STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056122	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrae Care Center	33 Mateo Avenue Millbrae, CA 94030

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 31524 Based on interview, record review, facility policy review, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to complete a discharge Minimum Data Set (MDS) for 1 (Resident #108) of 3 residents reviewed for closed records. Specifically, the facility failed to complete a discharge MDS assessment for Resident #108, after the resident was discharged to a hospital on 08/21/2024. Findings included: A facility policy titled, Minimum Data Set (MDS) Assessment Schedule, dated 10/2023, indicated, 1. The facility conducts a comprehensive assessment to identify patient's needs per the guidelines set by the RAI Manual. The policy specified MDS assessments, including g. Discharge Assessments, would be completed based on the guidelines set by the RAI Manual. The policy revealed, 5. The MDS nurse or RN [Registered Nurse] MDS Coordinator will be responsible for ensuring timely completion of all MDS assessments. The policy further revealed, 8. MDS Assessment time schedule will be completed per attachment A. The facility's Minimum Data Set (MDS) Assessment Schedule Attachment A revealed a discharge assessment should be completed discharge date + 14 calendar days. The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, dated 10/2024, section 2.5 Assessment Types and Definitions indicated, Any of the following warrants a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds: -Resident is discharged from the facility to a private residence (as opposed to going on a LOA [leave of absence]); -Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record); -Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident. The user's manual revealed, This assessment includes clinical items for quality monitoring as well as discharge tracking information. An Admission Record revealed the facility admitted Resident #108 on 10/31/2023. According to the Admission Record, the resident had a medical history that included diagnoses of a pressure ulcer of the sacral region, type two diabetes mellitus, acute kidney failure, essential hypertension, pressure ulcer of the right upper back, difficulty walking, and a history of falling. The Admission Record revealed the facility discharged Resident #108 on 08/28/2024 to an acute care hospital. (continued on next page)

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

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #108's Progress Notes revealed a Nurses Note, dated 08/20/2024 at 9:49 PM, that indicated the facility spoke with hospital staff who stated the resident would be there for approximately one month and asked the facility to make sure the resident brought their personal belongings. Resident #108's Progress Notes revealed a Nurses Note, dated 08/21/2024 at 7:40 AM, that the resident went to a surgery appointment with one bag of belongings, and the resident's family member planned to pick up the rest of the resident's personal effects. Resident #108's Census information in their electronic medical record (EMR) indicated the facility discharged Resident #108 on 08/21/2024, and the resident was on Hospital Paid Leave. Resident #108's MDS information in their EMR revealed the resident had been discharged , and a discharge assessment with an Assessment Reference Date (ARD) of 08/21/2024 was 43 days overdue. There was no documented evidence a discharge MDS was completed. During an interview on 10/17/2024 at 11:26 AM, the MDS Coordinator stated she was responsible for completing discharge MDS assessments. The MDS Coordinator further stated she did not complete Resident #108's discharge MDS. She stated the resident was long-term, and long-term residents typically came back to the facility after going to the hospital. The MDS Coordinator stated she did not identify that the resident did not return to the facility after a seven-day bed hold. During an interview on 10/17/2024 at 10:57 AM, the Director of Nursing (DON) stated she expected MDS assessments to be completed timely. The DON further stated the facility expected Resident #108 to return to the facility after surgery on 08/21/2024. According to the DON, she was unaware a discharge MDS was not completed for Resident #108. She stated it was important to complete MDS assessments according to the scheduled times to stay in compliance. During an interview on 10/17/2024 at 11:12 AM, the Administrator stated she expected the MDS team to follow the MDS schedule when completing assessments. The Administrator stated a discharge MDS should be completed when a resident discharged from the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37047 Based on interview, record review, facility policy review, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded to reflect the presence of behaviors for 1 (Resident #93) of 2 residents reviewed for behaviors. Specifically, the facility failed to ensure behavioral symptoms exhibited during the seven-day look-back period were coded on Resident #93's 08/23/2024 quarterly MDS. Findings included: A facility policy titled, Minimum Data Set (MDS) Accuracy, dated 10/2023, revealed, The facility shall establish a system in which MDS accuracy is checked to assure that each patient receives an accurate assessment by staff that are qualified to assess relevant care areas and are knowledgeable of the resident's status, needs, strength and areas of potential or actual decline. The policy revealed, 6. The IDT [interdisciplinary team] will verify coding accuracy of residents that triggered in the Resident Level Quality Measures. The policy indicated, 8. RAI Clinical consultant/Designee will conduct a sample of MDS for accuracy review at least annually or as needed. The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, dated 10/2024, Chapter 3, Section E: Behavior, revealed The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Section E0200: Behavioral Symptom-Presence & Frequency revealed, Steps for Assessment 1. Review the resident's medical record for the 7-day look-back period. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. Coding Tips and Special Populations specified, -Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated. -Code as present, even if staff have become used to the behavior or view it as typical or tolerable. An Admission Record indicated the facility admitted Resident #93 on 11/18/2022. According to the Admission Record, the resident had a medical history that included diagnoses of adjustment disorder with mixed anxiety and depressed mood, senile degeneration of the brain, psychotic disorder with hallucinations, and dementia. Resident #93's care plan included a problem statement, initiated on 02/25/2023, that indicated the resident had a history of refusing care. Another problem statement, initiated on 01/09/2024, indicated the resident had behaviors due to a diagnosis of dementia with behavioral disturbance, psychosis manifested by seeing other residents as dangerous intruders, a history of pilfering items, being physically aggressive toward others, and being an elopement risk. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93's Order Summary Report, listing active orders as of 10/16/2024, revealed an order dated 07/05/2023 to monitor for getting roommate's stuff, food, and for being physically aggressive towards their roommate; an order dated 03/21/2024 to monitor for episodes of hitting; and an order dated 08/09/2024 to monitor for noncompliance with wearing non-skid socks. Resident #93's Progress Notes revealed the following Nurses Notes: - a note dated 08/17/2024 that indicated the resident hit, scratched, and cut Licensed Vocational Nurse (LVN) #7; - a note dated 08/18/2024 that indicated the resident refused socks/shoes; - a note dated 08/19/2024 at 1:36 PM that indicated the resident was non-compliant with non-skid socks; - a note dated 08/19/2024 at 11:11 PM that indicated the resident was taking things from the nurses' station; - a note dated 08/20/2024 that indicated the resident was non-compliant with non-skid socks; and - a note dated 08/21/2024 that indicated the resident had a couple episodes of stealing items at the beginning of the shift. A quarterly MDS, with an Assessment Reference Date (ARD) of 08/23/2024, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Despite Resident #93's Progress Notes reflecting behaviors during the seven-day look-back period, Section E-Behavior was coded to reflect the resident did not display physical or verbal behavioral symptoms directed toward others or other behavioral symptoms not directed toward others and did not reject care during the seven-day look-back period. During an interview on 10/16/2024 at 12:57 PM, Certified Nursing Aide (CNA) #4 stated that Resident #93 took other residents' belongings. CNA #4 stated that Resident #93 also yelled at staff, and staff could not re-direct the resident. During an interview on 10/16/2024 at 1:14 PM, CNA #9 stated that Resident #93 exhibited behaviors that included taking items from the nurses' station and taking their roommate's belongings. During an interview on 10/17/22024 at 8:53 AM, the Director of Nursing (DON) stated if a resident had behaviors, the behaviors should be reflected on the MDS. During an interview on 10/17/2024 at 11:26 AM, the Administrator stated that if a resident had behaviors, the behaviors should be coded on the MDS.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 28193 Based on interview, record review, and facility policy review, the facility failed to resubmit a Level I Preadmission Screening and Resident Review (PASRR) for 1 (Resident #71) of 3 residents reviewed for PASRR requirements after receiving a letter that indicated a Level II Mental Health Examination was not scheduled and to reopen the case, a new Level I Screening would need to be submitted. Findings included: A facility policy titled, Pre-Admission Screening and Resident Review, dated 12/2017, revealed, PURPOSE To ensure that all facility applicants are screened for mental illness and/or intellectual disability prior to admission and to ensure this assessment effort is coordinated with the appropriate state agencies if indicated. Preadmission Screening and Resident Review [PASRR] is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing home for long term care. The policy further specified, h. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as [PASRR] Level II, which must be conducted prior to admission to a nursing facility. An Admission Record revealed the facility admitted Resident #71 on 12/09/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified schizophrenia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/16/2023, revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had an active diagnosis of schizophrenia and received an antipsychotic medication during the seven-day assessment look-back period. Resident #71's Pre-Admission Screening and Resident Review (PASRR) Level I Screening, completed on 12/12/2023 by a local hospital, reflected a diagnosis of schizophrenia. The PASRR Level I Screening was positive for a suspected mental illness. A letter from the State of California Department of Healthcare Services, dated 12/12/2023 and addressed to the local hospital, revealed Resident #71's PASRR Level I Screening done on 12/12/2023 was positive; however, the letter indicated a Level II Mental Health Evaluation was not scheduled, because the individual was discharged from the facility. The letter further indicated the case was closed and if the case needed to be reopened, please submit a new Level I Screening. During an interview on at 11:28 AM, the MDS Coordinator confirmed Resident #71 had not been discharged from the facility since their original admission. The MDS Coordinator stated the facility should have completed another PASRR for Resident #71. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 9:20 AM, the Director of Nursing (DON) stated that if the facility had a new admission, the hospital typically completed the PASRR before the resident was admitted , and the facility had to access the level I and Level II PASRRs via an online system. The DON said if a Level I PASRR was positive, the facility requested a Level II, if needed. The DON further stated she and the MDS Coordinator were responsible for reviewing the PASRRS to ensure they were correct. During an interview on 10/17/2024 at 9:27 AM, the Administrator stated that before a resident's admission, the hospital should complete a PASRR; the facility then pulled the PASRR results from the online system. According to the Administrator, if the Level I PASRR was positive, the facility would then submit a request for a Level II PASRR, then wait on a call from the state's PASRR office. The Administrator further stated the facility should respond to recommendations in Level II results letters. The Administrator stated she expected staff to ensure all PASRR paperwork was complete and correct.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 28193 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were not left at the bedside for 1 (Resident #21) of 5 residents observed during medication administration. Specifically, facility staff left medications at the bedside of a resident who had impaired eyesight and had not been assessed as safe to self-administer medications. Findings included: A facility policy titled, Medication Administration, dated 09/2028, revealed the section titled, Medication Administration specified, 4. Medications are to be administered at the time they are prepared. 5. The person who prepares the dose for administration is the person who administers the dose. The policy further specified, 15. Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT), and in accordance with procedures for self-administration of medication and state regulations, and 19. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR [Medication Administration Record] is 'flagged' (e.g. [exempli gratia, for example], tags, colored plastic strips, or paper clips). After completing the medication pass, the nurse returns to the missed resident to administer the medication. 20. The resident is always observed after administration to ensure that the dose was completely ingested. A facility policy titled, Self-Administration of Medication, dated 07/2017, revealed, It is the policy of this facility to (sic) that each resident has the right to self-administer medications, if able. The interdisciplinary team evaluates each resident who expresses wishes to self-administer medications to determine if the resident is safe to do so, and if so provides the education and monitoring necessary to ensure safe administration. The section of the policy titled, Responsible Discipline specified, The Director of Nurses (DON) and/or its designee shall be responsible for implementation and enforcement of this policy. The section of the policy titled, Procedure specified, 2. If a resident desire (sic) to participate in self-administration, the interdisciplinary team will assess the competence of the resident to participate, by completing a Self-administration of Medication Administration Assessment. 3. The nurse will interview the resident to determine the resident's ability to identify, prepare, and self-administer medications. The section of the policy titled, Documentation specified, 3. Use self-medication administration form to assess resident. An Admission Record revealed the facility originally admitted Resident #21 on 09/17/2021 and most recently admitted the resident on 01/05/2024. According to the Admission Record, the resident had a medical history that included diagnoses of age-related nuclear cataract of the left eye, legal blindness, glaucoma, hearing loss of the left ear, kidney transplant, end stage renal disease, hyperkalemia (high blood potassium), hypertension, and type two diabetes mellitus with diabetic neuropathy. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/13/2024, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had moderately impaired vision (limited vision; not able to see newspaper headlines but can identify objects) while utilizing corrective lenses. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21's care plan included a problem statement, initiated 09/19/2021, that indicated the resident had impaired visual function related to, Legally blind, Cataract, Glaucoma. An additional problem statement, initiated 9/19/2021, indicated Resident #21 had impaired visual function related to being Legally Blind (blurry vision), left eye Cataracts/Glaucoma, Right eye with prosthetic, Diabetes. Interventions initiated on 09/19/2021 directed staff to tell the resident where they were placing items and to be consistent and indicated the resident preferred to have their room and things arranged to promote independence. Resident #21's Order Summary Report, listing active orders as of 10/15/2024, included the following orders: - an order dated 04/11/224 for amlodipine besylate 5 milligram (mg) by mouth in the morning for hypertension, with instructions to hold for a systolic blood pressure less than 100 or a heart rate less than 60; - an order dated 12/15/2021 for Eliquis 2.5 mg by mouth two times a day for Atrial flutter; - an order dated 12/30/2023 for ferrous sulfate (an iron supplement) by mouth in the morning for supplement; - an order dated 07/16/2023 for hydralazine hydrochloric acid 25 mg by mouth two times a day for hypertension, with instructions to hold for a systolic blood pressure less than 100 or a heart rate less than 60; -an order dated 03/03/2024 for lidocaine external patch 4% (a topical anesthetic to relieve pain) to the right hip every twelve hours; - an order dated 12/15/2021 for metoprolol succinate extended release (XR) 200 mg by mouth one time a day for hypertension, with instructions to hold for a systolic blood pressure less than 100 or a heart rate less than 60; - an order dated 12/15/2021 for mycophenolate mofetil (an immunosuppressive drug used to prevent transplant rejection) 500 mg by mouth two times a day; - an order dated 12/15/2021 for sodium bicarbonate (an antacid used to relieve heartburn and indigestion) 325 mg by mouth two times a day; - an order dated 04/20/2024 for tacrolimus (used to lower the risk of organ rejection) 1 mg, three capsules by mouth two times a day; - an order dated 07/23/2023 for Veltassa oral packet 8.4 grams, one packet by mouth one time a day for hyperkalemia; and - an order dated 07/23/2023 for vitamin D3 1000 units by mouth in the morning for supplement. Additionally, the Order Summary Report contained an order dated 12/15/2021 for famotidine (a stomach acid blocker) 20 mg by mouth at bedtime. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/15/2024 at 8:32 AM, Registered Nurse (RN) #2 was observed preparing Resident #21's medications. RN #2 placed Resident #21's ordered amlodipine, ferrous sulfate, metoprolol succinate ER, vitamin D3, Eliquis, hydralazine, sodium bicarbonate, mycophenolate mofetil, and tacrolimus into a medication cup. She then placed the medication cup, the resident's lidocaine patch, a Veltassa packet, a cup of water, and a spoon onto a tray and entered the resident's room. Upon entering Resident #21's room, a cup with medication in it was observed on the bedside table, and RN #2 stated it was the resident's famotidine from the night before. RN #2 then applied the resident's lidocaine patch, cut open the top of the Veltassa packet, and placed the cup of water, spoon, and the cup of medications on Resident #21's bedside table. RN #2 stated Resident #21 would eventually take the medication but preferred to do it after breakfast. RN #2 then walked out of the room, leaving the medications at the bedside with Resident #21. When asked why last night's medications were on the bedside table and Resident #21 had not taken them, RN #2 replied that Resident #21 took the medication when the resident wanted, and that was how they had been doing it for some time. RN #2 stated she could see how it could be a problem if the resident waited too long to take medications and took two doses together. During an interview on 10/17/2024 at 9:51 AM, Resident #21 stated they wanted to take their medication after eating, and they were slow. Resident #21 stated when the nurse administering the medication came in too early, the resident told them to leave the medications on the table so the resident could take them later. Resident #21 stated they forgot to take their medicine the on the night of 10/14/2024. Resident #21 stated, I just take what they give to me. During a phone interview on 10/17/2024 at 10:04 AM, RN #2 stated she was not aware the residents had to have a special assessment done in order to leave their medications with them and not watch them take it. RN #2 stated she had always left the medications with Resident #21. During an interview on 10/17/2024 at 9:35 AM, the Director of Nursing (DON) stated she expected staff to not leave medication at the bedside for the residents unless the residents were assessed as safe to do so. The DON stated, if a resident did not want medication at the time it was passed, staff should take the medication back to the cart and attempt again later. The DON stated staff had been told to never to leave medications at the bedside for the residents. The DON verified there was no self-administration assessment completed for Resident #21 and no care plan or physician's order that indicated the resident was safe to self-administer medications. During an interview on 10/17/2024 at 9:36 AM, the Administrator stated she expected nurses to give medications as ordered and to ensure the residents took them. The Administrator said that if a resident did not take medications when the nurse attempted to give them, the nurse should take the medication back to the medication cart and offer them later within the two-hour timeframe for medication administration.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 31524 Based on interview, record review, and facility policy review, the facility failed to obtain laboratory services in a timely manner for 1 (Resident #15) of 5 residents reviewed for unnecessary medications. Specifically, Resident #15 had an order to check their Keppra (an anticonvulsant) level every six months. The facility failed to obtain the resident's Keppra level in September 2024, six months after the previous level was obtained. Findings included: The facility policy titled, Physician Orders, dated December 2016, indicated, Physician orders are obtained to provide a clear direction in the care of the resident. During an interview on 10/16/2024 at 1:02 PM, the Administrator stated the facility did not have a policy regarding laboratory services. An Admission Record revealed the facility initially admitted Resident #15 on 11/04/2022 and most recently admitted the resident on 02/18/2024. According to the Admission Record, the resident had a medical history that included diagnoses of convulsions and epilepsy. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/03/2024, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS also revealed the resident had an active diagnosis of seizure disorder or epilepsy. Resident #15's Order Summary Report, with active orders as of 10/15/2024, contained an order dated 02/18/2024 that directed staff to administer Keppra 1000 milligrams (mg) by mouth two times a day for seizures. The Order Summary Report also contained an order dated 03/10/2024 to check the resident's Keppra level every six months. Resident #15's October 2024 Medication Administration Record [MAR] revealed Keppra 1000 mg was documented as administered as ordered. Resident #15's Lab Report revealed a Keppra laboratory test was completed on 03/13/2024 and the resident's Keppra level was 20.1 micrograms per milliliter (mcg/mL), which was within therapeutic range. There was no documented evidence the facility obtained another Keppra level for Resident #15 six months after the 03/13/2024 level was obtained. During an interview on 10/16/2024 at 2:58 PM, Licensed Vocational Nurse (LVN) #1 stated the Director of Nursing (DON) asked her to check all residents' Keppra levels in 03/2024. LVN #1 stated laboratory orders that were required to be repeated every six months should be put on a communication board in Resident #15's electronic medical record so that all nurses could see the order daily. LVN #1 stated it was important to follow the physician's order and check the resident's Keppra level to ensure the medication was at a therapeutic level and ensure the physician could adjust the medication dosage, if needed. (continued on next page)

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Millbrae Care Center	33 Mateo Avenue Millbrae, CA 94030

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 9:22 AM, the Medical Director (MD) stated if a resident had an active standing order to check a Keppra level, she expected the facility to follow the order and obtain the laboratory test. During an interview on 10/17/2024 at 10:57 AM, the DON stated that, when a physician wrote an order for laboratory testing, she expected nursing staff to follow through and obtain the test as ordered. The DON stated Resident #15's Keppra level should have been obtained in September 2024. During an interview on 10/17/2024 at 11:12 AM, the Administrator stated if there was a standing order to obtain laboratory tests, she expected nursing staff to follow the physician's order and obtain the ordered tests.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37047 Based on observation, interview, and record review, the facility failed to maintain a system for preventing infection for 3 (Resident #81, #21, and #116) of 24 sampled residents. Specifically, the facility failed to disinfect Resident #81's mattress after staff stepped on the mattress and disinfect a blood pressure cuff after resident use and prior to use for Resident #21 and Resident #116. Findings included: 1. A facility policy titled, Enhanced Barrier Precaution, dated 06/2022, revealed, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: - Wounds or indwelling medical devices, regardless of MDRO colonization status. - Infection or colonization with an MDRO. The policy indicated, Use EBP for high-contact resident care activities by using gown and glove during: and f. Changing briefs or assisting with toileting. An Admission Record revealed the facility admitted Resident #83 on 07/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia, pleural effusion chronic congestive heart failure, Type 2 diabetes, and legal blindness. An admission Minimum Data Set (MDS), dated [DATE], revealed Resident #83 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident was always incontinent of bowel and bladder. An infection Progress Note dated 10/15/2024 revealed the Infection Preventionist (IP) documented that Resident #83 had clostridium difficile on 09/15/2024. According to the note, isolation had ended but the resident would remain on EBP for precautionary measures. The note revealed the resident's physician concurred with EBP precautions for the resident. On 10/16/2024 at 10:56 AM, Certified Nursing Aide (CNA) #10 entered Resident #83's room to provide incontinence care. CNA #10 donned gloves and closed the curtain. CNA #10 did not don a gown. An observation revealed a sign posted outside the resident's room that indicated Resident #83 was on EBP. The observation also revealed gowns and gloves were available in a shelf outside Resident #83's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/2024 at 11:07 AM, CNA #10 stated that they were aware they were supposed to wear a gown when providing incontinence care for a resident on EBP. CNA #10 stated an orange sticker indicated staff were supposed to wear PPE when caring for those residents. She stated there was normally a sign by the bed that indicated which type of PPE to use. According to CNA #10, she believed the signage outside the room was for another resident and she had not noticed an orange sticker for Resident #83. On 10/16/2024 at 1:39 PM, the IP stated that when a resident required EBP, they placed a sign outside their room and placed an orange sticker beside the resident's name. The IP stated she made rounds and tried to do surveillance. On 10/17/2024 at 8:53 AM, the Director of Nursing (DON) stated that if a resident needed EPB, the IP placed a container with the required Personal Protective Equipment (PPE) and informed the CNAs. The DON stated that CNAs were trained on donning and doffing gowns and gloves used for residents who were on EBP. During an interview on 10/17/2024 at 11:26 AM, the Administrator stated that CNAs were trained on EBP. The NHA stated that staff were aware which residents were on EPB because there was signage on the resident's door that indicated what PPE to use when providing direct care. The NHA stated that the PPE required was based on the infection type, but that the standard was to wear a gown and gloves. 2. On 10/17/2024 at 11:26 AM, the Administrator stated the facility did not have a policy related to sanitizing a mattress for a resident whose mattress was kept on the floor. An Admission Record indicated the facility admitted Resident #81 on 12/27/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, muscle weakness, difficulty in walking, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/16/2024, revealed Resident #81 had severe impairment in cognitive skills for daily decision making and had short- and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS revealed the resident had not had any falls since admission/entry/reentry or since the prior assessment. Resident #81's care plan included a problem statement, initiated on 10/17/2023, that indicated the resident had a gait abnormality and had sustained a fall. Interventions directed staff to provide a mattress on the floor for injury prevention related to crawling (initiated on 10/17/2023). During an observation on 10/16/2024 at 10:31 AM, Certified Nursing Aide (CNA) #9 and CNA #11 assisted Resident #81 to their bed. During the observation, CNA #11 stepped on Resident #81's mattress with one foot that was fully placed on the end of the mattress. CNA #11 was wearing shoes. The observation revealed both CNAs left the room and did not change the sheets or sanitize the resident's mattress. During an interview on 10/17/2024 at 8:21 AM, CNA #11 stated she accidentally stepped on the mattress when assisting Resident #81 to bed. CNA #11 stated they probably should have changed the sheets. The CNA stated they had not received any training related to ensuring the mattress on the floor remained sanitized. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/2024 at 8:26 AM, the Infection Preventionist (IP) stated that if a CNA stepped on a mattress, the sheet should have been changed. The IP stated that situation had not come up before; subsequently, the CNAs had not received training. During an interview on 10/17/2024 at 8:53 AM, the Director of Nursing (DON) stated that if staff accidentally stepped on a mattress, the linens should have been changed. During an interview on 10/17/2024 at 11:26 AM, the Administrator stated that if a staff member accidentally stepped on the mattress, she would have expected the mattress to be cleaned, and the sheets changed. 28193 3. During an interview on 10/17/2024 at 9:32 AM, the Administrator stated nurses were expected to clean resident care equipment between resident use. During an observation of medication administration on 10/15/2024 at 8:10 AM, Registered Nurse (RN) #2 obtained Resident #37's blood pressure and pulse with an automatic wrist blood pressure cuff. Once the blood pressure and pulse were obtained, RN #2 placed the blood pressure cuff on top of the medication cart and finished medication administration for Resident #37. RN #2 did not disinfect the blood pressure cuff after use. During an observation of medication administration on 10/15/2024 at 8:32 AM, RN #2 obtained Resident #21's blood pressure and pulse with the same automatic wrist blood pressure cuff, without first disinfecting the blood pressure cuff. Once the blood pressure and pulse were obtained, RN #2 placed the blood pressure cuff on top of the cart and finished medication administration for Resident #21. RN #2 did not disinfect the blood pressure cuff after removing the cuff from Resident #21's wrist. During an observation of medication administration on 10/15/2024 at 8:45 AM, RN #2 obtained Resident #116's blood pressure and pulse with the same automatic wrist blood pressure cuff used for Resident #37 and Resident #21 that had not been disinfected. During a telephone interview on 10/17/2024 at 10:04 AM, RN #2 stated she was nervous and aware that she forgot to wipe off the blood pressure cuff in between resident use. During an interview on 10/17/2024 at 9:31 AM, the Director of Nursing (DON) stated the facility provided two vital sign machines on every medication cart to prevent the issue in question. She stated she was not sure what happened to the second vital sign machine that day. The DON stated she expected nurses to clean and disinfect the machines between patient use. During an interview on 10/17/2024 at 9:32 AM, the Administrator stated the facility provided two machines on each medication cart for staff to disinfect the machine and allow it time dry.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683 Based on interview, record review, and facility document review, the facility failed to ensure 1 (room [ROOM NUMBER]) of 40 resident rooms was not equipped to accommodate more than four residents. room [ROOM NUMBER] was occupied by four residents but had six beds available for use when at full occupancy. Findings included: A letter from the facility to the California Department of Public Health (CDPH), dated 12/28/2023, revealed the facility requested a waiver of the room requirement for no more than four residents per room for room [ROOM NUMBER]. The letter indicated that room [ROOM NUMBER] had six beds and 86 square feet per resident. A Census, dated 10/13/2024, revealed room [ROOM NUMBER] had a six-bed capacity, but was occupied by only four residents as of 10/13/2024. A Client Accommodations Analysis, dated 10/17/2024, indicated room [ROOM NUMBER] had a floor area of 544.7 square feet with an approved capacity of six residents. During an interview on 10/17/2024 at 12:13 PM, the Director of Nursing (DON) stated the facility was not cited on the room requiring a variance during their last recertification survey. She stated the residents in that room received the same amount of care as any other residents. During an interview on 10/17/2024 at 11:23 AM, the Administrator said the facility did not have a policy that addressed room variances. During a follow-up interview on 10/17/2024 at 12:26 PM, the Administrator stated the residents in room [ROOM NUMBER] received the same care as any other residents in the facility and said the facility had applied for a waiver for that room.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 37683 Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure residents did not smoke in non-designated areas not equipped with needed safety equipment and devices. In addition, the facility failed to enforce their smoking policy regarding the storage of lighters for 2 (Resident #39 and Resident #106) of 3 sampled residents reviewed for smoking. This deficient practice had the potential to affect all 7 residents identified by the facility as smokers. Findings included: A facility policy titled, Smoking Policy - Residents, released 06/2022, indicated, 1. Prior to, or upon admission, residents shall be informed about any limitations on smoking, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences; for example, in making room assignments. The policy revealed, 5. Metal containers, with self-closing cover devices, shall be available in smoking areas. The policy further revealed, 12. Smoking articles for residents with independent smoking privileges: a. Residents who have independent smoking privileges shall be permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession. b. Residents may not keep even disposable safety lighters. All other forms of lighters, including matches, shall be prohibited. An undated document provided by the facility identified seven residents as smokers and reflected the facility's designated smoking area was the Backyard. During a random observation on 10/16/2024 at 7:50 AM, three residents were observed smoking around the garden area about 25 feet from the front door. Cigarette butts were observed in the raised flower bed. There were no No oxygen signs, no ashtrays or smoking chimneys, and no fire extinguisher observed. An Admission Record revealed the facility originally admitted Resident #39 on 11/21/2020 and readmitted the resident on 08/31/2024. According to the Admission Record, the resident had medical history that included a diagnosis of tobacco use. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/30/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #39's care plan included a problem statement, revised 09/07/2024, that indicated the resident was a smoker and preferred to keep their cigarettes in their room. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #39's Smoking Assessment, dated 09/07/2024, indicated, Resident is a safe smoker and perform [sic] function independently. The assessment indicated Resident #39 was able to hold the smoking device while smoking, could light and smoke a cigarette while demonstrating safe technique or putting out matches or lights and disposing ash. The assessment indicated Resident #39 remained alert during the course of smoking, could communicate that they understood the smoking materials were for their own personal use, and could communicate they understood smoking materials were only for the designated smoking area. On 10/16/2024 at 8:26 AM, Resident #39 stated they smoked wherever they wanted as long as it was 25 feet from the doorway of the facility. Resident #39 stated there were no ashtrays or fire extinguishers in the vicinity of where they usually smoked. On 10/16/2024 at 9:36 AM, Resident #39 stated they kept their own smoking materials, including their lighter. An Admission Record revealed the facility admitted Resident #106 on 10/02/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of nicotine dependence. A quarterly MDS, with an ARD of 07/10/2024, revealed Resident #106 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #106's care plan included a problem statement, initiated 02/02/2024, that indicated the resident was a smoker. Resident #106's Smoking Assessment, dated 07/17/2024, revealed Resident #106 was able to hold the smoking device while smoking, the resident could light and smoke a cigarette while demonstrating safe technique or putting out matches or lights and disposing ash, and the resident remained alert during the course of smoking. The interdisciplinary team (IDT) comments indicated, Smokes safely outside the facility, aware of smoking protocol. Will continue plan of care. During an interview on 10/16/2024 at 10:17 AM, Resident #106 stated they kept their smoking materials with them, including their lighter. During an interview on 10/16/2024 at 8:50 AM, Restorative Nursing Aide (RNA) #3 stated residents sometimes went out front to smoke, but she did not know if there were any smoking receptacles/ashtrays in that area. During an interview on 10/16/2024 at 8:59 AM, Certified Nursing Aide (CNA) #4 stated residents smoked in front of the building, but he was not sure if they had smoking receptacles/ashtrays or a fire extinguisher in that area. During an interview on 10/16/2024 at 9:02 AM, Registered Nurse (RN) #5 stated residents had a designated smoking area in the back of the facility, but they also smoked out front. RN #5 stated the facility educated residents often to go out back to smoke, but the designated smoking area out back was too far, especially for residents with difficulty walking. RN #5 stated she was unsure about whether there was a fire extinguisher out front. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/2024 at 9:32 AM, RN #6 stated the assigned smoking area was out back, but, since it was so far, residents preferred to smoke out front. RN #6 stated there was a trashcan out front that residents could use to dispose of their cigarette butts and ashes, and he believed that was sufficiently safe. RN #6 stated he was not sure if there was a fire extinguisher. During an interview on 10/16/2024 at 9:53 AM, the Director of Nursing (DON) stated the designated smoking area was out back. The DON stated there were ashtrays and a fire extinguisher in the designated smoking location. The DON further stated in California it was illegal to have a smoking section within 25 feet from doorways. The DON stated the only thing the facility had done to enforce its rules was reeducation of residents. The DON stated if residents were independent, they were permitted to keep their own smoking materials including their lighters. The DON stated there had been no accidents at the facility related to smoking. During an interview on 10/16/2024 at 9:58 AM, the Administrator stated the designated smoking area was out back. However, the Administrator stated residents often smoked out front. The Administrator stated the facility could not rescind residents' smoking privileges out of fear the residents would try to smoke inside the building. The Administrator stated residents who were independent were allowed to keep their smoking materials, including lighters. The Administrator stated she did not know where the closest fire extinguisher to the front of the building was located.