STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056151	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fullerton, LLC	330 W. Bastanchury Road Fullerton, CA 92835

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to facilitate the residents' preferences and choices for food for three of 19 final sampled residents (Residents 22, 61, and 70). * Residents 22, 61, and 70 were not offered Korean breakfast. In addition, the Korean menu was posted in English. These failures posed the risk of the residents not being able to choose food items according to their ethnic preferences. Findings: Review of the facility's P&P for Nutrition Care - Resident Food Preferences revised 2018 showed the resident food preferences should be reviewed with the resident by the DSS and ethnic food preferences should be taken into consideration. 1.a. On 9/3/24 at 0951 hours, an interview was conducted with the DSS. When asked about breakfast served to residents, the DSS stated all residents were served breakfast from the American menu. On 9/4/24 at 0851 hours, Resident 22 was observed with her breakfast tray of scrambled eggs, toast, oatmeal, orange slice, and milk. On 9/4/24 at 1218 hours, an interview was conducted with Resident 22 and Resident 22's RP. When asked about Resident 22's breakfast, the RP verbalized when Resident 22 lived at home Resident 22 would have Korean breakfast. The RP stated Resident 22 would like Korean breakfast and to have the Korean menu in Korean language. Resident 22 could read the Korean menu if provided in Korean language. On 9/4/24, medical record review for Resident 22 was initiated. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 4/1/24, showed Resident 22 was able to understand and express herself in Korean. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 9/4/25 at 0730 hours, Resident 70 was observed with her breakfast tray of eggs, oatmeal, orange slice, milk, and a red liquid. When asked about being served a Korean breakfast, Resident 70 stated she would like Korean breakfast if possible. When asked if the staff had offered her a Korean breakfast, Resident 70 stated no. On 9/4/24, medical record review for Resident 70 was initiated. Resident 70 was readmitted [DATE]. Review of Resident 70's H&P examination dated 12/21/23 showed Resident 70 was able to understand and express herself in Korean. On 9/4/24 at 1418 hours, a concurrent interview and medical record review was conducted with the DSS. The DSS verified Korean menus were not provided to the residents and Korean menus posted in the hallway outside the kitchen and in the dining room were posted in English. The DSS verified the majority of residents in the facility were Korean. On 9/6/24 at 1503 hours, an interview was conducted with the DON. When asked about the ethnic population of the residents at the facility, the DON stated 89 residents spoke and read primarily Korean. The DON stated 91 residents received meals prepared by the kitchen. 49780 c. Review of Resident 61's medical record showed the resident was admitted to the facility on [DATE], with diagnosis of unspecified protein-calories malnutrition. On 9/4/24 at 0735 hours, a breakfast observation was conducted with Resident 61. Resident 61 had poured scrambled eggs into a bland rice porridge and taken out a Korean Soy paste from the drawer and ate with the porridge. Resident 61 did not eat the sandwich. On 9/4/24 at 1215 hours, an interview was conducted with Resident 61 with a translator. Resident 61 stated she did not like the sandwich or toast so she did not eat them. Resident 61 stated nobody asked her what she preferred to eat or if she liked to eat the sandwich or toast. Resident 61 preferred Korean food but the facility always gave her American breakfast. On 9/4/24 at 1626 hours, an interview was conducted with RN 3. RN 3 stated most Korean residents liked to eat Korean food, and if they liked to eat American food, she could change it for them. RN 3 confirmed Resident 61 liked to eat Korean food and did not like American food.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, and facility P&P review, the facility failed to implement the P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility failed to report an abuse allegation to the local law enforcement for one of one final sampled resident investigated for abuse (Resident 47). This failure had the potential for a delay in law enforcement response to the allegation. Findings: Review of the facility's Abuse and Neglect Prevention Management revised August 2018 showed all allegation of abuse or mistreatment will be reported per state law including the local law enforcement. Medical record review for Resident 47 was initiated on 9/3/26. Resident 47 was admitted to the facility on [DATE]. On 9/3/24 at 1455 hours, an interview was conducted with Resident 47 at their bedside. Resident 47 made an abuse allegation that three staff members were mean to her and rough. On 9/3/24 at 1523 hours, the Administrator was informed of Resident 47's allegations. Review of the facility's Report of Suspected Dependent Adult/Elder Abuse faxed to CDPH on 9/3/24, failed to show the report was submitted to the local law enforcement. Review of the facility's Follow Up Abuse Investigation Report for the Facility Reported Incident on 9/3/24, the report faxed to CDPH on 9/5/24, failed to show the local law enforcement agency was notified of the abuse allegation. On 9/5/24 at 1552 hours, an interview was conducted with the Administrator. The Administrator verified the facility did not notify the local law enforcement of the abuse allegation.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the low air loss mattress (pressure redistributing support surface) was set appropriately according to the resident's weight for one of two final sampled residents (Resident 486) reviewed for pressure ulcer (skin injury caused by prolonged pressure on an area of the body). This failure had the potential of Residents 486 not receiving the appropriate care and services to promote healing or prevent the development of the pressure ulcers. Findings: Review of the facility's P&P titled Pressure Reducing Mattresses revised 1/2024 showed specialized mattress/beds are to be utilized according to suppliers' direction for use. Review of the facility's document titled Operating Instruction Comfy Aire Series, undated, showed the Comfy Aire system is designed for patient weighting between 35- 145 pounds, using the comfort control. Depending on the desired resident comfort level the micro-controller/sensor will set appropriate air pressure in the mattress and maintain the desired pressure in the mattress. On 9/3/24 at 0849 hours, 9/4/24 at 0931 hours, and 9/5/24 at 1250 hours, Resident 486 was observed lying on a low air loss mattress. The low air loss mattress was observed set to comfort level 4 which corresponded to the weight of 175 pounds. Medical record review for Resident 486 was initiated on 9/3/24. Resident 486 was admitted to the facility on [DATE]. Review of Resident 486's Weekly Skin Integrity Assessment for Pressure Sore dated 8/28/24, showed Resident 486 had a Stage 3 pressure ulcer (full-thickness skin loss that extends into deeper tissue and fat) to the sacrococcyx area. Review of Resident 486 's Order Summary Report showed a physician's order dated 8/1/24, for a low air loss mattress for wound management. Review of Resident 486's MDS dated [DATE], showed Resident 486 was totally dependent on the staff for bed mobility. Further review of the MDS showed Resident 486 had memory problem. Review of Resident 486's History and Physical Examination dated 7/23/24, showed Resident 486 did not have the capacity to understand and make medical decisions. Further medical record review for Resident 486 showed Resident 486's weight was documented as 99 pounds on 8/12/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 1301 hours, an observation, interview, and concurrent medical record review for Resident 486 was conducted with LVN 2. LVN 2 verified Resident 486's low air loss mattress was set to level 4. LVN 2 verified Resident 486 was 99 pounds and did not have the capacity to understand and verbalize comfort level of the mattress. LVN 2 further stated Resident 486's comfort level for the low air loss mattress was supposed to be set to Resident 486's weight of 99 pounds at level 2, not at level 4 (175 pounds). On 9/5/24 at 1318 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated if the resident could not verbalize the comfort level for the low air loss mattress, then it should be set to the resident's weight.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the physician order for oxygen therapy was followed for one of one final sampled resident reviewed for oxygen therapy (Resident 17). This failure had the potential for Resident 17 to not to receive appropriate respiratory care and posed the risk to negatively affect Resident 17's medical condition. Findings: Review of the facility's P&P titled Oxygen Therapy revised 1/2024, showed it is the policy of the facility that oxygen to be administered as ordered by the physician or as an emergency measure until the order could be obtained. Under the section Procedure showed to adjust oxygen flow as ordered by the physician. On 9/3/24 at 0940 hours, an observation was conducted for Resident 17. Resident 17 was observed lying in bed and receiving oxygen at six liters per minute via nasal cannula. Medical record review for Resident 17 was initiated on 9/3/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report dated 9/4/24, showed the following physician's orders: - dated 8/24/24, to administer oxygen at two liters per minute via nasal cannula continuously. - dated 8/24/24, may titrate up to five liters per minute via mask for respiratory comfort if oxygen saturation level less than 90%. On 9/3/24 at 0951 hours, an observation, interview and concurrent medical record review for Resident 17 was conducted with the IP. Resident 17 was observed lying in bed and receiving oxygen at six liters per minute via nasal cannula. The IP verified the observation and Resident 17's physician order for oxygen. The IP further stated Resident 17 was not receiving oxygen as per the physician order and Resident 17 should have received oxygen at two liters per minute via nasal cannula continuously as per the physician's order. The IP stated if the residents' condition needed an increase in oxygen, then the physician should be notified and documented in the medical record. On 9/5/24 at 1028 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.41% (for two medication errors out of 27 total opportunities). * The facility failed to ensure LVN 1 administered Resident 63's medication as ordered. This failure had the potential to cause the negative outcomes to Resident 63. Findings: Review of the facility's P&P titled Policy and Procedure In Medication Administration revised January 2024 showed medications must be administered in accordance with the physicians' orders. On 9/4/24 at 0838 hours, a medication administration observation was conducted with LVN 1 for Resident 63. LVN 1 administered the following medications: - one tablet of Extra Strength Glucosamine Hcl (hydrochloride) with MSM (methylsulfonylmethane). - one softgel of Vision Formula 50+ dietary supplement with Lutein, Zeaxanthin, and Omega 3. LVN 1 stated Resident 63's family member brought the supplements to the facility. Review of the medication labels showed the following: -For the Extra Strength Glucosamine Hcl with MSM medication, the dosage showed for two tablets to provide 1500 mg of glucosamine and 1500 mg of MSM. The medication did not contain chondroitin. -For the Vision Formula 50+ dietary supplement with Lutein, Zeaxanthin and Omega 3 medication, the label showed one softgel contained Lutein 5 mg, Omega-3 fatty acids 250 mg, Zeaxanthin Isomers 1 mg. Medical record review for Resident 63 was initiated on 9/3/24. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report dated 9/4/24, showed the following physician's orders: -dated 7/28/24, to administer glucosamine-chondroitin (a supplement) one tablet by mouth daily. -dated 8/4/24, to administer lutein (a supplement) 20 mg by mouth daily. On 9/4/24 1058 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 reviewed the medication labels for the Extra Strength Glucosamine Hcl with MSM, and Vision Formula 50 + dietary supplement with Lutein, Zeaxanthin, and Omega 3 medication. LVN 1 compared the labels for the above medications to Resident 63's physician's orders and verified the physician's orders did not match what LVN 1 administered to Resident 63.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents obseved for the medication administration (Residents 28 and 62) were free from significant medication errors. * Residents 28 and 62's blood pressure medications were not held as ordered by the physician. These failures had the potential for the adverse outcomes to the residents. Findings: Review of the facility's P&P titled Policy and Procedure In Medication Administration revised 1/2024 showed medications must be administered in accordance with the physicians' orders 1. Medical record review for Resident 28 was initiated on 9/3/24. Resident 28 was admitted to the facility on [DATE]. a. Review of Resident 28's Order Summary Report dated 9/6/24, showed an order dated 9/20/22, for amlodipine besylate (a medication to treat high blood pressure) 5 mg daily, hold for a SBP less than 110 mmHg. Review of Resident 28's MAR for July 2024 showed on 7/19/24, amlodipine besylate was administered to the resident with SBP of 102 mmHg instead of holding the medication as per the ordered parameter. b. Review of Resident 28's Order Summary Report dated 9/6/24, showed an order dated 9/20/22, for losartan potassium-HCTZ (hydrochlorothiazide) (a medication to treat high blood pressure) 100-12.5 mg daily, hold for a SBP (systolic blood pressure) less than 110 mmHg. Review of Resident 28's MAR for July 2024, showed on 7/19/24, losartan potassium-HCTZ was administered to the resident with SBP of 102 mmHg instead of holding the medication as per the ordered parameter. On 9/6/24 at 0904 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 28's MAR showed the amlodipine besylate losartan potassium-HCTZ was documented as administered on 7/19/24 at 0900 hours, with a SBP within the ordered parameters to hold the medication. The DON stated the medications should not have been administered with a SBP of 102 mmHg. 44175 2. Medical record review for Resident 62 was initiated on 9/3/24. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's Order Summary Report dated 7/14/24, showed to administer carvedilol oral tablet 6. 25 mg by mouth two times a day with meal, and to hold the medication if systolic blood pressure less 110 mmHg, or heart rate less than 60 beats per minute. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 62's MAR for September 2024 showed on 9/3/24 at 0730 hours, Resident 62's heart rate was 57 beats per minute. The MAR further showed on 9/3/24 at 0730 hours, medication carvedilol 6.25 mg was administered to Resident 62. On 9/5/24 at 0952 hours, an interview and concurrent record review for Resident 62 was conducted with RN 5. RN 5 verified the above findings and stated when the heart rate for Resident 62's was 57 beats per minute on 9/3/24 at 0730 hours, the licensed nurse should have held the medication as per the physician order. RN 5 further stated administering medication when the resident's heart rate was below ordered parameters could further lower the heart rate and affect the resident. On 9/5/24 at 1024 hours, a concurrent interview and medical record review for Resident 62 was conducted with the DON. The DON verified above findings and stated that was a medication error incident and she would in-service licensed nurse involved.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35346 Based on observation, interview, and facility document review, the facility failed to ensure the ice machine was cleaned and sanitized according to the manufacturer's instructions. This failure posed the risk of the residents contracting the illnesses from the ice served to them. Findings: Review of the facility matrix showed 93 of 93 residents residing in the facility received food prepared in the kitchen. On 9/3/24 at 0951 hours, a concurrent observation, interview, and facility document review was conducted with the Maintenance Director. The facility was equipped with one ice machine. When asked about cleaning and sanitizing the ice machine, the Maintenance Director showed an inner panel on the ice machine containing the instructions on how to clean and sanitize. Review of the instructions on the panel included the descaling and sanitizing solutions were to be mixed with water. On 9/4/24 at 1544 hours, a concurrent interview and facility document review was conducted with the Maintenance Director. The Maintenance Director verified he was not mixing the descaling and sanitizing solutions correctly as per the manufacturer's instructions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, and facility P&P review, the facility failed to document the medication as refused for one nonsampled resident observed for the medication adminstration (Resident 83). This failure resulted in inaccurate medication administration records, which had the potential for the resident's well-being. Findings: Review of the facility's P&P titled Policy and Procedure In Medication Administration revised 1/2024 showed the medications must be documented immediately after administering. Medical record review for Resident 83 was initiated on 8/4/24. Resident 83 was admitted to the facility on [DATE]. On 9/4/24 at 0848 hours, an observation was conducted of Resident 83's medication administration by LVN 1. During the observation, LVN 1 poured polyethylene glycol (laxative medication) 17 gm and mixed it with water. LVN 1 brought the medication to Resident 83's bedside for administration. Resident 83 refused it because he was leaving for an appointment. LVN 1 administrated the rest of the resident's scheduled medications and took the polyethylene glycol with her. LVN 1 then documented the medication as administered in the resident's medical record. Review of Resident 83's MAR dated 9/4/24, showed Resident 83's polyethylene glycol 17 gm was documented as administered. On 9/4/24 at 1058 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 reviewed the MAR and verified it showed polyethylene glycol 17 gm was administered to Resident 83 that morning, and stated she forgot to document the resident had refused the medication. On 9/6/24 at 0904 hours, an interview was conducted with the DON. The DON stated when a resident refused a medication, it should be documented as refused.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49780 Based on interview, medical record review and facility P&P review, the facility failed to ensure the arbitration agreement was explained to one nonsampled resident (Resident 12). This failure posed the risk for the resident to not have the right to file an appeal if there was any issue of medical malpractice. Findings: Review of the facility's Admission Agreement P&P - Binding Arbitration Agreements revised 4/2024 showed the facility will explain the agreement in a form, manner and language the resident and representative understand. Medical record review for Resident 12 was initated on 9/5/24. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's MDS showed her BIMS score was 9, indicating the resident had moderate cognitive impairment. Review of Resident 12's Facesheet showed the resident had one son and three daughters listed as responsible parties. Review of Resident 12's Arbitration Agreement, undated, showed Resident 12 signed the statement agreeing to have any issue of medical malpractice decided by neutral arbitration and giving up the right to a jury or court trial. On 9/5/24 at 0903 hours, an interview with Resident 12 was conducted with a translator. Resident 12 confirmed it was her signature on the Arbitration Agreement. Resident 12 further stated she did not know English, and at that time, the staff came to her with the document and told her to sign it, so she did. Resident 12 stated she did not know what the document was about. On 9/5/24 at 1251 hours, a concurrent interview and medical record review was conducted with the Director of Admissions. The Director of Admissions verified the front desk staff brought the document to Resident 12. The Director of Admissions stated the front desk staff did not speak Korean (the resident's language). The Director of Admissions also stated Resident 12 was not fully alert, so she probably did not know what she signed. The Director of Admissions further also stated the facility should have the Arbitration Agreement in Korean, so the Korean residents and family members could read and understand the document before they signed it.

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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** 44175 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infections. * The facility failed to plan and implement the control measures to prevent the growth of the Legionella (a bacteria that can cause a serious type of lung infection) in the facility's water system. * The facility failed to ensure LVN 2 performed hand hygiene in between glove change while providing wound care to Resident 486. These failures had the potential for the spread of infection in the facility. Findings: According to the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease revised 7/6/2018, the facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; - Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) industry standard and the CDC (Center for Disease Control and Prevention) tool kit; and, - Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's P&P titled Legionella Water Management Program revised 7/2017 showed as part of the infection prevention and control program, the facility has a water management program which is overseen by the water management team. The P&P further stated water management program included specific measures used to control the introduction and/or spread of legionella (e.g. temperature, disinfectant), the control limits or parameters that are acceptable and that are monitored, and a diagram where the control measures are applied. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056151	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fullerton, LLC	330 W. Bastanchury Road Fullerton, CA 92835

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/6/24 at 0834 hours, a concurrent interview and facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated the facility had a legionella risk assessment with areas of possible legionella growth in the water system and tested the water for legionella every six months; however, the Maintenance Supervisor was not able to show if the facility had planned and implemented the control measures to prevent the growth of the legionella or other opportunistic waterborne pathogens in the facility's water system. On 9/6/24 at 0840 hours, a concurrent interview and facility document review was conducted with the Administrator. The Administrator verified and acknowledged the above findings. 2. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 8/2019 showed to use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: - Before handling clean or soiled dressings, gauze pads, etc.; - After handling used dressings, contaminated equipment, etc.; and, - After removing gloves. Further review of the facility's P&P showed the use of gloves does not replace hand washing/hand hygiene. Integration of gloves use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Medical record review for Resident 486 was initiated on 9/3/24. Resident 486 was admitted to the facility on [DATE]. Review of the Resident 486's Physician Order Summary dated 9/4/24, showed to cleanse sacrococcyx Stage III with normal saline, pat dry, apply thera honey gel (a gel that supports removal of dead tissue and promotes wound healing), barrier, lotrizone (antifungal ointment) cream to fungal dermatitis periwound (tissue surrounding a wound) and a foam dressing once a day for 30 days. On 9/6/24 at 0734 hours, a wound care observation for Resident 486 was conducted with LVN 2 and RN 5. RN 5 was observed assisting LVN 2. Resident 486 was observed awake in bed. LVN 2 performed hand hygiene, donned gloves and gown, and entered the room with prepared medications on the tray. LVN 2 removed the dressing from Resident 486's sacrococcyx area. LVN 2 doffed her gloves, washed her hands with soap and water, and donned a clean pair of gloves. LVN 2 then cleaned Resident 486's wound with normal saline and patted it dry with a gauze. LVN 2 changed her gloves without performing hand hygiene in between and was observed donning a clean pair of gloves without performing hand hygiene. LVN 2 proceeded to apply thera honey on the wound, barrier cream, and lotrizone to the periwound of Resident 486. Finally, LVN 2 covered and secured Resident 486's wound with a foam dressing. On 9/6/24 at 0754 hours, an interview was conducted with LVN 2. LVN 2 verified the above observation and stated she should have performed hand hygiene in between glove change and before donning another pair of clean gloves. On 9/6/24 at 0757 hours, an interview was conducted with RN 5. RN 5 verified the above observation and stated LVN 2 should have performed hand hygiene in between glove change during wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/6/24 at 1110 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 44175 Based on interview, medical record review, and facility P&P review, the facility failed to monitor and address the use of antibiotics when the resident's condition did not meet McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) for one of 19 final sample residents (Resident 24) and one nonsampled resident (Resident 73); and failed to identify if the residents' condition met the McGeer's criteria for infection for one nonsampled resident (Resident 29). These failures had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria. Findings: Review of the facility's P&P titled Antibiotic Stewardship- Order for Antibiotics dated 12/2016 showed appropriate use of antibiotic included criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). Review of the facility's P&P titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcome revised 12/2016 showed the IP or designee, will review antibiotic utilization as a part of the antibiotic stewardship program and identify specific situation that are not consistent with the appropriate use of antibiotic. The P&P further showed at the conclusion of the review, the provider to be notified of the review findings. Review of the facility's document titled Infection Prevention and Control Surveillance dated July 2024 showed Residents 24 and 73 were prescribed antibiotics but did not meet the McGeer's criteria for infection. Further review of the document showed Resident 29 was prescribed an antibiotic for swelling and tenderness for right lower gum. The document did not show if the Resident 29's condition met the McGeer's criteria for infection. Review of the Surveillance Data Collection Form dated 7/10/24, showed Resident 73 was prescribed triple antibiotic ointment to apply to skin tear in the occipital area. Further review of the document showed the symptoms did not meet the McGeer's criteria for infection. Review of the Surveillance Data Collection Form dated 7/9/24, showed Resident 24 was prescribed triple antibiotic ointment to open blister on the right anterior and right posterior leg. Further review of the document showed the symptoms did not meet the McGeer's criteria for infection. Review of the Surveillance Data Collection Form dated 7/6/24, showed Resident 29 was prescribed Amoxicillin (antibiotic) 500 mg three times a day for 5 days for swelling and tenderness for right lower gum. Further review of the document did not show if the symptoms of Resident 29 met the McGeer's criteria for infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/24 at 1003 hours, an interview and concurrent facility document review was conducted with the IP. The IP verified the above findings. The IP was asked about the facility's antibiotic stewardship program. The IP stated the facility used the McGeer criteria. The IP stated if a resident did not meet the criteria for an infection using McGeer criteria, the physician would be notified. The IP was asked to show the documentation if the physicians had been notified when the infection criteria were not met for Residents 24 and 73, and if Resident 29's condition met the criteria for infection. The IP reviewed the medical records for the above residents and stated he was unable to provide the documentation of the physician's notification for Residents 24 and 73. The IP further stated he followed up with the public health nurse and was advised Resident 29's condition did not met the criteria for infection; however, he did not document it and stated he should have followed up with the physician when the antibiotic was ordered. On 9/6/24 at 1110 hours an interview with the DON was conducted. The DON was informed and acknowledged the above findings.