimum Data Set (MDS - a resident assessment tool), dated 3/22/24, 6/19/24, 9/9/24. and 11/29/24, indicated, Section E - No behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/5/24, the Executive Mental Health Doctor's (EMH) 1 Progress Note indicated, Please discontinue [quetiapine] 25 mg twice a day for GDR trial and will continue to consider reducing [quetiapine] dose as tolerated. Please decrease escitalopram to 10 mg, due to [resident's] older age the max dose is 10 mg for escitalopram.</p> <p>On 11/25/24, EMH 1's Progress Note indicated, Discontinue [quetiapine] for GDR. Please decrease escitalopram to 10 mg due to patient's older age the max dose is 10 mg for escitalopram.</p> <p>On 12/23/24, EMH 1's Progress Note indicated, Proceed with [quetiapine] GDR. No behavioral concerns reported.</p> <p>There was no documentation in Resident 61's medical record which indicated a GDR was attempted for Resident 61 from 1/4/24-1/13/25 (1 year).</p> <p>During an interview on 1/15/25 at 3:20 p.m. with Medical Director (MD), MD stated Resident 61 had not exhibited any behaviors. MD further stated she was aware of the Mental Health Physician's recommendations to discontinue quetiapine and decrease escitalopram. MD confirmed she did not attempt a GDR over the past year for either medication. MD stated she did not discuss a GDR with Resident 61's Responsible Party over the past year.</p> <p>During an interview on 1/16/25 at 3:14 p.m. with Pharmacist (PHARM), PHARM stated he made a recommendation regarding Resident 61 for a GDR of quetiapine on 4/11/24, and the recommendation was declined by MD. PHARM stated he made a recommendation for a dose reduction for escitalopram in May of 2024 as 10 mg was the maximum recommended dose for the elderly, and the recommendation was declined by MD.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication (medications that affect how the brain works and cause changes in mood, awareness, thoughts, feelings, or behavior) Use, dated October 2017, the P&P indicated, Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted Annually, unless clinically contraindicated.</p> <p>During a review of the FDA (Food and Drug Administration) instructions for use and black box warning for escitalopram oxalate, revised January 2017, the instructions indicated, 10 mg per day is the recommended dose for most elderly patients . elderly may be at greater risk for hyponatremia (low salt in the blood).</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview and record review, the facility failed to ensure the medication error rate did not exceed 5 percent when five out of five licensed nurses were observed and made the following medication errors:</p> <ol style="list-style-type: none"> 1. Potassium (medication used to treat low amount of potassium in the blood) was not administered in accordance with physician order to Resident 36. 2. Resident 81 was not instructed to stay sitting in upright position after being administered Potassium-Phosphate (supplement to increase potassium and phosphate in the blood,) despite manufacturer guidelines to not lie down for 10 minutes after to prevent stomach irritation and discomfort. 3. Resident 81 was administered twice the ordered dose of cholecalciferol (Vitamin D-medication). 4. A powdered medication, polyethylene glycol (laxative- medication that draws more water into bowels to facilitate a bowel movement), was not mixed with enough water per manufacturer's guidelines and administered to Resident 291. 5. Insulin (medication that lowers the level of glucose [sugar] in the blood) was administered after meals, despite the physician order stating before meals to Resident 71. 6. Incorrect dose of insulin was attempted to be administered to Resident 291. <p>These failures resulted in six identified medications errors out of 25 opportunities for medication administration. The facility's overall medication error rate was 24%.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 36's Face Sheet (demographics), the Face Sheet indicated Resident 36 was admitted on [DATE] with diagnoses including chronic kidney disease, stage 3 (moderate level of kidney damage where the kidneys are not filtering waste effectively). <p>During an observation on 1/15/25 at 8:31 a.m. with Registered Nurse (RN) 4 in Resident 36's room, RN 4 administered one tablet of Potassium 10 mEq (milliequivalent- unit of measure) with approximately 2 oz (ounces- unit of measurement) of water.</p> <p>During a review of Resident 36's Physician's Order, dated 6/7/24, the Physician's Orders indicated, K (potassium) Tablet 10 MEQ. Give 1 tablet by mouth two time a day related to chronic kidney disease, stage 3 (moderate). Please give with 4 oz H2O [water] and food to help minimize GI [gastrointestinal, stomach] irritation.</p> <p>During an interview on 1/15/25 at 10:44 a.m. with RN 4, RN 4 stated she did not give 4 oz of water and, Oh, I should have given more water!</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/16/25 at 11:17 a.m. with the Director of Nursing (DON), the DON stated nurses should always follow the direction on the order.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, .Medications are administered in accordance with written orders of the attending physician .</p> <p>2. During a review of Resident 81's Face Sheet (demographics), the Face Sheet indicated Resident 81 was admitted on [DATE] with diagnoses including hypokalemia (low levels of potassium in the blood).</p> <p>During an observation on 1/15/25 at 9:07 a.m. with Registered Nurse (RN) 6 in Resident 81's room, RN 6 administered one tablet of [Potassium-Phosphate] 250mg. The label printed on the medication pack stated, Do not lie down for at least 10 minutes after. RN 6 did not instruct Resident 81 to not lie down for 10 minutes.</p> <p>During an observation on 1/15/25 at 9:14 a.m. in Resident 81's room, Resident 81 was lying down, flat in bed.</p> <p>During a concurrent observation and interview on 1/15/25 at 10:31 a.m. with RN 6 in the hallway, RN 6 took out Resident 81's [Potassium-Phosphate] medication and read the warning, located on the label. RN 6 stated she forgot to educated Resident 81 on not lying down after taking the medication.</p> <p>During an interview on 1/16/25 at 11:19 a.m. with the Director of Nursing (DON), the DON stated the expectation was for nurses to follow the direction and educate the patient.</p> <p>During a review of Resident 81's Physician's Orders, dated 9/13/24, the Physician's Orders indicated, [Potassium-Phosphate] Oral Tablet . Give 1 tablet by mouth with meals for supplement.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, .Medications are administered in accordance with written orders of the attending physician .</p> <p>3. During a review of Resident 81's Face Sheet (demographics), the Face Sheet indicated Resident 81 was admitted on [DATE] with diagnoses including cervical disc degeneration (natural part of aging that occurs when the spinal discs in the neck wear down).</p> <p>During an observation on 1/15/25 at 9:07 a.m. with Registered Nurse (RN) 6 in Resident 81's room, RN 6 administered two tablets of cholecalciferol 125 mcg (microgram-unit of measure).</p> <p>During a review of Resident 81's Physician's Orders, dated 9/13/24, the Physician's Orders indicated, Cholecalciferol Oral Tablet 125 MCG. Give 1 tablet by mouth one time a day for supplement.</p> <p>During an interview on 1/15/25 at 10:31 a.m. with RN 6, RN 6 stated, I did give two; it should have been one.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/16/25 at 11:17 a.m. with the Director of Nursing (DON), the DON stated nurses should always follow the direction on the order.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, .Medications are administered in accordance with written orders of the attending physician .</p> <p>4. During a review of Resident 291's Face Sheet (demographics), the Face Sheet indicated Resident 291 was admitted on [DATE] with diagnoses including metabolic encephalopathy (brain disorder that occurs when an underlying condition impairs brain function).</p> <p>During an observation on 1/15/25 at 9:26 a.m. with Registered Nurse (RN) 5 in Resident 291's room, RN 5 prepared [Polyethylene Glycol] 17 grams with approximately 2.5 ounces of water and then administered to Resident 291. The directions on the bottle of [Polyethylene Glycol] stated, stir and dissolve in any 4 to 8 ounces of beverage.</p> <p>During an interview on 1/15/25 at 1:12 p.m. with RN 5, RN 5 stated she did not know how much water to mix with the medication.</p> <p>During an interview on 1/16/25 at 11:20 a.m. with the Director of Nursing (DON), the DON stated nurses should mix Polyethylene Glycol with 4-6 oz of water and follow the directions that are directly on the bottle.</p> <p>During a review of Resident 291's Physician's Order, dated 12/20/24, the Physician's Orders indicated, [Polyethylene Glycol] Oral Packet 17 gram. Give 17 grams by mouth two times a day for constipation.</p> <p>During a review of the ClearLax- polyethylene glycol, dated February 2024, the ClearLax polyethylene glycol indicated, . Directions . stir and dissolve in any 4 to 8 ounces of beverage .</p> <p>5. During a review of Resident 71's Face Sheet (demographics), the Face Sheet indicated Resident 71 was admitted on [DATE] with diagnoses including diabetes mellitus type 2 (disease that causes high blood sugars).</p> <p>During an observation on 1/15/25 at 12:04 p.m. in Resident 71's room, Resident 71 had eaten 1/2 of a grilled cheese and one bag of chips.</p> <p>During an observation on 1/15/25 at 12:14 p.m. in Resident 71's room, Registered Nurse (RN) 4, administered 1 unit (unit measurement) of insulin.</p> <p>During a concurrent interview and record review on 1/15/25 at 12:27 p.m. with RN 4, Resident 71's Medication Administration Record (MAR), dated 1/15/25 was reviewed. The MAR indicated insulin was to be administered before meals. RN 4 stated, Oh, I missed that.</p> <p>During an interview on 1/16/25 at 11:21 a.m. with the Director of Nursing (DON), the DON stated nurses should always follow the order.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 71's Physician's Orders, dated 12/14/24, the Physician's Orders indicated, insulin injected per sliding scale (increasing administration of the insulin dose based on blood sugar levels) . before meals .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, .Medications are administered in accordance with written orders .</p> <p>6. During a review of Resident 291's Face Sheet (demographics), the Face Sheet indicated Resident 291 was admitted on [DATE] with diagnoses including diabetes mellitus type 2 (disease that causes high blood sugars).</p> <p>During a concurrent observation and interview on 1/15/25 at 4:15 p.m. with Registered Nurse (RN) 3 in Resident 291's room, RN 3 checked Resident 291's blood sugar with a glucometer (handheld device that measures the amount of sugar in the bloodstream) and stated the result was 205 milligram/deciliter (mg/dL, unit of measurement). RN 3 went to the medication cart and documented 305 mg/dL into Resident 291's Medication Administration Record (MAR) for the blood sugar result. RN 3 stated the sliding scale for blood sugar result of 305, was to administer 8 units of insulin (medication that manages blood sugar levels). RN 3 turned the dial to 8 units of insulin and confirmed the prefilled pen injector was turned to 8 units. RN 3 stated, Yes, I'm ready to give, and began to walk towards Resident 291. RN 3 was then stopped and was asked to show the history on the glucometer results. RN 3 recalled the history on the glucometer and stated the value was 205! Oh, my god! That would have been so bad. RN 3 reviewed Resident 291's MAR and confirmed the correct dose of insulin should have been 4 units.</p> <p>During a review of Resident 291's Physician's Order, dated 1/8/25, the Physician's Orders indicated, insulin injected per sliding scale (increasing administration of the insulin dose based on blood sugar levels) was for blood sugar value of 0-149= 0 units to be given, 150-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, and 401-500= 12 units and call physician.</p> <p>During an interview on 1/15/25 at 4:54 p.m. with the Medical Director (MD), MD stated, It's always life threatening to give too much insulin.</p> <p>During an interview on 1/16/25 at 3:30 p.m. with the Pharmacist (PHARM), the PHARM stated if double the dose of insulin was administered, that would be quite a jump, and significant damage could be caused to Resident 291.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, .Medications are administered in accordance with written orders .</p>		

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NAME OF PROVIDER OR SUPPLIER North Bay Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Douglas Street Petaluma, CA 94952	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure the correct dosage of insulin (medication that lowers the level of glucose [sugar] in the blood) was in the prefilled pen injector per physician's sliding scale order for Resident 291. This failure had the potential to result in hypoglycemia (medical condition where blood sugar level is too low) and death for Resident 291.</p> <p>Findings:</p> <p>During a review Resident 291's Face Sheet (demographics), the Face Sheet indicated Resident 291 was admitted on [DATE] with diagnoses including diabetes mellitus type 2 (disease that causes high blood sugars).</p> <p>During a review of Resident 291's Face Sheet (demographics), the Face Sheet indicated Resident 291 was admitted on [DATE] with diagnoses including diabetes mellitus type 2 (disease that causes high blood sugars).</p> <p>During a concurrent observation and interview on 1/15/25 at 4:15 p.m. with Registered Nurse (RN) 3 in Resident 291 's room, RN 3 checked Resident 291's blood sugar with a glucometer (handheld device that measures the amount of sugar in the bloodstream) and stated the result was 205 milligram/deciliter (mg/dL, unit of measurement). RN 3 went to the medication cart and documented 305 mg/dL into Resident 291's Medication Administration Record (MAR) for the blood sugar result. RN 3 stated the sliding scale for blood sugar result of 305, was to administer 8 units of insulin (medication that manages blood sugar levels). RN 3 turned the dial to 8 units of insulin and confirmed the prefilled pen injector was turned to 8 units. RN 3 stated, Yes, I'm ready to give, and began to walk towards Resident 291. RN 3 was then stopped and was asked to show the history on the glucometer results. RN 3 recalled the history on the glucometer and stated the value was 205! Oh, my god! That would have been so bad. RN 3 reviewed Resident 291's MAR and confirmed the correct dose of insulin should have been 4 units.</p> <p>During a review of Resident 291's Physician's Order, dated 1/8/25, the Physician's Orders indicated, insulin injected per sliding scale (increasing administration of the insulin dose based on blood sugar levels) was for blood sugar value of 0-149= 0 units to be given, 150-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, and 401-500= 12 units and call physician.</p> <p>During an interview on 1/15/25 at 4:54 p.m. with the Medical Director (MD), MD stated, It's always life threatening to give too much insulin.</p> <p>During an interview on 1/16/25 at 3:30 p.m. with the Pharmacist (PHARM), the PHARM stated if double the dose of insulin was administered, that would be quite a jump, and significant damage could be caused to Resident 291.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated October 2017, the P&P indicated, .Medications are administered in accordance with written orders .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119</p> <p>Based on observation, interview, and record review, the facility failed to safely store and label drugs and supplies in accordance with acceptable standards of practice when:</p> <p>1a. A yellow-colored tablet was on the floor under the bed in room [ROOM NUMBER].</p> <p>1b. One of two Treatment Carts was left unlocked and unattended.</p> <p>2. In room [ROOM NUMBER]C, one 1 collagenase (Santyl) ointment tube (used to remove damaged skin tissue from burns and wounds- [broken skin]) was on top of Resident 191's bedside cabinet.</p> <p>3. One of four medication carts was left unlocked and unattended.</p> <p>4. Three insulin pens (hormone medication that helps manage blood sugar levels preloaded into a device that injects the medication into the body) were not dated when opened for two of 23 sampled residents (Resident 90 and Resident 192).</p> <p>These failures had the potential to result in residents and staff obtaining unauthorized access to medications and supplies that could lead to adverse effects. In addition, Resident 90 and Resident 192 were at risk for receiving expired insulin.</p> <p>Findings:</p> <p>1a. During a concurrent observation and interview on [DATE] at 10:06 a.m. with Licensed Vocational Nurse (LVN) 4 in Resident 240's room, a yellow-colored tablet was under the bed. LVN 4 stated she could not identify the type of medication that was underneath Resident 240's bed. LVN 4 stated the medication should not be left on the ground to prevent improper use which could lead to adverse effects.</p> <p>During a concurrent interview and record review on [DATE] at 10:15 a.m. with the Director of Nursing (DON), the facility policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023 was reviewed. The policy indicated, . The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls .Medications and biologicals are stored in the packaging, containers or dispensing systems in which they are received . The DON stated medication should not be left on the ground because someone could potentially consume it.</p> <p>1b. During an observation on [DATE] at 9:37 a.m., Station 2's Treatment Cart was located against the wall next to the nurses' station. The treatment cart was unlocked and unattended.</p> <p>During an observation on [DATE] at 9:55 a.m., Station 2's Treatment Cart remained unlocked and unattended.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on [DATE] at 9:59 a.m. Licensed Vocational Nurse (LVN) 5 was observed walking towards Station 2's Treatment Cart. LVN 5 acknowledged the Treatment Cart was left unlocked and unattended. LVN 5 stated the Treatment Cart should be locked when unattended to prevent unauthorized access.</p> <p>During a concurrent interview and record review on [DATE] at 10:15 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023 was reviewed. The policy indicated .Compartments (including, but not limited to, .carts .containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others . The DON stated the Treatment Cart should be locked when unattended to prevent unauthorized access.</p> <p>34959</p> <p>2. During a review of Resident's 191's Face Sheet (demographics), the Face Sheet indicated Resident 191 was admitted on [DATE], with diagnoses including cellulitis of right lower limb (swelling and skin infection of the lower leg); unspecified fracture of shaft of right tibia (a break in the lower leg bone below the knee); initial encounter for closed fracture (the first time a resident is seen by a healthcare provider for a broken bone where the skin is intact), and burn of unspecified degree of right lower leg (the burn cannot be definitely determined at the time of assessment).</p> <p>During a concurrent observation and interview on [DATE] at 9:00 a.m. with Resident 191 in room [ROOM NUMBER] C, there was one collagenase (Santyl) ointment tube located on top of Resident 191's bedside cabinet. Resident 191 was alert and oriented. Resident 191 stated he has had the Santyl ointment tube stored in the bedside cabinet since [DATE].</p> <p>During a concurrent interview and record review on [DATE] at 8:59 a.m. with Infection Preventionist (IP), Resident 191's Physician's Orders, dated [DATE], was reviewed. IP stated there was no physician order for bedside storage of collagenase (Santyl) ointment tube. The IP also stated the ointment should not be stored on the bedside cabinet without a physician's order.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Bedside Medication Storage, dated [DATE], the P&P indicated, . A written order for the bedside storage of medication is present in the residents' medical record .</p> <p>50669</p> <p>3. During an observation on [DATE] at 8:41 a.m. outside of room [ROOM NUMBER], a medication cart was unattended and unlocked. In the top drawer of the medication cart, there was a medicine cup with one unidentified pill that was white, round, and labeled G785.</p> <p>During a concurrent observation and interview on [DATE] at 8:51 a.m. with Registered Nurse (RN) 6, outside of room [ROOM NUMBER]. RN 6 walked towards the medication cart and moved the medication cart to room [ROOM NUMBER] to administer medication. RN 6 confirmed the medication cart was unlocked and unattended. RN 6 stated, Sorry, I forgot. RN 6 further stated it ' s important to lock the medication cart, so a patient or anyone else doesn't get access to medications.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:18 a.m. with Director of Nursing (DON), DON stated all medication carts need to be locked when left unattended.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023, the P&P indicated . Compartments (including, but not limited to . carts . containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others .</p> <p>52029</p> <p>4 a. During a review of Resident 90's Face Sheet (demographics), the Face Sheet indicated Resident 90 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (condition that causes the level of sugar in the blood to become too high).</p> <p>During a concurrent observation and interview on [DATE] at 2:10 p.m. with Registered Nurse (RN) 7, the Station Three medication cart was observed. RN 7 removed one insulin pen from the medication cart. The insulin pen was labeled with Resident 90's name, and instructions to inject insulin glargine (long-acting insulin used to control high blood sugar), 35 units (measurement of the amount of insulin in a liquid medication) one time daily. The insulin pen was missing the opened date. The label indicated, Discard unused portion after 28 days. RN 7 confirmed the insulin pen was opened and had been used. RN 7 was unaware when the insulin pen was opened and unaware of when it should be discarded. RN 7 confirmed the insulin pen should have been labeled with the date it was opened.</p> <p>During an interview on [DATE] at 3:15 p.m. with Pharmacist (PHARM), PHARM stated insulin injector pens should be dated when they are opened. PHARM stated, Insulin pens are generally good for 28 days. PHARM further stated it was important to label the insulin pen with the opened date because insulin would start to breakdown after 28 days.</p> <p>During a review of the facility's policy and procedures (P&P) Medication Labeling and Storage, dated February 2023, P&P indicated, Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days . 'If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items'.</p> <p>4 b. During a review of Resident 192's Face Sheet (demographics), Face Sheet indicated, Resident 192 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (condition that causes the level of sugar in the blood to become too high) with diabetic neuropathy (nerve damage caused by diabetes).</p> <p>During a concurrent observation and interview on [DATE] at 2:10 p.m. with Registered Nurse (RN) 7, the Station Three medication cart was observed. RN 7 removed two insulin injector pens (hormone medication that helps manage blood sugar levels preloaded into a device that injects the medication into the body) from the medication cart 3.</p> <p>One insulin pen was labeled with Resident 192's name, and instructions to inject insulin glargine, 20 units (measurement of the amount of insulin in a liquid medication) one time daily. The insulin pen was missing the opened date. The label indicated, Discard unused portion after 28 days.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A second insulin pen was labeled with Resident 192's name, and instructions to inject insulin lispro (rapid-acting insulin used to control blood sugar) seven units three times a day before meals. The insulin pen was missing the opened date. The label indicated, Discard unused portion after 28 days.</p> <p>RN 7 confirmed both insulin pens were opened and had been used. RN 7 was unaware when Resident 192's insulin pens were opened and unaware of when they should be discarded. RN 7 confirmed the insulin pens should have been labeled with the opened date.</p> <p>During an interview on [DATE] at 3:15 p.m. with Pharmacist (PHARM), PHARM stated insulin injector pens should be dated when they are opened. PHARM stated, Insulin pens are generally good for 28 days. PHARM further stated it was important to label the insulin pen with the opened date because insulin would start to breakdown after 28 days.</p> <p>During a review of the facility's policy and procedures (P&P) Medication Labeling and Storage, dated February 2023, P&P indicated, Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days . 'If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items'.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to provide routine dental services for Resident 71 for 16 months. This failure had the potential to result in a decline in oral health for Resident 71.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 1/16/25 at 9:35 a.m. with Resident 71, Resident 71 had multiple teeth missing. Resident 71 stated she had only seen the dentist one time since admission. Resident 71 further stated she verbally requested a dental visit multiple times.</p> <p>During an interview on 1/16/25 at 9:46 a.m. with Social Services Director (SSD), SSD stated Resident 71 was admitted on [DATE] and was not seen by dental until 11/14/24. SSD stated the resident should have been seen every 6 months and as needed.</p> <p>During a review of Resident 71's Minimum Data Set (MDS-an assessment tool), dated 12/26/24, the MDS indicated, Resident 71's Oral/Dental Status is no natural teeth or tooth fragment(s) (edentulous-lacking teeth). The MDS indicated Care Area Triggered was Dental Care.</p> <p>The facility was unable to provide a policy and procedure regarding dental services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50933</p> <p>Based on observation, interview, and record review, the facility failed to protect equipment from contamination via dust and grease.</p> <p>This failure posed the risk for food borne illness in a medically fragile resident population of 98 facility residents who received food prepared in the kitchen.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 1/13/25 at 8:21 a.m., with the Dietary Supervisor (DS) a white powdery (dusty) substance was noted on top of the dishwasher. The dishwasher was also noted to have a thick greasy buildup up on the bar going across the bottom of the equipment. The DS agreed that the equipment was dirty and needed to be cleaned.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Shelves, Counters, and Other surfaces Including Sinks (Handwashing, Food Preparation, ETC.), dated 2023, the P&P indicated, Remove any large debris and wash surface with warm detergent solution .Rinse with clear water using a clean sponge or cloth. Wipe dry with a clean cloth.</p>

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41119</p> <p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>Based on observation, interview, and record review, the facility failed to provide three of five sampled residents (Resident 54, 56, and 341) a designated refrigerator to store personal, perishable food items.</p> <p>This failure resulted in Resident 56, unsafely storing perishable personal food items in her bedside drawer, which had the potential to result in a foodborne illness for Resident 56. This failure resulted in a non-homelike environment for Residents 54 and 341.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 1/13/25 at 10:57 a.m., in Resident 56's room, Resident 56 was observed opening her bedside bottom drawer and pulling out a container of butter and jar of pickled beets. Resident 56 stated she knew the food items needed to be refrigerated but there was no available refrigerator.</p> <p>During an interview on 1/14/25 at 2:54 p.m. with Dietary Manager (DM), DM stated residents were encouraged to eat food brought from outside within two hours. DM stated the facility did not have a separate refrigerator to store food for residents.</p> <p>During an interview on 1/14/25 at 3:21 p.m. with Registered Nurse (RN) 5, RN 5 stated the facility did not have a refrigerator to store perishable foods for the residents, and there should be a refrigerator for residents.</p> <p>During an interview on 1/14/25 at 4:14 p.m. with Resident 56, Resident 56 stated, I wish they had a fridge for us to use but I know it's not going to happen.</p> <p>During an interview on 1/15/25 at 8:22 a.m. with Resident 54, Resident 54 stated she would like the facility to have a refrigerator to store food for her. Resident 54 stated approximately a year ago the facility did have a refrigerator for residents but was unsure why it was taken away.</p> <p>During an interview on 1/15/25 at 8:25 a.m. with Resident 341, Resident 341 stated at home he stored tea in the refrigerator to drink throughout the day. Resident 341 stated he wished the facility had a refrigerator because he had to rely on drinking the tea with ice.</p> <p>During an interview on 1/16/25 at 10:08 a.m. with Social Services Director (SSD), SSD stated the facility used to have a refrigerator for resident use but was unsure why the facility no longer had one.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/16/25 at 10:22 a.m. with the Director of Nursing Services (DON), the facility's policy and procedure (P&P) titled, Foods Brought by Family/Visitors, dated March 2022, was reviewed. The P&P indicated, . Food brought to the facility by visitors and family is permitted .Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable . Potentially hazardous food that are left out then for the resident without a source of heat or refrigeration longer than 2 hours are discarded . The DON stated since he had started working at the facility there was no refrigerator for resident use available. The DON stated residents have the right to store food brought in from outside.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52029</p> <p>Based on interview and record review, the facility failed to ensure Physician's Progress Notes were documented in the medical record for 3 of 23 sampled residents (Resident 25, 61, and 75). This failure resulted in the potential for communication delays and potential delays in coordination of care.</p> <p>Findings:</p> <p>1. During a review of Resident 25's Face Sheet (demographics), the Face Sheet indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the temporal lobe (brain tumor) and urinary tract (organs that make urine) infection.</p> <p>During a concurrent interview and record review of Resident 25's medical record on 1/14/25 at 4 p.m. with the Director of Nursing (DON), the medical record review indicated there were no documented Physician's Progress Notes. DON stated he was unaware how often the Medical Director (MD) examined the residents and confirmed there were no documented Physician's Progress Notes. DON stated MD had her own charting system and did not document progress notes at the facility; instead MD documented from home and faxed her notes later. DON stated it was important for the Physician's Progress Notes to be readily available in the residents' medical records.</p> <p>During an interview on 1/15/25 at 3:20 p.m. with MD, MD confirmed Resident 25's Physician Progress Notes were not in the medical record. MD stated she documented her progress notes at her office and faxed them to the facility at a later date. MD stated the facility requested Physician's Progress Notes for multiple residents for the survey team and she would be faxing them later. MD confirmed she did not have remote access to the progress notes and could not provide them.</p> <p>During an interview on 1/17/25 at 9:17 a.m. with the Administrator (ADMIN), ADMIN confirmed MD did not document Physician's Progress Notes while at the facility. ADMIN further stated the facility did not have access to Physician's Progress Notes for multiple residents, and staff were unable to review the notes if needed. ADMIN stated if a resident required transfer to a higher level of care, then the facility would need to contact MD and request to fax the progress notes.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Physician Visits, dated April 2013, the P&P indicated, The Attending Physician must perform all relevant tasks at the time of each visit, including appropriate documentation.</p> <p>2. During a review of Resident 61's Face Sheet (demographics), Face Sheet indicated Resident 61 was admitted to the facility on [DATE] with diagnoses which included Lewy body dementia (brain disease that causes a gradual decline in thinking, movement, and behavior).</p> <p>During a concurrent interview and record review of Resident 61's medical record on 1/14/25 at 4 p.m. with the Director of Nursing (DON), the medical record review indicated there were no documented Physician's Progress Notes. DON stated he would request MD fax the Physician's Progress Notes for the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 1 p.m. with the Director of Nursing (DON), DON stated he was waiting for MD to send the progress notes. DON stated, We do not have the progress notes at the facility. MD does not complete her progress notes when she assesses the residents; she faxes them to us- she is old school. DON stated he expected MD to document progress notes in the record while she was at the facility so that the notes were readily available.</p> <p>During an interview on 1/15/25 at 3:20 p.m. with MD, MD confirmed Resident 25's Physician Progress Notes were not in the medical record. MD stated she documented her progress notes at her office and faxed them to the facility at a later date. MD stated the facility requested Physician's Progress Notes for multiple residents for the survey team and she would be faxing them later. MD confirmed she did not have remote access to the progress notes and could not provide them.</p> <p>During an interview on 1/17/25 at 9:17 a.m. with the Administrator (ADMIN), ADMIN confirmed MD did not document Physician's Progress Notes while at the facility. ADMIN further stated the facility did not have access to Physician's Progress Notes for multiple residents, and staff were unable to review the notes if needed. ADMIN stated if a resident required transfer to a higher level of care, then the facility would need to contact MD and request to fax the progress notes.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Physician Visits, dated April 2013, the P&P indicated, The Attending Physician must perform all relevant tasks at the time of each visit, including . appropriate documentation.</p> <p>3. During a review of Resident 75's Face Sheet (demographics), the Face Sheet indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (disorder wherein body is unable to regulate blood sugar).</p> <p>During a concurrent interview and record review of Resident 75's medical record on 1/14/25 at 4 p.m. with the Director of Nursing (DON), the medical record review indicated there were no documented Physician's Progress Notes. DON stated he would request MD to fax the Physician's Progress Notes for the medical record.</p> <p>During an interview on 1/15/25 at 1 p.m. with the Director of Nursing (DON), DON stated he was waiting for MD to send the progress notes. DON stated, We do not have the progress notes at the facility. MD does not complete her progress notes when she assesses the residents; she faxes them to us- she is old school. DON stated, he expected MD to document progress notes in the chart while she was at the facility so that the notes were readily available.</p> <p>During an interview on 1/15/25 at 3:20 p.m. with MD, MD confirmed Resident 25's Physician Progress Notes were not in the medical record. MD stated she documented her progress notes at her office and faxed them to the facility at a later date. MD stated the facility requested Physician's Progress Notes for multiple residents for the survey team and she would be faxing them later. MD confirmed she did not have remote access to the progress notes and could not provide them.</p> <p>During an interview on 1/17/25 at 9:17 a.m. with the Administrator (ADMIN), ADMIN confirmed MD did not document Physician's Progress Notes while at the facility. ADMIN further stated the facility did not have access to Physician's Progress Notes for multiple residents, and staff were unable to review the notes if needed. ADMIN stated if a resident required transfer to a higher level of care, then the facility would need to contact MD and request to fax the progress notes.</p> <p>(continued on next page)</p>		

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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 policy and procedure (P&P) titled, Physician Visits, dated April 2013, the P&P indicated, The Attending Physician must perform all relevant tasks at the time of each visit, including . appropriate documentation.		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>49936</p> <p>Based on interview and record review, the facility's Quality Assurance Performance Improvement (QAPI, data-driven approach to improving quality in healthcare facilities) committee failed to maintain documentation and demonstrate evidence that the QAPI program was sustained during transitions in leadership when there were no follow-ups for medication administration audits (observations to help identify potential and actual medication errors at different stages) conducted by Pharmacy (Cross-reference F658, F726, F759, F760).</p> <p>These findings resulted in a medication error rate of 24%, including one considered significant, and had the potential to result in severe adverse effects for all residents. The facility census was 94.</p> <p>Findings:</p> <p>During a review of the facility's QAPI Minutes (a written record of a QAPI meeting that documents topics discussed, decisions made, and actions taken), dated January to December 2024, the minutes indicated that for January and February of 2024, Medication Administration Audits by the Pharmacist (PHARM) were planned to be completed monthly and reported to QAPI. The minutes indicated the audits were not completed for February.</p> <p>During an interview on 1/15/25 at 12:47 p.m. with the Director of Nursing (DON), the DON stated PHARM was responsible for conducting monthly medication administration audits.</p> <p>During an interview on 1/16/25 at 3:26 p.m. with PHARM, PHARM denied being responsible for conducting medication administration audits.</p> <p>During an interview on 1/17/25 at 9:17 a.m. with the Administrator (ADMIN), the ADMIN stated his start of employment was June 2024. The ADMIN stated he had no knowledge of the medication administration audits to be completed by PHARM and declined to discuss any further issues identified and addressed by QAPI prior to his start of employment because those issues were before my time.</p> <p>The facility was unable to provide documentation that medication administration was audited by PHARM monthly during February to December 2024.</p> <p>During a review of the facility's policy and procedure (P&P) titled, QAPI Plan, dated 10/24/24, the P&P indicated, The facility QAPI program is ongoing, comprehensive and addresses all care and services provided by the facility.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>49936</p> <p>Based on interview and record review, the facility's Quality Assurance and Performance Improvement (QAPI, data-driven approach to improving quality in healthcare facilities) program failed to identify, address, and evaluate the following systemic quality deficiencies (issues that fall below the standards of quality for a facility's care, which QAPI programs were designed to identify and fix):</p> <ol style="list-style-type: none"> 1. Nursing Medication Administration Competency (Cross-reference F658, F726, F759, F760) 2. Infection Control (Cross-reference F880, F881) 3. Abuse Program (Cross-reference F606, F607, F943) 4. Incomplete Resident's Records (Cross-reference F842) 5. Social Services (Cross-reference F607, F685, F742, F745, F791) <p>These failures resulted in a lack of oversight over these necessary care services and had the potential to negatively affect the safety and quality of care provided to all residents. The facility census was 94.</p> <p>Findings:</p> <p>During a review of the facility's QAPI Minutes (a written record of a QAPI meeting that documents topics discussed, decisions made, and actions taken), dated January to December 2024, the minutes indicated the following were not identified as quality deficiencies to be addressed:</p> <ol style="list-style-type: none"> 1. Nursing Medication Administration Competency 2. Infection Control 3. Abuse Program 4. Incomplete Resident's Records 5. Social Services <p>During an interview on 1/17/25 at 9:17 am. with the Administrator (ADMIN), the ADMIN confirmed, the issues identified during survey were not previously identified or addressed by QAPI. The Admin confirmed, there were no Performance Improvement Projects (PIP, focused effort to identify and address a specific problem within a facility) conducted for issues identified during survey.</p> <p>During a follow-up interview on 1/17/25 at 9:20 a.m. with the ADMIN, the ADMIN stated he was unaware of the existence of the QAA Log (Quality Assessment and Assurance Log, a record of data and current PIPs to be reviewed as part of QAPI).</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's QAPI Agenda and Minutes, dated June 2024, the documents indicated no PIPs were discussed, planned, or evaluated.</p> <p>During a review of the facility's QAPI Agenda and Minutes, dated August 2024, the documents indicated a PIP for Baseline Care Plans was initiated/ongoing, but with no discussion or evaluation. The minutes indicated Infection Control had a broken process, but did not include a discussion of conducting a PIP.</p> <p>During a review of the facility's QAPI Agenda and Minutes, dated September 2024, the documents indicated the following PIPs were assigned/ongoing: Handwashing, COVID (disease that can cause coughs, fevers, and death) Vaccines, Call Lights, and Care Conferences, but did not include any evaluation or discussion regarding the PIPs.</p> <p>During a review of the facility's QAPI Agenda and Minutes, dated October 2024, the documents indicated the following PIPs were assigned/ongoing: Call Lights, Care Conferences, and Falls, but did not include any evaluation or discussion regarding the PIPs.</p> <p>During a review of the facility's policy and procedure (P&P) titled, QAPI Plan, dated 10/24/24, the P&P indicated, The QAPI program is designed to address all systems and practices in this facility that affect residents . Information is collected, evaluated and monitored by the QAPI committee . Facility will conduct performance improvement projects that are designed to take a systemic approach to revise and improve care or services in areas that we identify as needing attention . An important aspect of our PIPs is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained . the QAPI committee will review data and input on a monthly basis to look for potential topics for PIPs .The facility will use the QAA log to include listing of current projects and outcomes . Quality deficiencies that are identified through feedback and data will undergo appropriate corrective action . The QAPI program, overseen by the QAPI committee, is designed to identify and address quality deficiencies through the analysis of underlying cause and actions targeted at correcting systems at a comprehensive level.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34959</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection prevention and control measures were implemented when:</p> <p>1a. Water testing was not done to identify the presence of Legionella bacteria (can cause severe pneumonia [inflammation and fluid in the lungs]) in the building water system (cold and hot water distributed through the water pipes).</p> <p>1b. Policies and Procedures (P&P) were not revised annually and updated as needed.</p> <p>1c. Toilet plungers (used to free waste outlets of obstruction) located on the floor next to toilets in restroom of rooms 124, 130, 132, and 146.</p> <p>1d. Four unlabeled urinals were in the restroom of rooms [ROOM NUMBERS].</p> <p>1e. One House Keeping staff did not know the dwell time (the amount of time the disinfectant needed to sit on the surface) of the [name of manufacturer] disinfectant.</p> <p>2. Resident 83's used urinal with no lid cover was observed on the edge of his bedside table for approximately one hour.</p> <p>3. Certified Nurse Assistant (CNA) 1 was observed not wearing a gown while providing perianal hygiene care and brief change for Resident 24 who was on Enhanced Barrier Precautions (EBP, a set of infection control measures that use personal protective equipment (PPE) such as gloves and gown to reduce the spread of multidrug-resistant organisms (MDROs, bacteria resistant to antibiotics).</p> <p>4a. Enhanced Barrier Precaution (EBP) was not followed for one resident (Resident 344)</p> <p>4b. Contact Precaution was not followed for two residents (Resident 35 and Resident 21)</p> <p>4c. Droplet Precaution sign was not posted for one resident (Resident 344)</p> <p>These failures had the potential to result in cross contamination (bacteria or other germs are unintentionally transferred from one person to another with harmful effects) and the spread of communicable diseases (illnesses that spread from one person to another) to Residents, staff, and visitors.</p> <p>Findings:</p> <p>1a. During an interview on 1/14/25 at 3:45 p.m. with Maintenance (MAIN), MAIN stated he was unable to provide documentation for water testing to identify the presence of legionella bacteria for the following months of January 2024 through January 2025. MAIN also stated he had not done the monthly water testing of Legionella.</p> <p>During an interview on 1/15/25 at 9:53 a.m. with Administrator (ADMIN), ADMIN stated maintenance staff should have completed the water testing for Legionella bacteria monthly.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Legionella Water Management Program, undated, the P&P indicated, Facility shall establish an infection control program that will prevent, detect, and control water-borne contaminants, including Legionella which is overseen by the water management team. The water management program will identify areas in the water system where legionella bacteria can grow and spread .</p> <p>1b. During a concurrent interview and record review on 1/14/25 at 2:22 p.m. with Infection Preventionist (IP), the facility's binder of Infection Prevention and Control Policy and Procedure Manual was reviewed. The binder contained Policies and Procedures (P&P) (Infection Prevention and Control Program, Enhanced Barrier Precautions, Pneumococcal Vaccine, Influenza Vaccine, Personal Protective Equipment, Handwashing/Hand Hygiene, and Isolation Categories of Transmission-Based Precautions), dated 2001. The IP stated the P&P were supposed to be revised annually and updated as needed.</p> <p>During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 2001, the P&P indicated, . The infection prevention and control committee, medical director, director of nursing services, and other key clinical and administrative staff review the infection control policies at least annually. The review will include updating or supplementing policies and procedures as needed .</p> <p>1c. During an observation on 1/15/25 at 8:52 a.m. in the restroom of room [ROOM NUMBER], there was one toilet plunger on the floor next to the toilet.</p> <p>During an observation on 1/15/25 at 8:53 a.m. in the restroom of rooms [ROOM NUMBERS], there was one toilet plunger on the floor next to the toilet.</p> <p>During an observation on 1/15/25 at 9:14 a.m. in the restroom of room [ROOM NUMBER], there was one toilet plunger on the floor next to the toilet.</p> <p>During an interview on 1/15/25 at 9:15 a.m. with Housekeeping Manager (HKM), HKM stated the toilet plungers should have been in a clear bag and taken to the dirty utility room.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, dated 2001, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment .</p> <p>1d. During a concurrent observation and interview on 1/15/25 at 9:37 a.m. with Certified Nurse Assistant (CNA) 7 in the restroom of rooms [ROOM NUMBERS], one unlabeled urinal was located on the shower floor and three unlabeled urinals were hanging from the handle grab bar. CNA 7 stated the urinals should have been labeled with Resident's room number, and placed clean and dry next to the Residents bedside table.</p> <p>During an interview on 1/15/25 at 10:24 a.m. with Infection Preventionist (IP), IP stated the urinals are supposed to be labeled with the Residents room number and initials. The urinals should have been placed clean and dry next to the Residents bedside table.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Bedpan/Urinal, Offering/Removing, dated 2001, the P&P indicated, . Empty and clean it as necessary . Remove the urinal from the bedside stand. Be sure that it is clean and dry .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 2001, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment .</p> <p>1e. During an interview on 1/13/25 at 9:47 a.m. with Housekeeping (HK) 1, HK 1 stated the [name of manufacturer] dwell time to disinfect floors, bedside tables, and toilets was one minute.</p> <p>During an interview on 1/16/25 at 10:05 a.m. with Housekeeping Manager (HKM), HKM stated the dwell time to disinfect the floors, furniture, toilets, showers, and sinks were three to five minutes.</p> <p>During a review of the facility's [name of manufacturer] bottle indicated . Effective against SARS [Severe Acute Respiratory Syndrome- severe cold symptoms]-related Coronavirus two in three minutes . To clean and disinfect hard (includes countertops, doorknobs, and bathroom surfaces), nonporous (a floor that does not absorb water or other liquids) finished floors, sinks, and tubs . Sanitizes soft surfaces as a spot treatment in 5 minutes. For use as a spot treatment on soft surfaces such as upholstery, fabric, and furniture .</p> <p>During a review of the [name of manufacturer] disinfectant: General Guidelines for use, dated 8/15/22, the disinfectant general guidelines indicated, . To disinfect all surfaces must remain wet for 3 minutes . Soft surface sanitizing in 5 minutes .</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, dated 2001, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment .</p> <p>41119</p> <p>2. During an observation on 1/13/25 at 9:00 a.m. in Resident 83's room, Resident 83's urinal with approximately 150 milliliters(ml- unit of measure) of urine without a lid was placed at the edge of the bedside table, next to a cup of water.</p> <p>During a concurrent observation and interview on 1/13/25 at 10:05 a.m. in Resident 83's room, Certified Nursing Assistant (CNA) 6 acknowledged Resident 83's urinal had approximately 150 ml of urine in it and stated the urinal should have been emptied, cleaned and dried, and placed in a bag within Resident 83's reach. CNA 6 stated the urinal should not have been placed on Resident 83's bedside table because there was a potential for the spread of infection.</p> <p>During a concurrent interview and record review on 1/16/25 at 10:18 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Bedpan/Urinal, Offering/Removing dated February 2018 was reviewed. The policy indicated, .urinal at his bedside, check it frequently. Empty and clean it as necessary . The DON stated the urinal should not be left open on the beside table for potential infection control issues. The DON stated the urinal should be hung at the bedside in a bag.</p> <p>During a review of the facility's P&P titled, Bedpan/Urinal, Offering/Removing, dated 2001, the P&P indicated .Empty and clean it as necessary . Remove the urinal from the bedside stand. Be sure that it is clean and dry .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>49936</p> <p>3. During an observation on 1/13/25 at 9:36 a.m. in the hallway of the Special Care Unit, there was a sign posted in front of Resident 24's door that indicated, Enhanced Barrier Precautions (EBP) .Bed B . Providers and staff must .wear gloves and a gown for the following High-Contact Resident Care Activities: .Providing hygiene .Changing briefs .</p> <p>During an observation on 1/13/25 at 11:24 a.m. in Resident 24's room, Certified Nurse Assistant (CNA) 1 was not wearing a gown while she provided perianal hygiene care and changed Resident 24's briefs.</p> <p>During an interview on 1/13/25 at 11:45 a.m. with Registered Nurse (RN) 1, RN 1 stated that staff needed to wear a gown during brief change for Resident 24 because he was on EBP for his wound on his back.</p> <p>During an interview on 1/13/25 at 11:48 a.m. with CNA 1, CNA 1 confirmed she did not wear a gown while providing perianal hygiene care and changing Resident 24's briefs.</p> <p>During an interview on 1/14/25 at 2:26 p.m. with Infection Preventionist (IP), IP stated Resident 24 was on EBP due to the wound on his sacrum. IP stated that staff should be wearing a gown and gloves when performing care like changing Resident 24's briefs.</p> <p>During a review of Resident 24's Skin/Wound Note, dated 12/23/25, the note indicated, [Resident 24] was noted with a pressure ulcer (wound caused by pressure on the skin) to sacral (lower back).</p> <p>During a review of Resident 24's Physician's Orders, dated 12/26/24, the order indicated, Resident 24 was on Enhanced Barrier Precautions .related to wounds .instruct staff to use PPE gown, glove with high care contact activities.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated August 2022, the P&P indicated, Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms . The P&P indicated, High contact resident care activities requiring the use of gown and gloves for EBP's include: . providing hygiene . changing briefs or assisting with toileting . The P&P indicated, EBP's are indicated . for residents with wounds .</p> <p>50669</p> <p>4a. During an observation on 1/15/25 at 10:46 a.m. in room [ROOM NUMBER]B, Enhanced Barrier Precaution (EBP) signage, that stated, staff must also: wear gloves and a gown for the following High-Contact Resident Care Activities . bathing/showering . providing hygiene . was posted outside of the door with a personal protective equipment (PPE) cart. The Occupational Therapist (OT) was observed providing oral care and washing Resident 344's face without a gown.</p> <p>During an interview on 1/15/25 at 10:53 a.m. with the OT, the OT stated EBP did not apply to OT staff, so she did not have to wear PPE. OT read the sign and then stated, oh it says hygiene, so I guess I need it.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/15/25 at 3:22 p.m. with Infection Preventionist (IP), IP stated Resident 344 was placed on EBP for foley catheter (medical device- tube that drains urine from the bladder into a collection bag). IP stated that all staff needed to follow the precaution sign posted and must wear the correct PPE.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated August 2022, the P&P indicated, .EBPs employ targeted gown and glove use during high contact resident care activities .examples of high-contact care activities requiring the use of gown and gloves for EBPs include: .bathing .providing hygiene .EBPs are indicated .for residents with .indwelling medical devices . Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required .</p> <p>4b. During a concurrent observation and interview on 1/15/25 at 11:40 a.m. with Registered Nurse (RN) 5 in room [ROOM NUMBER]. A contact precaution sign was posted outside the door with a personal protective equipment (PPE) cart. In room [ROOM NUMBER], there were three residents, Resident 63 was in bed A, Resident 35 was in bed B, and Resident 21 was in bed C. Resident 63 was positive for MRSA (Methicillin-resistant Staphylococcus aureus- bacterial infection that becomes resistant to many antibiotics). RN 5 walked into room [ROOM NUMBER] without a gown and checked Resident 35's and Resident 21's blood sugar. RN 5 stated I didn't have to wear a gown because Resident 35 and Resident 21 were not on contact isolation, it was only their roommate- Resident 63.</p> <p>During an interview on 1/15/25 at 3:20 p.m. with Infection Preventionist (IP), IP stated if one resident was on contact isolation and they shared a room with other residents, staff must wear gown and gloves regardless upon entering the room.</p> <p>During a review of Resident 63's Medication Administration Record (MAR), dated 1/15/24, the MAR indicated, CONTACT PRECAUTIONS every shift for r/t [related to] MRSA positive on the wound culture .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Isolation- Categories of Transmission-Based Precautions (TBP), dated September 2022, the P&P indicated, .Staff and visitors wear a disposable gown upon entering the room .</p> <p>4c. During an observation on 1/17/25 at 9:58 a.m. in room [ROOM NUMBER], Registered Nurse (RN) 5 entered Resident 344's room wearing a surgical mask. An Enhanced Barrier Precaution sign was posted outside the door with a personal protective equipment (PPE) cart.</p> <p>During a concurrent interview and record review on 1/17/25 at 10:07 a.m. with RN 5, Resident 344's Medication Administration Record (MAR), dated 1/17/25 was reviewed. The MAR indicated, on 1/15/25 Resident 344 had Droplet Precaution related to influenza and Enhanced Barrier Precaution related to foley catheter. RN 5 confirmed there was not a Droplet Precaution sign posted.</p> <p>During an interview on 1/17/25 at 10:25 a.m. with Infection Preventionist (IP), IP stated if there was an order, there should have been a sign posted on the door.</p> <p>During an interview on 1/17/25 at 10:21 a.m. with the Director of Nursing (DON), the DON stated the expectation was to post the correct sign in accordance with the order for isolation precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Isolation- Categories of Transmission-Based Precautions (TBP), dated September 2022, the P&P indicated, .When a resident is placed on transmission-based precautions appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for the type of precaution .</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34959</p> <p>Based on interview and record review, the facility failed to ensure the antibiotic stewardship (monitors the effective use of antibiotics) monitored the effective use of Amoxicillin-Pot Clavulanate (antibiotic to treat urinary tract infections-[UTI- infection in your urinary system]) for the month of October 2024 and November 2024 for Resident 84. This failure had the potential to result in an inappropriate use of antibiotics for Resident 84.</p> <p>Findings:</p> <p>During a review of Resident 84's Face Sheet (demographics), the Face Sheet indicated Resident 17 was admitted on [DATE] with diagnoses to include a UTI.</p> <p>During a review of Resident 84's Physician Orders, dated 10/27/24, the Physician Order indicated, Amoxicillin-Pot Clavulanate tablet 875-125 milligram (unit of measurement), give 1 tablet by mouth two (2) times a day for urinary tract infection for 14 days.</p> <p>During a concurrent interview and record review on 1/15/25 at 10:48 a.m. with Infection Preventionist (IP), the facility's binder of Monthly Infection Control Log, dated 2024 was reviewed. IP stated there was no documentation that the antibiotic stewardship monitored the effective use of Amoxicillin-Pot Clavulanate for urinary tract infection in October 2024 and November 2024 for Resident 84. IP also stated the IPs should have monitored for the effective use of antibiotics monthly.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, dated 2001, the P&P indicated, The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents .</p>		

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate space for all 24, three residents residing rooms. This failure resulted in 23 Residents (Resident 1, 5, 11, 21, 23, 31, 51, 54, 56, 59, 61, 64, 65, 68, 69, 70, 74, 79, 81, 190, 191, 193, and 345) not having the required amount of usable living space and had the potential to compromise the safety of residents due to limited space.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 1/13/25 at 9:03 a.m. with Resident 54 in room [ROOM NUMBER], the room had three residents residing in it. Bed C's individual living space was visibly smaller than Bed A and B's living spaces. Resident 54 in Bed C, stated, Look how small this is; I can't even get by. Resident 54 used a walker for an assistive device.</p> <p>During a concurrent observation and interview on 1/15/25 at 4:06 p.m. with Maintenance (MAIN) in room [ROOM NUMBER], MAIN measured Bed C's individual living space, the result was 11.5 feet by 6.5 feet, the Maintenance Director calculated living space was 74.75 square footage (sqft.). MAIN stated, Oh, too small! She needs at least 80.</p> <p>During a concurrent observation and interview on 1/15/25 at 6:01 p.m. with the Administrator (ADMIN), in room [ROOM NUMBER], the ADMIN had the MAIN measure Bed C's individual living space, 11.5 feet by 6.5 feet, the ADMIN calculated living space was 74.75 sqft. The ADMIN confirmed Bed C's individual living space was under 80 sqft.</p> <p>During a concurrent interview and record review on 1/16/25 at 12:01 p.m. with the ADMIN, [facility name] Resident Room Measurements, was reviewed. The [facility name] Resident Room Measurements indicated rooms labeled 1-24, in red ink, had three residents in one room. The ADMIN stated all 24 rooms with a Bed C had an individual living space below 80 sqft.</p> <p>Facility was unable to provide policy and procedure for adequate resident living space.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>49936</p> <p>Based on interview and record review, the facility failed to provide procedures for reporting incidents of abuse and training for seven staff members (Social Services Director (SSD), Registered Nurse (RN) 2, Licensed Vocational Nurse (LVN) 3, Certified Nurse Assistants (CNA) 3, 4, 5, and 6).</p> <p>These findings resulted in staff ineffectively identifying the facility's procedure for reporting incidents of abuse and had the potential to compromise the safety of all residents, staff, and visitors.</p> <p>Findings:</p> <p>During an interview on 1/13/25 at 12:32 p.m. with Resident 23, Resident 23 stated he has heard staff members at night being verbally abusive to his roommate, and he reported it to staff. Resident 23 stated, nothing happened after he reported the incident.</p> <p>During an interview on 1/14/25 at 1:47 a.m. with LVN 3, LVN 3 stated that if there was an abuse incident, she would report it during the next shift to the Director of Nursing (DON) because she's night shift and she wouldn't want to wake the DON up.</p> <p>During an interview on 1/14/25 at 1:48 a.m. with CNA 5, CNA 5 stated that if there was an abuse incident, she would report it to the DON in the morning after her shift and that she wasn't sure if she had to fill out a specific report.</p> <p>During a concurrent interview and record review on 1/16/25 at 6:43 p.m. with the Director of Staff Development (DSD), LVN 3's Employee Files, [undated], was reviewed. The abuse training post-test indicated, LVN 3 selected the incorrect answer that mandated reporters must report known or suspected instances of physical abuse, abandonment, isolation, financial abuse, or neglect by telephone to the long-term care ombudsman or law enforcement within 24 hours, instead of selecting the correct answer to report immediately, or as soon as possible. The DSD stated the abuse training consisted of staff taking a pretest, watching an abuse training video, then re-evaluating their learning with a post test .</p> <p>During a concurrent interview and record review on 1/16/25 at 6:44 p.m. with the DSD, CNA 6's Employee Files, [undated], was reviewed. The abuse training post-test was missing from CNA 6's employee files. The DSD confirmed there was no abuse training post-test in CNA 6's employee files .</p> <p>During a concurrent interview and record review on 1/16/25 at 6:45 p.m. with the DSD, CNA 4's Employee Files, [undated], was reviewed. The abuse training post-test was missing from CNA 4's employee files. The DSD stated, If [the abuse training post-test] is not in the employee file, we assume they didn't do it.</p> <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of RN 2's Employee Files, dated 6/25/24, the abuse training post-test indicated, RN 2 selected the incorrect answer that according to California law, mandated reporters are required to report all instances of abuse in a long-term care facility to the facility administrator, instead of the correct answer which was to report to the long-term care ombudsman or local law enforcement agency .</p> <p>During a review of CNA 5 's Employee Files, dated 6/25/24, the abuse training post-test indicated, CNA 5 selected the incorrect answer that according to California law, mandated reporters are required to report all instances of abuse in a long-term care facility to the facility administrator, instead of the correct answer which was to report to the long-term care ombudsman or local law enforcement agency.</p> <p>During a review of CNA 3 's Employee Files, dated 6/25/24, the abuse training post-test indicated, CNA 3 selected the incorrect answer that according to California law, mandated reporters are required to report all instances of abuse in a long-term care facility to the facility administrator, instead of the correct answer which was to report to the long-term care ombudsman or local law enforcement agency.</p> <p>During a concurrent interview and record review on 1/16/25 at 6:49 p.m. with the DSD, the SSD's Employee Files, dated 10/25/24 was reviewed. The abuse training post-test indicated the SSD selected the incorrect answer that mandated reporters must report known or suspected instances of physical abuse, abandonment, isolation, financial abuse, or neglect by telephone to the long-term care ombudsman or law enforcement within 24 hours, instead of the correct answer to report immediately, or as soon as possible. The abuse training post-test also indicated that the post-test was incomplete. The DSD confirmed that SSD's abuse training post-test was not completed.</p> <p>During an interview on 1/16/25 at 6:52 p.m. with the DSD, the DSD stated, the facility did not have a tracking system for staff that are struggling with the information from the abuse trainings. The DSD stated wrong answers on the abuse training post-test were corrected verbally, but education was not re-evaluated afterwards .</p> <p>During an interview on 1/16/25 at 6:53 p.m. with the Administrator (ADMIN), the ADMIN stated the questions on the abuse post-test seemed confusing and may need to be fixed. The ADMIN stated staff should be required to rewatch the abuse training video and complete the post-test until they get all the answers correct.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated April 2021, the P&P indicated, Provide staff orientation and training orientation programs that include topics such as . reporting of abuse . Implement measures to address factors that may lead to abusive situations, for example: adequately prepare staff for caregiving responsibilities . Report any allegations within time frames required by federal requirements.</p> <p>50669</p>		