STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Oak Nursing & Rehabilitation Center	4635 College Oak Drive Sacramento, CA 95841

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48874 Based on observation, interview and record review the facility failed to ensure resident needs were accommodated for two of 23 sampled Residents (Residents 6 and 307), when the call light was not within reach. This failure had the potential to result in the residents not attaining their highest practicable physical, psychosocial and emotional well-being. Findings: Review of an Admission Record indicated Resident 6 was admitted in January of 2025 with multiple diagnoses of aftercare following joint replacement surgery, other abnormalities of gait and mobility, and muscle weakness. Review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 1/13/24, indicated Resident 6 was cognitively intact. The MDS also indicated Resident 6 was dependent to required partial/moderate assistance (helper does less than half of the effort) for activities of daily living (ADL's-routine tasks such as bathing, dressing and toileting a person performs daily care themselves). During a concurrent observation and interview on 2/4/25 at 9:56 a.m. Resident 6 was in her bed and her call light was on the floor and out of reach. Licensed Nurse 3 (LN3) confirmed the call light was on the floor and is not within reach and stated the call lights should be clipped to the linens or by their side where they can reach it. Review of Resident 6's Care Plan, dated 1/8/25, indicated Residents 6 was at risk for falls related to impaired mobility .interventions .Ensure call light is within reach when in room. During an interview on 2/6/25 at 9:21 a.m., Resident 6 stated she likes the call light where she can reach it. Resident 6 stated, It is difficult to call for help when I can't reach my call light. Review of an Admission Record indicated Resident 307 was admitted [DATE] with several diagnoses including acute respiratory failure (a condition that can cause trouble breathing), history of falling, and muscle weakness. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of MDS dated [DATE] indicated that Resident 307 had severely impaired cognition. The MDS also indicated Resident 307 was dependent to required substantial/maximal assistance (Resident requires significance assistance to complete the task) or ADLs. During a concurrent observation and interview on 2/4/25 at 9:25 a.m., Resident 307 was lying in bed and stated, I need to be changed. Observed call light wrapped under Resident 307's bedrail and out of reach. LN 5 was prompted to assist Resident 307. LN 5 stated that the call light should be within reach of the resident so they can call easily when they need help. During an interview with Resident 307 on 2/6/25 at 9:25 a.m., Resident 307 stated that he waited a long time for help and felt really uncomfortable because I needed to be changed. Review of Resident 307's Care Plan, dated 2/4/2025, indicated that Resident 307 was on .Bladder re-training program .interventions .have call light within reach and answer promptly . During an interview with Director of Nursing 1 (DON 1) on 2/5/25 at 10:47 a.m., the DON 1 stated that the call light should be within reach for each resident. The DON 1 stated a resident could become distressed if they could not reach the call light. A review of the facility's policy and procedure (P&P) titled, Call light System, Resident, dated 9/22, the P&P indicated, .Each resident is provided with a means to call a staff member directly .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49933 Based on interview and record review, the facility failed to timely submit a Minimum Data Set (MDS- a federally mandated resident an assessment tool) for one of 23 sampled residents (Resident 85) when a discharge MDS from 10/24 had not yet been submitted. This failure resulted in inaccurate data being transmitted and resulted in Resident 85's discharged MDS data not received by the Centers for Medicare and Medicaid Services (CMS). Findings: A review of Resident 85's admission record indicated Resident 85 was admitted to the facility in 9/24 and discharged on [DATE]. During an interview on 2/6/25 at 3:33 p.m., the Minimum Data Set Coordinator (MDS) confirmed Resident 85's discharge MDS had not yet been submitted to CMS and was overdue and further stated that it needed to be turned into CMS with required timeframes for MDS submission. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, revised 7/17, the policy indicated the facility would conduct and submit resident assessments in accordance with current federal and state submission . timeframes for completion and submission is based on current requirements published in the Resident Assessment Instrument (RAI) Manual. During a review of CMS's RAI Manual, dated 10/24, the manual indicated the discharge MDS was to be submitted within seven days of completion.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50517 Based on observation, interview and record review the facility failed to ensure a comprehensive and person-centered care plan was implemented for one of 23 sampled residents (Resident 26). This failure posed the risk of not providing appropriate, consistent and individualized care plan for Resident 26 to attain their highest practicable physical, mental and psychosocial wellbeing. A review of Resident 26's admission record indicated he was admitted ,d+[DATE] with diagnoses including dementia (a progressive state of decline in mental abilities.) A review of Resident 26's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/26/24 indicated Resident 26 was totally dependent for all his care, with dependent assistance for bed mobility, dressing, hygiene, activities including for sit to stand. The MDS indicated bed to chair transfer was not attempted by staff. A review of Resident 26's care plan dated, 5/11/24 indicated, Activities: Up in chair daily, be out of the room daily. During an observation on 2/4/25 at 1:00 p.m. in room [ROOM NUMBER] C, the Resident 26 was in bed. No activities observed. During an observation on 2/5/25 at 11 a.m., 11:30 a.m., 1:45 p.m., in room [ROOM NUMBER] C, Resident 26 was in bed and not in a chair and out of the room, no activities observed. During an interview on 2/5/25 at 12:30 p.m., in room [ROOM NUMBER] C, CNA 1 stated, Resident 26 was still not up and out of bed. During an observation on 2/6/25 at 8:50 a.m., 9:25 a.m., and 1:00 p.m. in room [ROOM NUMBER] C, Resident 26 was in bed and not out of the room, no activities observed. During a concurrent observation and interview on 2/7/25 at 9:26 a.m. with Resident 26 in room [ROOM NUMBER] C, Resident 26 was in bed and had not gotten up into chair. Resident 26 stated, I would love to get up, but they don't let me. During a concurrent interview and record review on 2/6/25 at 9:45 a.m. with Activities Director (AD), the AD confirmed that Resident 26 was not up for activities. The AD confirmed that there was no documented evidence of daily log or daily progress notes written for Activities offered for Resident 26, and no documented evidence of Resident 26 refusal to participate with activities. During a review of the facility's policy and procedure titled, Activity Programs dated August 2006, indicated, . Activities are scheduled seven days a week and residents are given opportunity to contribute .Individualized activities are provided and offered at hours convenient to the residents .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48874 Based on observation, interview and record review the facility failed to meet the professional standards of nursing practice for one of 23 sampled residents (Resident 7), when there was no order for a Foley catheter. This failure placed the resident with a Foley catheter at risk for not getting proper nursing care. Findings: Review of an Admission Record indicated Resident 7 was admitted December of 2024 with several diagnoses including obstructive and reflux uropathy (a blockage in the urinary tract), infection and inflammatory reaction due to indwelling catheter (a tube inserted outside of the body that helps drain urine from the bladder). Review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/24/25 indicated for Urinary Continence (the ability to control urinary function) Resident 7 had a catheter (indwelling-a tube that is left inside the body). Review of a Order Summary Report dated 2/4/25 indicated no active orders for a Foley catheter for Resident 7. Review of Resident 7's Care plan, dated 12/30/24 indicated Resident 7 has an Indwelling Catheter related to Obstructive and Reflexive Uropathy and interventions included, Catheter per MD [Medical Doctor] orders. During a concurrent observation and interview on 2/5/25 at 10:20 a.m. with Licensed Nurse 3 (LN 3), LN 3 reviewed MD orders for Resident 7 and confirmed that Resident 7 did have a Foley catheter but did not have an active order for a Foley catheter. Review of Resident 7's Medication Administration Record (MAR) on 2/7/25 indicated no documented evidence of Foley Catheter Care. During an interview on 2/5/25 at 10:30 a.m. with the Director of Nursing 2 (DON 2), DON 2 stated that a Foley catheter order would include catheter care, changing the catheter as needed, a diagnosis that indicates why the resident has the Foley catheter and further stated her expectation would be that every resident that has a Foley Catheter should have an active order for one. During a review of the facility's policy and procedure (P &P) titled, Indwelling [Foley] Catheter Insertion, Male Resident, dated 8/22, the P&P indicated .Verify there is a physician's order for the procedure .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44946 Based on observation, interview and record review the facility failed to ensure accurate accountability of controlled medication when: 1. There was a discrepancy between the Controlled Drug Record (CDR-inventory sheet that keeps record of the usage of controlled medications) and medication blister card (medcard-a type of medication packaging) for Resident 76, Resident 151 and Resident 17. 2. A bottle of morphine sulfate solution (controlled medication [medication with high potential for abuse or addiction] to relieve pain) was not reconciled properly. These failures resulted in the facility not having an accurate accountability of controlled medications, and the potential for abuse or misuse of these medications. Findings: 1. During a medication cart check of the south B medication cart on 2/5/25 starting at 12:20 p.m. with LN 5, controlled medications were reconciled. The following discrepancies were found between the CDR and the medcard: a. Resident 76's CDR for clonazepam (used to treat anxiety-feeling of worry) 0.5 mg (milligram-a unit of measure) indicated there were 28 doses left, however, the medcard contained 27 doses. b. Resident 76's CDR for hydrocodone-apap (a combination of acetaminophen and hydrocodone, used to treat pain) 5-325 mg indicated there were 25 doses left, however the medcard contained 24 doses. c. Resident 151's CDR for methadone hydrochloride (used to treat pain) 5 mg indicated there were 22 doses left, however, the medcard contained 21 doses. d. Resident 17's CDR for lacosamide (used to treat seizures) 200 mg indicated there were 29 doses left, however, the medcard contained 28 doses. During an interview on 2/5/25 at 1:06 p.m. with Licensed Nurse (LN) 5, LN 5 stated that once a controlled medication was taken out of the medcard, it should also be signed out in the CDR. During an interview on 2/5/25 at 1:09 p.m. with Director of Nursing (DON) 2, DON 2 stated that controlled medication should be signed out and reconciled with the CDR before the nurses left the cart to administer medication to resident. During a review of the facility's policy and procedure (P&P) titled, Controlled Medications undated, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enter the following information on the accountability record .date and time of administration, amount administered and signature of the nurse administering the dose . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 2/5/25 at 1:06 p.m. with LN 5, Resident 63's bottle of morphine sulfate 20mg/ml solution was checked, and LN 5 stated that the liquid in the bottle was at 24 ml. During a review of Resident 63's CDR for morphine sulfate 20mg/ml solution, the CDR showed that 17 ml remained in the bottle. During a telephone interview on 2/7/25 at 12:07 p.m. with Pharmacist/Pharmacy Manager (PM), PM stated that morphine was provided by the manufacturer in 15 ml or 30 ml containers. Manufacturers do not overfill the containers; at most, there might have been an extra 1 ml of residue left in the medication or plastic container, but overfilling a liquid medication was not standard practice. During a review of the facility's P&P titled, Controlled Medication Storage, undated, the P&P indicated, Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately . separate records of use shall be maintained on all Schedule II drugs, such records shall be maintained accurately .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44946 Based on observation, interview and record review, the facility failed to ensure medication error rate was not less than 5% when the error rate was 17.86% based on five medication errors out of 28 opportunities observed during a medication pass observation for three out of six residents (Resident 7, Resident 204 and Resident 351). This failure resulted in medications not given in accordance with the prescriber's orders or manufacturer's specifications and had the potential to affect the resident's clinical conditions. Findings: 1. During a concurrent medication observation and interview on 2/5/25 at 7:29 a.m. with Licensed Nurse (LN) 3, LN 3 was observed preparing 11 medications for Resident 7, including ArgiMent AT packet (medical food specifically formulated to provide essential nutrients for the dietary management of pressure injuries and wounds). LN 3 emptied the contents of the packet into a Styrofoam cup and mixed it with water without measuring it. At 7:48 a.m., LN 3 went inside the room to give the medication to Resident 7, Styrofoam cup was placed on the overbed table. LN 3 was intervened and was asked to take the cup out to measure the liquid in it. At 7:49 a.m., LN 3 measured the mixture by pouring it into a graduated cup (a cup that has visible markings on its side indicating specific volume measurements), which measured 230 mL (milliliter, a unit of measurement) plus an additional 150 mL, for a total of 380 ml. LN 3 confirmed that this was more than the recommended amount. During a review of the ArgiMent AT packaging, the dosing and administration recommendation for oral intake was to mix one packet with 180-240 mL of water or juice twice a day. During a review of Resident 7's OSR, dated 2/6/25, the OSR indicated, Resident 7 had an order for an ArgiMent oral packet, to be given one packet by mouth twice a day as a supplement. During a review of the facility's policy and procedures (P&P) titled Administering Oral Medications, dated October 2010, the P&P indicated, Prepare the correct dose of medication .for powdered medications, mix with liquids as indicated. 2. During a medication observation on 2/6/25 at 8:03 a.m. with LN 4, LN 4 went inside Resident 204's room and checked the blood pressure but was not observed to have taken the pulse rate at that time. At 8:06 a.m., LN 4 was observed preparing three medications for Resident 204, including Glycolax 3350 (medication to treat occasional constipation) 17 gm (grams-unit of measurement) mixed with 130 mL of water, Irbesartan (medication used to lower blood pressure) 150 mg (milligram-unit of measurement), and Isosorbide Dinitrate 30 mg (medication used to treat chest pain). During an observation on 2/6/25 at 8:09 a.m. LN 4 asked Resident 204 if he still wanted the water with Glycolax mixed in it. Resident 204 did not respond, and LN 4 took the water cup out with about 1/4 of the water remaining in it and tossed it in the garbage. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 204's OSR, dated 2/6/25, the OSR indicated that Resident 204 had the following orders: Glycolax powder, 17 gm by mouth once a day, mixed with 4-8 oz (ounces-unit of measurement) of fluids; Irbesartan 150 mg tablet (tab), one tab by mouth once a day for hypertension (HTN- high blood pressure), to be held if SBP (systolic blood pressure- top number in blood pressure reading) less than (<) 110 or pulse <60; and Isosorbide Dinitrate 30 mg tab, 1 tab by mouth once a day for HTN, to be held if SBP was <110 or pulse <60. During an interview on 2/6/25 at 10:08 a.m. with Director of Nursing (DON) 1, DON 1 stated that the pulse rate should have been checked for one whole minute before medication administration. During an interview on 2/7/25 at 10:25 a.m. with DON 2, DON 2 stated that for Glycolax medication administration, the entire mixture should have been consumed by the resident to ensure the proper dose was administered. During a review of the facility's P&P titled Administering Medications, dated April 2019, the P&P indicated, The following information is checked/verified for each resident prior to administering medications .vital signs, if necessary. During a review of the facility's P&P titled Administering Oral Medications, dated October 2010, the P&P indicated, Remain with the resident until all medications have been taken. 3. During a medication administration observation on 2/6/25 at 8:27 a.m. with LN 8, LN 8 was observed preparing 5 medications for Resident 351, including aspirin (medication for pain that can be used as prevention for heart disease) 81 mg chew tablet. During a review of Resident 351's OSR, dated 2/6/25, the OSR indicated, Resident 351 had an order for aspirin EC (enteric coated-a special coating that prevents it from dissolving in the stomach) tablet by mouth once a day for prophylaxis. LN 8 did not administer the right form of aspirin as indicated in the OSR. LN administered the chewable form instead of the EC form. During a review of the facility's P&P titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in accordance with prescriber orders .the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44946 Based on observation, interview and facility policy and procedure (P&P) review, the facility failed to ensure the residents' medications were stored and labeled properly when: 1. An insulin pen did not have an open date on it. 2. Methadone (controlled medication to relieve pain) pills were not stored in their original packaging. 3. A bottle of morphine sulfate solution was not in the correct box and did not have the correct administration instruction on the label. These failures had the potential for medication diversion, medication errors and resident exposure to the expired medication. Findings: 1. During a medication cart check of the south B medication cart on [DATE] starting at 12:20 p.m. with Licensed Nurse (LN) 5, an opened (Brand name)(an insulin pen used to lower blood sugar level) 100 u/ml (unit per milliliter, unit of measurement) was found in the cart. LN 5 confirmed that the (Brand name) pen had been opened and used. During an interview on [DATE] at 10:08 a.m. with Director of Nursing (DON) 1, DON 1 stated that it was important to put open dates on insulin pens because they expired within 28 or 30 days after opening and should be replaced by then. During a review of the facility's P&P titled, Proper Storage of Insulin, undated, the P&P indicated, .the pharmacy will send pens maintaining the cold chain and place an 'Opened Date' label on each pen . Facility nursing staff will need to indicate the date opened on that label when removing from the refrigerator and placing on the medication cart. 2. During a medication cart check of the south B medication cart on [DATE] at 12:42 p.m. with LN 5, a Ziploc bag contained a bottle of methadone with four tablets inside it and a pill crusher pouch that had been stapled, which contained ten tablets of unlabeled medication. LN 5 confirmed that the proper storage of the medication should be inside the bottle. During an interview on [DATE] at 10:08 a.m. with DON 1, DON 1 stated that medications should be kept in their original packaging because the information on the label, such as the resident's name and the expiration date, is essential. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a medication cart check of the south B medication cart on [DATE] at 12:50 p.m. with LN 5, a 30 ml bottle of morphine sulfate solution without label was in a box for morphine sulfate that indicated 15 mL on the outside for Resident 63. LN 5 confirmed that the medication bottle did not match the box it was in. During a record review of Resident 63's CDR for morphine sulfate solution, the CDR indicated a different prescription number than the one on the medication box. During a concurrent interview and record review on [DATE] at 12:57 p.m. with DON 1, Resident 63's OSR and CDR for morphine sulfate 20mg/ml solution was reviewed, DON 1 confirmed that the medication administration instruction on the label on the box and the label on the CDR did not match the Medical Doctor's order. The label on the CDR indicated morphine sulfate 20mg/ml soln, take 0.25ml by mouth every 4 hours as needed for pain or SOB [shortness of breath]. Resident 63's OSR indicated the following orders for morphine sulfate: a. Morphine sulfate (concentrate) solution 20mg/ml, give 0.25 ml by mouth every 1 hour as needed for pain or respiration >,d+[DATE]/min b. Morphine sulfate (concentrate) solution 20mg/ml, give 0.5 ml by mouth every 1 hour as needed for moderate pain or respiration ,d+[DATE]/min c. Morphine sulfate (concentrate) solution 20mg/ml, give 1 ml by mouth every 8 hours as needed for severe pain or respiration above 32. During a review of the facility's P&P titled, Medication Storage in the Facility, undated, the P&P indicated, The provider pharmacy dispenses medications in containers that meet legal requirements . Medications are kept in these containers . The drugs of each patient shall be kept and stored in their originally received containers. No drug shall be transferred between containers.

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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. 29825 Based on observation, interview and record review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety for a census of 103 residents out of a census of 104 who ate facility prepared food when: 1. Thick, black, charcoal-like debris was found between all spokes of the two front gas burners of the facility stove, 2. [NAME] 2 handled parsley with her bare hands then placed it directly on the resident plate, and when 3. [NAME] 2 scratched her back and continued plating food without washing her hands. These failures increased the risk for the spread of infection and reduced the facility's potential to prepare residents' food in a sanitary manner. Findings: 1. During a concurrent observation and interview on initial tour of the kitchen with the Dietary Manager (DM) on 2/4/25 at 8:25 a.m., the DM verified there was a heavy accumulation of black, charcoal-like debris between all spokes of the two front gas burners on the industrial stove. 2. During a subsequent lunch tray line observation and interview with the DM on 2/5/25 at 11:17 a.m., [NAME] 2 used her bare fingers to break parsley into small pieces for garnish and placed them on the resident plates. When the DM was asked her expectations, she said, Technically, she should be using tongs for the parsley. 3. During a further observation on 2/5/25 at 11:21 a.m., [NAME] 2 scratched her back and continued to plate food with utensils. The DM verified the observation and said, She should not touch the back of her shirt and continue plating the food. During an interview with the Registered Dietician (RD) on 2/6/25 at 10:32 a.m., the RD was asked her expectations regarding dietary staff using bare hands to break up parsley and scratching their back without re-washing their hands and said, They should be wearing gloves whenever touching ready to eat food. Any time you make contact with clothing, hands should be washed before continuing to serve food. During a review of the facility policy and procedure (P&P) titled SANITATION, dated 2023, the P&P indicated All equipment shall be maintained as necessary .All .equipment shall be kept clean .Hands must not contact the food surface .Separate chopping boards are to be used for .vegetables . During a review of the facility P&P, untitled, dated 2023, the P&P indicated, Pay close attention to prevent cross-contamination of workers going from handling dirty .and then clean, touching .body .etc. Wash hands and change gloves whenever cross-contamination occurs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled FOOD HANDLING, dated 2023, the P&P indicated Food and Nutrition Services personnel should never use bare hand contact with any foods, ready to eat or otherwise. This includes .food item preparation .personnel shall use suitable utensils such as deli tissue, spatulas, tongs, or single use gloves.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 29825 Based on observation, interview and record review, the facility failed to ensure garbage and refuse was disposed of properly when a large amount of cardboard and miscellaneous items was strewn around and under the garbage dumpsters at the back of the facility. This failure increased the risk of attracting of pests and spread of infection. Findings: During a concurrent observation and interview with Dietary Assistant Supervisor (DAS), on 2/4/25 at 1:30 p. m., two dumpsters were at the back of facility. A large amount of empty cardboard boxes was in front of one dumpster on the left and miscellaneous garbage strewn about the area including milk cartons, straws, sugar packets, plastic gloves, a coffee pot top, soft drink cans, a Christmas tree decoration, Styrofoam pieces, a metal tube about 1/3 wide by 18 inches long was protruding out from under the dumpster, and zip lock bags. The DAS was helping throw cardboard into the empty dumpster and was asked how long the large quantity of cardboard and trash had been there and said, Maybe it's been out here for a day or so, I don't know. Dumpsters are emptied once or twice a week. I think Maintenance is responsible, During an interview with the Maintenance Supervisor (MS) on 2/4/25 at 1:33 p.m., MS was asked about a pest control servicing and garbage pickup and said, Pest control comes to spray one time a month. The dumpsters are emptied by [name of garbage collection company] once a day, cardboard three times a week . maintenance is supposed to keep the area clean around the dumpsters . During an observation on 2/5/25 around 6:30 a.m., cardboard was seen still protruding out from under right dumpster. During an interview with the Maintenance Assistant (MA) on 2/5/25 at 8:37 a.m., the MA said, If nothing else is urgent, I will clean up around the dumpsters around 8:45 a.m. every day .Normally the cardboard pieces should be thrown in the dumpster and the lid closed. They come from the kitchen, central supply, janitorial. It makes no sense to leave the cardboard out if the dumpster is empty .The Maintenance Supervisor, [name of MS] should be checking and cleaning up the area . During a review of the facility document titled, Daily Maintenance Trash Area/Outside Cleaning log 2025, dated 2023, the log indicated To ensure the outside of the building and the trash area is clean and clear of trash and debris to maintain a cleanliness look for the exterior of the facility .I have performed the above maintenance - Initial date was not initialed as done on 12/26/24, 12/17/24,1/20/25, 1/21/25, had a handwritten note with an arrow pointing to 2/4/25 which indicated New Trash cans Delivered - Cleaned Late . During a review of the facility policy and procedure titled, Grounds, revised 5/08, the P&P indicated Maintenance shall be responsible for keeping the grounds free of litter .Areas around the buildings shall be maintained in a safe and orderly manner at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29825 Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for a census of 104 when: 1.TB (tuberculosis, a contagious lung infection) screening and testing was not done for three sampled residents (Resident 3, Resident 8 and Resident 79), 2. No Enhanced Barrier Precautions (EBP, wearing a gown and gloves during high-contact care activities with patients who are at risk of spreading multidrug-resistant organisms (MDROs), like those with open wounds or indwelling medical devices, to prevent the spread of these infections, even when full contact precautions aren't needed) were used for three sampled residents (Resident 9 and Resident 151) who had wounds, 3. Resident 201's nebulizer mask (a face mask that fits over the nose and mouth to deliver medication into the lungs), Resident 84's oxygen tubing was on the floor and Resident 202's oxygen tubing was on the floor and nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not stored properly. 4. Restorative Nursing Assistant (RNA) 2 did not perform hand hygiene when feeding multiple residents during lunch. 5. Certified Nursing Assistant (CNA) 3 provided care without wearing all the required personal protective equipment (PPE) for Resident 351 who was on Droplet Precautions (isolation precautions for an individual that is infected with microorganisms transmitted by droplets) These failures increased the risk for the spread of infection. Findings: 1. Resident 3 was admitted to the facility in September of 2021 with diagnoses which included asthma (a chronic lung condition where the airways in the lungs become inflamed and narrow, making it difficult to breathe, often causing symptoms like wheezing, coughing, chest tightness, and shortness of breath). During a review of Resident 3's physician order (PO), dated 9/10/21, the PO indicated Aplisol Solution .Inject .intradermally [into the skin] one time only for TB . During a review of Resident 3's immunization record (IR), dated 9/10/21, the IR indicated Resident 3 had a two-step TB test (a method for screening for tuberculosis where a person receives the initial TB skin test, and if the result is negative, they get a second identical test a few weeks later to minimize the chance of missing a past infection due to a weak initial reaction) on 9/10/21 and 9/27/21. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/11/24, the MDS indicated Resident 3 had a mildly impaired memory. During an interview on 2/7/25 around 7:15 a.m., Resident 3 was asked if she had a TB test and said she only remembered having one when she was admitted in 2021. During a concurrent interview and record review on 2/7/25 at 10:18 a.m. with the MDS Coordinator (MDSC), the MDSC verified Resident 3 was not screened and had not received another TB test since the initial test on 9/10/21. MDSC verified there was no documented evidence of other PO for TB testing in 9/22, 9/23, or 9/24. MDSC verified there was no documented evidence on the Medication Administration Record (MAR) for 9/22, 9/23, or 9/24. MDSC also verified there was no documented evidence of nurses note (NN) for a TB test in 9/22, 9/23, or 9/24. Resident 8 was admitted to the facility in September of 2023 with diagnoses which included bronchiectasis (a condition that occurs when the tubes that carry air in and out of your lungs get damaged, causing them to widen and become loose and scarred). During a review of Resident 8's MDS, dated [DATE], indicated Resident 8 had severe memory impairment. During a review of Resident 8's physician order (PO), dated 9/28/23, the PO indicated Aplisol solution .inject . intradermally one time only .[to rule out] TB . During a review of Resident 8's MAR, dated 9/27/23, the MAR did not indicate whether the TB test was given to or refused by Resident 8. During a review of the Progress Notes (PN), dated 9/27/23, the PN had no documented evidence which indicated Resident 8 received or refused the TB test. Resident 8's immunization record was requested multiple times but not provided. During a concurrent record review and interview on 2/7/25 at 7:24 a.m. with the MDSC, the MDSC reviewed the physician orders, progress notes, the nurses notes, and MAR since admission to the facility and said, [Residents] should have a two step TB test the day of admit or the following day .[Staff] should have notified the doctor if the patient refused. There's no note from admit until today regarding doctor notification of her refusal or a chest X-ray order .There [was] no order or X ray done to rule out TB . During an interview on 2/7/25 at 8:24 a.m. with the Infection Preventionist (IP), the IP was asked his expectations for TB screening and testing and said, For all residents the TB test should be done on admission. It should be documented if refused by the resident or RP [responsible party]. The physician should be notified so a chest X-ray can be done to rule out TB. We have to have some result to ensure they are free of TB . Resident 79 was admitted to the facility in March 2023 with diagnoses which included acute respiratory failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's IR, dated 2/7/23, the IR indicated Resident 79 had a two-step TB test on 3/13/23 and 5/8/23. During a concurrent interview and record review on 2/7/25 at 11:00 a.m.with the IP , the IP verified Resident 79 was not annually screened for TB. The IP confirmed there was no documented evidence that a TB annual assessment was done. During a review of the facility policy and procedure (P&P), titled, Tuberculosis, Screening Residents for, dated 8/19, the P&P indicated The facility will conduct an annual risk assessment to determine risk of exposure . 2. Resident 9 was admitted to the facility in October of 2021 with multiple diagnoses which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 9's MDS, dated [DATE] the MDS indicated Resident 9 had a severe memory problem and had the treatment of Application of non-surgical dressings .ointments/medications . During a review of the PO, dated 1/10/25, the PO indicated Right Temporal [area to the right of eyebrow] Ca [cancer] lesion: Cleanse with normal saline [salt water], pat dry, apply Calcium alginate [a water-insoluble salt derived from brown seaweed that's used in wound care], cover with clear dressing, change daily until healed . During a review of Resident 9's CP titled .Right temporal face lesion- carcinoma suspected ., dated 11/26/24, the CP indicated Follow facility protocols for treatment . During a wound care observation and interview on 2/5/25 at 9:40 a.m. with Licensed Nurse (LN) 7, LN 7 walked into the room of Resident 9 without wearing a gown. There was no EBP sign posted outside the door to indicate the personal protective equipment (PPE) to wear when in close contact with Resident 9. LN 7 placed barrier between skin and cancerous area, touching the Resident 9. LN 7 soaked gauze with saline, wiped inside to out, opened the dressing, patted the wound and said, .Calcium Alginate helps absorb drainage .We clean it every day. There was no EBP sign observed outside Resident 9's door, LN 7 did not wear a gown during wound care, and LN 7 was observed not washing hands between two residents dressing changes. During a review of Resident 9's skin assessment (SA), dated 2/6/25, the SA indicated, .biopsy results is positive for squamous cell acarcinoma (sic) of the right temporal area . Resident 151 was admitted to the facility in January of 2025 with multiple diagnoses which included carcinoma [cancer] of the right breast. During a review of Resident 151's CP titled Resident has alteration in skin status r/t [related to] .RIGHT BREAST - CANCER ., dated 1/22/25, the CP indicated Monitor scab/abrasions for s/s/ [signs/symptoms] of infection or worsening of condition . During a review of Resident 151's PO, dated 1/23/25, the PO indicated RIGHT BREAST CANCER - CLEANSE WITH NORMAL SALINE, PAT DRY, APPLY XEROFORM [a non-adherent gauze dressing that contains medication used to treat wounds.] DRESSING DAILY TILL HEALED . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation of Resident 151 and interview with LN 7 on 2/5/25 at 9:52 a.m., LN 7 placed a barrier pad on bedside table with supplies, assisted Resident 151 to remove her T-shirt which exposed the Xeroform dressing on the right breast. Plain gauze was resting on top to catch drainage. Resident 151 stated the wound had a little smell. LN 7 patted the wound and stated it drained quite a bit. Drainage was observed on the front of Resident 151's shirt. LN 7 wiped it well and stated It usually has an ABD [abdominal, a medical dressing used to treat wounds that are draining a lot of fluid] pad but it fell off. LN 7 put Xeroform and dry gauze on wound then placed an ABD with large piece of tape to hold it in place. LN 7 stated he changed the dressing every day. There was no EBP sign observed outside Resident 151's door and LN 7 did not wear a gown during wound care. During an interview with LN 7 on 2/5/25 at 10 a.m., LN 7 said, I don't wash my hands with every resident . During a concurrent observation and interview on 2/6/25 at 10 a.m. with the IP, the IP confirmed Resident 9 and Resident 151 did not have EBP precautions signage outside their rooms. The IP stated that all residents with wounds needed to be on EBP precautions. IP also confirmed that Resident 9 and Resident 151 had chronic wounds and should be with Enhanced Barrier Precautions. During a review of the facility P&P titled Enhanced Barrier Precautions, dated 6/24, the P&P indicated Enhanced Barrier Precautions [EBPs] are used as an infection prevention and control intervention .Gloves and gown are applied prior to performing high contact resident care activity .Examples .wound care .any skin opening requiring a dressing that is considered a longer lasting wound . Standard precautions apply to the care of residents regardless of suspected or confirmed infection . 44946 3. During a review of Resident 201's Admission Record (AR), the AR indicated, Resident 201 was admitted on [DATE] with diagnoses which included morbid obesity (severe form of having too much body fat) with alveolar hypoventilation (condition where the lungs don't get enough oxygen or remove enough carbon dioxide), obstructive sleep apnea (sleep disorder that occurs when the airway becomes blocked while sleeping), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing.) During a review of Resident 201's Order Summary Report (OSR), dated 2/6/25, the OSR indicated Resident 201 had an order for ipratropium-albuterol solution (used to treat air flow blockage and prevent worsening of COPD) 0.5-2.5 (3) milligram/milliliter (mg/ml), 1 vial inhale orally four times a day for COPD. During a review of Resident 84's AR, the AR indicated, Resident 84 was admitted on [DATE] with diagnoses which included COPD with exacerbation, chronic respiratory failure with hypoxia (long-term condition that occurs when the lung can't get enough oxygen into the blood), chronic respiratory failure with hypercapnia (condition that occurs when the lungs can't get rid of enough carbon dioxide from the blood), malignant neoplasm of unspecified part of bronchus or lung (cancerous tumor that develops in the lungs), dependence on supplemental oxygen, shortness of breath. During a review of Resident 84's OSR, dated 2/6/25, the OSR indicated Resident 84 had an order to start oxygen at 2 liters per minute (L/min) for shortness of breath (SOB), chest pain, oxygen saturation less than 90% and to notify the MD. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 202's AR, the AR indicated, Resident 202 was admitted on [DATE] with diagnoses which included influenza due to other identified influenza virus with other respiratory manifestations (viral infection of the nose, throat and lungs), acute respiratory failure with hypoxia (condition where the lungs are unable to get enough oxygen into the blood), COPD, During a review of Resident 202's OSR, dated 2/6/25, the OSR indicated Resident 202 had an order to administer oxygen via nasal cannula at 2L/min as needed for SOB. During a concurrent observation and interview on 2/4/25 at 10:59 a.m. with IP in Resident 84's room, Resident 84's oxygen tubing was touching the floor. IP stated that the tubing was too long but should not be touching the floor. During a concurrent observation and interview on 2/4/25 at 10:46 a.m. with LN 6 in Resident 201's room, Resident 201's nebulizer mask was seen on the floor behind the oxygen concentrator. LN 6 stated that this was not the proper way to store the nebulizer mask and that it could be a source of infection. During an observation on 2/4/25 at 11:34 a.m. in Resident 202's room, Resident 202 had the oxygen concentrator on, but the nasal cannula was on top of the overbed table, and the tubing was touching the floor. During an interview on 2/4/25 at 11:45 a.m. with IP, IP stated that oxygen tubing should not be touching the floor due to infection control concerns, as someone should not be breathing it in since it is dirty. IP stated that when oxygen tubing touched the floor, the Certified Nursing Assistant (CNA) or other staff should inform the nurses so it could be changed right away. During an interview on 2/6/25 at 11:35 a.m. with Director of Nursing (DON) 2, DON 2 stated that oxygen tubing should not be touching the floor as it is part of their infection control practices. If not in use, it should be stored in a bag to prevent infection. During a review of the facility's P&P titled, Departmental (Respiratory Therapy)-Prevention of Infection, dated November 2011, the P&P indicated, Infection Control Considerations Related to Oxygen Administration: Change the oxygen cannula and tubing every seven (7) days, or as needed .keep the oxygen cannula and tubing used PRN (given as needed or requested) in a plastic bag when not in use .Infection Control Considerations Related to Medication Nebulizers: store the circuit in plastic bag, marked with resident's name, between uses . 49933 4. During an observation on 2/4/25 at 11:40 a.m. in RNA dining room, five residents were sitting around the dining table. There were four hand sanitizer bottles that were on the table within reach of staff and residents. At 11:45 a.m., RNA 2 was holding a juice cup next to Resident 8's mouth to help the resident sip from the straw. RNA 2 then went to Resident 36 and picked up the utensils and prompted Resident 36 to hold it. RNA 2 further assisted Resident 36 to hold the chocolate milk carton. RNA 2 then went to the coffee station to get coffee for Resident 56. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:48 a.m., RNA 2 assisted and held Resident 24's hands to hold the milk carton up to Resident 24's mouth. At 11:49 a.m., RNA 2 wiped Resident's 24's mouth and nose after resident 24 sneezed. RNA 2 continued to help assist and prompt resident. At 11:51 a.m., RNA 2 touched Resident 60's shirt, tapped resident on the shoulder and returned to Resident 24 to assist with feeding. At 11:56 a.m., RNA 2 returned to Resident 8 and touched Resident 8's utensil and cup. RNA 2 did not perform proper hand hygiene between residents and between the tasks observed. During an interview on 2/4/25 at 12:25 p.m. with RNA 2, RNA 2 confirmed that she did not perform hand hygiene in between residents when assisting them with their lunch. During an interview on 2/6/25 at 9:00 a.m. with the IP, the IP stated that hand hygiene should be performed in between residents due to the risk of spreading infection. During a review of the facility's P&P titled, Hand washing/Hand Hygiene, revised 8/19, the P&P indicated, Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water .Before and after assisting a resident with meals .after contact with resident's intact skin . after contact with objects . before and after .handling food . 5. A review of Resident 351 Admission Record indicated Resident 351 was admitted [DATE] with multiple diagnoses that included influenza (flu). During an observation on 2/4/25 at 11:19 a.m. outside of Resident 351's room, a sign was posted above resident name card which indicated, Droplet Precaution. A plastic bin was observed in the hallway outside of resident 351's room. The bin contained disposable masks and face shields available for staff to use. During an observation on 2/5/25 at 9:50 a.m., CNA 3 entered Resident 351's room wearing only a mask. CNA 3 came out and put on a face shield after having gone into the room already to assist Resident 351. During a concurrent observation and interview on 2/5/25 at 10:00 a.m., CNA 3 disposed face shield before leaving Resident 351's room but did not discard disposable mask. CNA 3 confirmed she did not use proper PPE before entering Resident 351's room. CNA 3 further confirmed that she did not dispose of the mask before exiting resident room. During an interview on 2/6/25 at 9:19 a.m. with the IP, the IP confirmed that proper PPE should be worn for residents in droplet precautions. IP confirmed that staff must wear the correct PPE and dispose of PPE due to the risk of spreading infection. During a review of the facility's P&P titled, Isolation-Categories of Transmission-Based Precautions, dated 10/18, the P&P indicated Droplet precautions .gloves, gown and goggles should be worn if there is risk of spraying respiratory secretions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Centers for Disease Control (CDC) guidelines titled, HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) undated, indicated, 4. MASK OR RESPIRATOR .Front of mask/respirator is contaminated .Discard in a waste container .