STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056169	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamitos West Health & Rehabilitation	3902 Katella Avenue Los Alamitos, CA 90720

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 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** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs for one of 24 final sampled residents (Resident 414) and seven nonsampled residents (Residents 1, 24, 31, 36, 60, 78, and 104). * Resident 24 had waited for 30 minutes for a staff to assist her to use the toilet which resulted the resident to wet her diaper. * The facility failed to ensure the call light was within reach and accessible for Residents 1, 60, and 78. * The facility failed to ensure Resident 104's call light was within the resident's reach. * The facility failed to ensure Resident 36's bed control was within the resident's reach. * The facility failed to ensure Resident 414's head light cord was within reach. * The facility failed to ensure Resident 31's TV remote control was within reach. These failures had the potential to negatively impact the resident's psychosocial well-being or result in a delay to receive care. Findings: Review of the facility's P&P titled Call Lights: Accessibility and Timely response revised 10/4/23, showed the following: - All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide with the resident desires, the appropriate personnel should be notified; - All staff will be educated on the proper use of the resident's call system, including how the system works and ensuring access to the call light; - Staff will ensure the call light is within reach of resident and secured as needed; and (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	- The call system will be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. 1. On 9/25/24 at 1205 hours, a concurrent observation and interview was conducted with Resident 24. Resident 24 was observed awake, lying in bed in her room. Resident 24 stated on 9/24/24 at nighttime, she used her call light because she needed to use the restroom, but she had waited for 30 minutes for someone to assist her which resulted her to wet her diaper. Resident 24 could not recall exactly what the time was at night. Resident 24 stated she kept track of the time by checking the wall clock in front of her. The wall clock hanging on the wall in front of the resident's bed was observed working properly. Resident 24 further stated she would prefer to use the toilet if she needed to void or move her bowel but thought that she just had to wait or do it in her diaper when it was short staffed. Medical record review for Resident 24 was initiated on 9/25/24. Resident 24 was readmitted to the facility on [DATE]. Review of Resident 24's H&P examination dated 3/20/24, showed Resident 24 had the capacity to understand and make decisions. Review of Resident 24's MDS dated [DATE], showed Resident 24 had BIMS score of 15 (meaning cognitively intact) and needed partial to moderate assistance with toileting hygiene (including how the resident cleansed herself after elimination, changed pad, and adjusted clothes) and with bed to chair and toilet transfer. On 9/25/24 at 1243 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 24 was still able to use the toilet for both voiding and moving her bowel and would call using her call light if she needed to. CNA 1 stated Resident 24 would need assistance from staff to transfer to her wheelchair and go to the restroom. CNA 1 further stated the staff should answer the call light as soon as possible and attend to the needs of the residents. On 9/26/24 at 0948 hours, an interview was conducted with RN 1. RN 1 stated the residents should not be left waiting for a long time to be assisted when they called. RN 1 stated if the resident was able to use the toilet, the staff should assist the resident with that as it also could promote more mobility. On 9/27/24 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 24. 50953 2. Medical record review for Resident 1 was initiated on 9/24/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 7/19/24, showed Resident 1 had the capacity to understand and make decision. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 0800 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed sitting in her wheelchair with the call light on the floor and not within the resident's reach. Resident 1 stated she used the call light when she needed help from the staff. On 9/24/24 at 0812 hours, an observation and concurrent interview was conducted with LVN 1 for Resident 1. LVN 1 stated the call light should be reachable and accessible to the resident. LVN 1 verified Resident 1's call light was on the floor and not within the resident's reach. 3. Medical record review for Resident 60 was initiated on 9/24/24. Resident 60 was admitted to the facility on [DATE]. On 9/24/24 at 0932 hours, during initial tour of the facility, Resident 60 was observed lying in bed with the call light clipped to the curtain. The call light was not within the resident's reach. On 9/24/24 at 0935 hours, an observation and concurrent interview was conducted with CNA 2 for Resident 60. CNA 2 verified Resident 60's call light was hanging on the curtain and not within the resident's reach. 4. Medical record review for Resident 78 was initiated on 9/24/24. Resident 78 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 78's MDS dated [DATE], showed Resident 78 had BIMS score of 1 (meaning severe cognitive impairment). On 9/24/24 at 0936 hours, during an initial tour of the facility, Resident 78 was observed lying in bed with the call light inside the bedside drawer and not within the resident's reach. On 9/24/24 at 0940 hours, an observation and concurrent interview was conducted with CNA 2 for Resident 78. CNA 2 verified Resident 78's call light was inside the bedside drawer and not within the resident's reach. On 9/27/24 at 1418 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the call light should be within reach and accessible for all the residents. 39453 5. On 9/24/24 at 0953 hours, during the initial tour of the facility, Resident 104 was observed sitting in the wheelchair near the foot of the bed. The call light was observed tucked inside the blanket near the head of the bed and not within Resident 104's reach. On 9/24/24 at 0955 hours, an observation for Resident 104 and concurrent interview was conducted with CNA 13. Resident 104 was observed sitting in the wheelchair near the foot of the bed. The call light was observed tucked inside the blanket near the head of the bed and not within Resident 104's reach. CNA 13 verified the above findings. CNA 13 stated the call light should always be within the resident's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 104 was initiated on 9/24/24. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's Initial H&P examination dated 8/30/24, showed Resident 104 had the capacity to understand and make decisions. 6. On 9/24/24 at 0941 hours, during the initial tour of the facility, Resident 36 was observed awake and lying in bed. Resident 36 stated she would like her head of the bed elevated. The bed control was found on the floor and not within Resident 36's reach. Resident 36 stated, I can use the bed control, but I cannot use it if I cannot reach it. I guess they want to do it for me. On 9/24/24 at 0947 hours, an observation for Resident 36 and concurrent interview was conducted with CNA 13. Resident 36 was observed awake and lying in bed. Resident 36 stated she would like her head of the bed elevated. The bed control was found on the floor and was not within Resident 36's reach. CNA 13 verified the above findings. Medical record review for Resident 36 was initiated on 9/24/24. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's MDS dated [DATE], showed Resident 36 had severe cognitive impairment, with no impairment to upper extremities. 7. On 9/27/24 at 1018 hours, Resident 414 was observed awake and lying in bed. Resident 414 stated he would like to turn the headlight on. The headlight cord was observed hanging on the right side of the bed and not within the resident's reach. On 9/27/24 at 1020 hours, an observation for Resident 414 and concurrent interview was conducted with CNA 14. Resident 414 was observed awake and lying in bed. Resident 414 stated he would like to turn the headlight on. The headlight cord was observed hanging on the right side of the bed and not within the resident's reach. CNA 14 verified the above findings. CNA 14 turned the headlight on for Resident 414. Medical record review for Resident 414 was initiated on 9/24/24. Resident 414 was readmitted to the facility on [DATE]. Review of Resident 414's MDS dated [DATE], showed Resident 414 was cognitively intact, with no impairment to upper extremities. 8. On 9/24/24 at 1006 hours, during the initial tour of the facility, Resident 31 was observed awake and lying in bed. Resident 31 stated he would like to watch a sports program on TV. The TV remote control was found on top of the nightstand and not within Resident 31's reach. On 9/24/24 at 1010 hours, an observation for Resident 31 and concurrent interview was conducted with CNA 15. Resident 31 was observed awake and lying in bed. Resident 31 stated he would like to watch a sports program on TV. The TV remote control was found on top of the nightstand and not within Resident 31's reach. CNA 15 verified the above findings. CNA 15 turned the TV on, and the TV showed a static or noise. CNA 15 stated she would call the maintenance to fix the TV. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 31 was initiated on 9/24/24. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's MDS dated [DATE], showed Resident 36 had severe cognitive impairment, with no impairment to upper extremities. On 9/27/24 at 1100 hours, an interview was conducted with the DON. The DON verified the above findings. The call light cord, headlight cord, remote control, and bed control should be within the residents' reach.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the copy of advance directive was obtained or information on how to formulate an advance directive was provided for eight of 24 final sampled residents (Residents 34, 59, 75, 81, 89, 109, 414, and 566). * The facility failed to offer Resident 34 with written information regarding advance directives. * The facility failed to review the copy of the advance directives provided by Resident 59 and resident's representative, and ensure it was complete to show the resident's wishes and instructions for healthcare. * The facility failed to provide Resident 75 with written information regarding advance directives and ensure Resident 75's right to formulate an advance directive. * The facility failed to review the copy of POA provided by Resident 89 to ensure the POA was for healthcare authority and if it showed resident's wishes and instructions for healthcare. In addition, the facility failed to ensure a copy of the resident's advance directive for healthcare was obtained and maintained in the resident's medical record for Residents 89. * The facility failed to ensure a copy of the resident's advance directive for healthcare was obtained and maintained in the resident's medical record for Residents 81, 109, 414, and 566. These failures had the potential for the facility to provide treatments and services against the residents' wishes. Findings: Review of the facility's P&P titled Advance Directive and POLST Policy and Procedure revised 4/2024 showed it is the facility's policy to inform and provide information to all new residents upon admission regarding the right to accept or refuse medical or surgical treatment, and at the resident's option, formulate an advance directive. We will inquire of all new residents upon admission whether he or she has an advance directive or Physician Orders for Life-Sustaining Treatment (POLST) in place or would like to create an advance directive or POLST. We strongly encourage all competent residents to make his or her medical wishes knowns and we will honor individual treatment wishes. If a resident is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, we will give advance directive information to the individual's resident representative the same manner that we issue other materials about policies and procedures to the family of the incapacitated individual or other concerned persons. The P&P further showed the facility shall periodically review and document as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Medical record review for Resident 34 was initiated on 9/24/24. Resident 34 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 34's H&P examination dated 8/26/24, showed Resident 34 had the capacity to understand and make decisions. Review of Resident 34's POLST dated 7/27/24, showed Resident 34 had no advance directive. Further review of Resident 34's medical record showed no documented evidence Resident 34 was offerred the inforamtion on how to formulate the advance directive. 2. Medical record review for Resident 81 was initiated on 9/24/24. Resident 81 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 81's H&P examination dated 6/30/24, showed Resident 81 had the capacity to understand and make decisions. Review of Resident 81's POLST dated 9/18/23, showed Resident 81 had an advance directive. Further review of Resident 81's medical record showed no documented evidence a copy of Resident 81's advance directive was obtained or an attempt was made to obtain Resident 81's advance directive. 3. Medical record review for Resident 566 was initiated on 9/24/24. Resident 566 was admitted to the facility on [DATE]. Review of Resident 566's H&P examination dated 9/18/24, showed Resident 566 was a poor historian due to cognitive and psychiatric impairment. Review of Resident 566's POLST dated 9/17/24, showed Resident 566's Advance Directive was not available. Further review of Resident 566's medical record showed no documented evidence a copy of Resident 566's advance directive was obtained or an attempt was made to obtain Resident 566's advance directive. On 9/27/24 at 0939 hours, a concurrent interview and facility's document review was conducted with the SSD. The SSD verified the above findings for Residents 34, 81, and 566. The SSD stated the advance directive designates an agent to make medical decisions for the resident in the event the resident becomes incapacitated and unable to make their own decisions. The SSD further stated he would be following up with the residents and families to obtain copies of the advance directive. On 9/27/24 at 1620 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON acknowledged the above findings. The DON stated the SSD would be trained on the protocol for obtaining and educating the residents and families about the advance directive. 39453 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Medical record review for Resident 59 was initiated on 9/24/24. Resident 59 was admitted to the facility on [DATE]. Review of Resident 59's MDS dated [DATE], showed Resident 59 had severe cognitive impairment. Review of Resident 59's POLST dated 1/27/16, showed Resident 59 had no advance directive. The POLST form did not show a physician's signature. Review of Resident 59's Advance Healthcare Directive (undated) showed the names of Resident 59's agent. However, there was no initials indicated as when the agent's authority became effective, for the instructions for healthcare, and for donations of organs at death. In addition, the form did not show the Resident 59's signature, and it was not signed by two qualified witnesses nor acknowledged before a notary public. Further review of Resident 59's medical record failed to show a complete copy of the resident's advance directive. On 9/26/24 at 0827 hours, an interview and concurrent medical record review for Resident 59 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the admitting nurse would ask the resident or the resident's representative if the resident had a POLST and an advance directive. RN 1 stated if the resident had a POLST or an advance directive, upon admission, then the admissions personnel would upload a copy to the electronic health record. RN 1 stated Resident 59's POLST and advance healthcare directive were uploaded by the admissions personnel. RN 1 verified Resident 59's advance healthcare directive was incomplete as there were no initials and date and it was not signed by the resident. RN 1 acknowledged the nursing department did not verify whether the copy of Resident 59's advance healthcare directive was completed or not before uploading into the electronic health record. On 9/26/24 at 1236 hours, an interview and concurrent medical record review for Resident 59 was conducted with the Health Records Director. The Health Records Director verified the above findings. The Health Information Director stated the RN asked the resident or resident representative regarding advance healthcare directive upon admission. The Health Records Director stated the admissions personnel uploaded the copy of the advance healthcare directive to the electronic health record. RN 1 verified Resident 59's advance healthcare directive was incomplete as there were no initials and date and it was not signed by the resident. The Health Records Director acknowledged she did not verify whether the uploaded copy of Resident 59's advance healthcare directive was completed or not. 5. Medical record review for Resident 75 was initiated on 9/24/24. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's Initial H&P examination dated 5/14/24, showed Resident 75 had the capacity to understand and make decision. Review of Resident 75's POLST dated 3/26/24, under Section D Information and Signatures, showed Resident 75 did not have an advance directive. Review of Resident 75's SS (Social Services) - History and Initial assessment dated [DATE], did not show Resident 75 had an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 75's SS - Care Conference - V 9 dated 4/2/24, showed the consents/ forms were reviewed/ done during care conference, including POLST and Advance Directives. However, the care conference form did not show Resident 75 was given written information on advance directive. Review of Resident 75's SS - Quarterly Note - V 3 dated 6/25/24, showed there were no changes in status whether the resident/responsible party requested/made any changes related to advance directives. Further review of Resident 75's medical record failed to show documentation Resident 75 was provided with written information regarding the advance directives. On 9/26/24 at 1318 hours, an interview and concurrent medical record review for Resident 75 was conducted with the SSD. The SSD stated the POLST and advance directives were discussed during the initial assessment, care conference, and quarterly assessment by the social services department. The SSD stated if the resident wished to formulate an advance directive, the social services department would offer to provide an assistance; and if they did offer an assistance to formulate an advance directive, the social services department would document in the progress notes. The SSD reviewed Resident 75's medical record and verified there was no documentation Resident 75 was provided with written information regarding advance directives. 6. Medical record review for Resident 89 was initiated on 9/24/24. Resident 89 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 89's Initial H&P examination dated 9/23/24, showed Resident 89 had the capacity to understand and make decisions. Review of Resident 89's POLST dated 2/9/23, under Section D Information and Signatures, showed discussed with the resident (had capacity) and legally recognized decisionmaker were checked off, and Resident 89's advance directive was available and reviewed, but the date for the advance directive was left blank. Review of Resident 89's SS - History and Initial Assessment - V 6 dated 2/9/23, showed the resident had POA for healthcare authority. Review of Resident 89's Progress Notes dated 9/19/24, showed, an initial assessment completed for Resident 89 by the SSD. The progress notes did not show Resident 89's advance directive was discussed. Review of Resident 89's POA dated 1/9/23, showed Resident 89 appointed an attorney-in-fact to engage only in tangible personal property transactions, banking and financial transactions, insurance and annuity transactions, legal actions, personal and family care. The POA was for financial responsibility but did not show for the resident's wishes and instructions for healthcare. Further review of Resident 89's medical record failed to show a copy of Resident 89's advance directive for healthcare was obtained, or an attempt was made to obtain Resident 89's advance healthcare directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 414's SS - History and Initial assessment dated [DATE], did not show Resident 414 had an advance directive. Further review of Resident 414's medical record failed to show a copy of Resident 414's advance directive was obtained, or an attempt was made to obtain Resident 414's advance directive. On 9/26/24 at 1300 hours, an interview and concurrent medical record review for Resident 414 was conducted with the SSD. The SSD verified the above findings. The SSD stated the POLST was signed by the resident or the resident representative and obtained by the nursing department. The SSD stated the POLST and advance directive were discussed during the care conference with the resident and/or resident representative. The SSD stated if the resident had an advance directive, the family would have to provide a copy of the advance directive; and if the advance directive was not available, the social services department would follow-up, and any follow-up for a copy of the advance directive was to be documented in the progress note. The SSD verified there was no documented evidence a copy of Resident 414's advance directive was obtained, or an attempt was made to obtain Resident 414's advance directive. The SSD stated they had a meeting for Resident 414 yesterday. The SSD stated Resident 414's POLST was incorrect because the ombudsman was not called, which should have been verified by the nursing department, and why he documented Resident 414 did not have an advance directive. When asked if the SSD verified Resident 414's POLST was incorrect during their meeting yesterday, the SSD acknowledged he did not verify whether Resident 414 was correct or not.

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	056169	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamitos West Health & Rehabilitation	3902 Katella Avenue Los Alamitos, CA 90720

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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** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plans were developed to reflect the individual care needs for three of 24 final sampled residents (Residents 20, 42, and 81). * The facility failed to develop a care plan to address Resident 20's fall on 9/15/24. * The facility failed to develop a care plan to address Resident 42's use of antidepressant medication. * The facility failed to develop a care plan to address Resident 81's Keflex medication. These failures had the potential for the residents to not be provided with appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Baseline Care Plan revised 10/1/23, showed a written summary of a baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatment to be administered by the facility to be administered by the facility and personnel acting on behalf of the facility. 1. Medical record review for Resident 20 was initiated on 9/24/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's MDS dated [DATE], showed Resident 20 had a BIMS score of zero (meaning severe cognitive impairment). On 9/24/24 at 0838 hours, during the initial tour of the facility, Resident 20 was observed lying in bed with bilateral floor mats on the floor. On 9/25/24 at 1102 hours, an observation and concurrent interview was conducted with LVN 1 for Resident 20. Resident 20 was observed lying in bed with bilateral floor mats on the floor. When LVN 1 was asked about Resident 20's bilateral floor mats, LVN 1 stated the resident had a fall on 9/15/24. Review of Resident 20's plan of care failed to show a care plan problem was developed to address Resident 20's fall on 9/15/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 1010 hours, a medical record review and concurrent interview was conducted with RN 1. RN 1 verified there was no care plan developed to address Resident 20's fall incident on 9/15/24. 2. Medical record review for Resident 42 was initiated on 9/24/24. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's H&P examination dated 6/5/24, showed Resident 42 had no capacity to understand and make decision. Review of Resident 42's Order Summary Report dated 9/25/24, showed a physician's order dated 6/4/24, to administer sertraline (antidepressant) HCl 50 mg by mouth one time a day for depression (mental disorder that causes persistent feeling of sadness and loss of interest). Review of Resident 42's plan of care failed to show a care plan problem was developed to address Resident 42's use of setraline medication for depression. On 9/26/24 at 0837 hours, medical record review and concurrent interview was conducted with LVN 3. LVN 3 verified there was no care plan developed to address Resident 42's antidepressant medication. On 9/27/24 at 1418 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 49644 3. Medical record review for Resident 81 was initiated on 9/26/24. Resident was admitted to the facility on [DATE], and readmitted on [DATE] Review of Resident 81's MDS dated [DATE], showed Resident 81's cognition was intact. Review of Resident 81's Order Summary Report for September 2024 showed a physician's order dated 9/23/24, to administer Keflex (a medication used to treat bacterial infections) oral capsule 500 mg by mouth four times a day for infected wound for seven days. Review of Resident 81's plan of care failed to show a care plan was developed to address the use of Keflex medication. On 9/27/24 at 0958 hours, a concurrent interview and medical record review was conducted with LVN 13. LVN 13 stated Resident 81 was receiving Keflex for the skin tear on her left shin that was started to get inflamed. LVN 13 verified there was no care plan formulated to address Resident 81's use of the antibiotic. LVN 13 stated Resident 81's care plan should have been developed by the licensed nurse. On 9/27/24 at 1158 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure eight of 24 final sampled residents (Residents 10, 42, 75, 76, 89, 414, 564, and 814) and three nonsampled residents (Residents 87, 417, and 418) reviewed for respiratory care were provided the appropriate respiratory care when: * The facility failed to ensure Resident 814's oxygen nasal cannula tubing, humidifier, and Yankauer were dated, labeled, and the nasal cannula and Yankauer were stored in a set-up bag when not in use. The facility failed to develop a care plan to address Resident 814's oxygen use and monitoring of oxygen saturation level when the Resident 814 was using the oxygen. In addition, the facility failed to obtain a physician's order for Resident 814's oral suction at bedside and develop a care plan to monitor the suction use and effectiveness * The facility failed to ensure Resident 76's oxygen tubing, humidifier, and the set-up bags for the nebulizer and suction devices were dated and labeled. In addition, there was no set-up bag observed for the oxygen tubing. * The facility failed to ensure Resident 564's storage bag for the nebulizer was dated and labeled. * The facility failed to ensure the oxygen tubing and humidifier for Residents 10, 42, and 87 were dated and labeled. * The facility failed to ensure Resident 75's oxygen tubing and nebulizer mask were changed weekly. * The facility failed to ensure Resident 89's oxygen tubing was labeled and dated. In addition, the facility failed to ensure the set-up bags containing the nebulizer mask and Yankauer suction were labeled and dated. * The facility failed to ensure the oxygen tubing for Residents 414, 417 and 418 was labeled and dated. In addition, there was no set-up bag observed for these residents' oxygen tubing. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: 1. On 9/24/24 at 0850 hours, during the initial tour of the facility, Resident 814 was observed lying in bed, awake and nonverbal. Resident 814's bedside was observed with an oxygen concentrator and the humidifier was undated and unlabeled. Resident 814's oxygen nasal cannula was observed undated and unlabeled hanging on the call light cord, and not stored inside a set-up a bag. In addition, Resident 814's Yankauer connected to the suction machine was observed undated, unlabeled, and not stored inside a set-up bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 0855 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified Resident 814's oxygen nasal cannula, humidifier, and Yankauer were not dated and labeled. In addition, LVN 3 verified Resident 814's oxygen nasal cannula and yankauer were not stored inside a set-up bag. LVN 3 stated the oxygen nasal cannula, humidifier and Yankauer must be dated and labeled. LVN 3 stated the oxygen nasal cannula and Yankauer must be stored inside a set-up bag when not in use. On 9/25/24 at 1029 hours, a follow-up interview was conducted with LVN 3. LVN 3 stated, Resident uses the oxygen as needed and suction for oral secretions. Medical record review for Resident 814 was initiated on 9/26/24. Resident 814 was readmitted to the facility on [DATE]. Review of Resident 814's H&P examination dated 9/18/24, showed Resident 814 had the capacity to understand and make decisions. Review of Resident 814's Order Summary Report dated 9/26/24, showed a physician's order dated 9/17/24, to administer oxygen at two liters per minute via nasal cannula for SOB as needed. However, further review of Resident 814's Order Summary Report did not show a physician's order for oral suctioning. Review of Resident 814's plan of care failed to show a care plan was developed to address Resident 814's oxygen and suction use. On 9/26/2024 at 0852 hours, a follow-up interview and concurrent medical record review was conducted with LVN 3. When LVN 3 was asked to show Resident 814's physician's order for the oral suction and the care plan for oxygen and oral suction use, LVN 3 verified there were none. On 9/26/24 at 0916 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated the facility's policy for oxygen nasal cannula and Yankauer management was to change it weekly and as needed to include the date, label, and to store the equipment inside a set-up bag when not in use. RN 1 added the humidifier must be dated, labeled, and changed as needed. When RN 1 was asked to show the physician's order for the oral suction and care plan for the oxygen and oral suction, RN 1 stated, There is no order for suction and no care plan for oxygen and suction use. RN 1 stated there must be a physician's order for the suction prior to use and care plan for suction and oxygen use. On 9/26/24 at 1440 hours, an interview was conducted with the DON. The DON stated the oxygen tubing and suction Yankauer must be change weekly by the central supply staff every Monday or Tuesday and as needed. The DON also stated there should be a physician's order for the suction prior to use and develop a care plan for oxygen and suction use. The DON was informed and acknowledged the above findings. 47474 2. Medical record review for Resident 76 was initiated on 9/24/24. Resident 76 was admitted to the facility on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 76's H&P examination dated 8/13/24, showed Resident 76 had the capacity to understand and make decisions. Review of Resident 76's Orders Summary Report dated September 2024 showed the following: - an order dated 8/13/24, to suction as needed for excessive secretions. - an order dated 9/16/24, to administer oxygen at four liters per minute via nasal cannula every shift for SOB. - an order dated 8/15/24, to administer ipratropium-albuterol solution 0.5-2.5 (3) mg/3 ml (bronchodilator breathing medication) 3 ml inhale via nebulizer every four hours as needed for SOB or wheezing mix with hypertonic saline 3% solution. - an order dated 8/16/24, to administer ipratropium-albuterol solution 0.5-2.5 (3) mg/3 ml 3 ml inhale via nebulizer at bedtime for PNA. On 9/24/24 at 0956 hours, a concurrent observation and interview was conducted with LVN 17. LVN 17 verified Resident 76's oxygen tubing, humidifier, and the storage bags for the nebulizer and suction devices were not dated and labeled. LVN 17 further verified there was no storage bag for the oxygen. LVN 17 stated the respiratory devices and storage bags should be dated and labeled and changed weekly. 3. Medical record review for Resident 564 was initiated on 9/24/24. Resident 564 was admitted to the facility on [DATE]. Review of Resident 564's Medicare 5-Day MDS dated [DATE], showed Resident 564 had a BIMS score of 15 which meant the resident was cognitively intact. Review of Resident 564's Orders Summary Report dated September 2024 showed the following: - an order dated 9/11/24, to administer ipratropium-albuterol solution 0.5-2.5 (3) mg/3 ml one vial inhale via nebulizer three times a day for cough due to s/p COVID-19 positive. On 9/24/24 at 0911 hours, a concurrent observation and interview was conducted with the LVN 2. LVN 2 verified Resident 564's storage bag for the nebulizer observed was not dated or labeled. LVN 2 stated the storage bags for the respiratory supplies should be dated and labeled. LVN 2 further stated the respiratory supplies including the storage bags were changed out weekly and as needed for infection control. On 9/27/24 at 1620 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings for Residents 76 and 564. 50953 4. Medical record review for Resident 10 was initiated on 9/24/2024. Resident 10 was admitted to the facility on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's Order Summary Report showed a physician's order dated 3/14/24, to administer oxygen at two liters per minute via nasal cannula for congestive heart failure. On 9/24/24 at 0832 hours, during the initial tour of the facility, Resident 10 was observed lying in bed with oxygen being administered via nasal cannula at two liters per minute. An oxygen concentrator was observed next to the resident 's bed. Resident 10's nasal cannula and humidifier were dated 9/16/24. On 9/24/24 at 0932 hours, an observation and concurrent interview was conducted with LVN 1. When LVN 1 was ask about the process for the oxygen equipment maintenance and care in the facility, LVN 1 stated the nasal cannula and humidifier were changed every week and should be dated. LVN 1 verified Resident 10's nasal cannula and humidifier were dated 9/16/24. 5. Medical record review for Resident 42 was initiated on 9/24/2024. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's Order Summary Report showed a physician's order dated 6/4/24, to administer continuous oxygen at two liters per minute via nasal cannula for SOB. On 9/24/24 at 0946 hours, during the initial tour of the facility, Resident 42 was observed lying in bed with oxygen being administered via nasal cannula at two liters per minute. An oxygen concentrator was observed next to the resident's bed. Resident 42's nasal cannula and humidifier were dated 9/16/24. On 9/24/24 at 0956 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 42's nasal cannula and humidifier were dated 9/16/24. 6. Medical record review for Resident 87 was initiated on 9/24/2024. Resident 87 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 87's Order Summary Report showed a physician's order dated 2/1/24, to administer oxygen at two liters per minute via nasal cannula for SOB maintenance, and may titrate oxygen to four liters per nasal cannula if oxygen saturation below 90%. On 9/24/24 at 0800 hours, Resident 87 was observed lying in bed with oxygen being administered via nasal cannula at two liters per minute. A humidifier was observed attached to the oxygen concentrator next to the resident 's bed. Resident 87's nasal cannula and humidifier were observed undated and unlabeled. On 9/24/24 at 0932 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 87's nasal cannula and humidifier were undated and unlabeled. LVN 1 was unable to identify when the nasal cannula and humidifier were last changed. On 9/27/24 at 1418 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39453 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. On 9/24/24 at 1002 hours, during the initial tour of the facility, Resident 75 was observed in bed wearing a nebulizer mask. Resident 75's nebulizer tubing was dated 9/4/24, and the set-up bag was dated 9/4/24. In addition, a nasal cannula was observed with the date of 9/16/24, inside a set-up bag. Medical record review for Resident 75 was initiated on 9/24/24. Resident 75 was readmitted to the facility on [DATE]. Review of Resident 75's Order Summary Report showed the following physician's orders dated: - On 6/26/24, to administer oxygen at two liters per minute via nasal cannula as needed for hypoxia, SOB, or when oxygen saturation level less than 94% on room air; and - On 8/30/24, to administer ipratropium-albuterol inhalation solution 0.5-2.5 mg/3 ml every four hours as needed for SOB and/or wheezing. On 9/24/24 at 1101 hours, an observation for Resident 75 and concurrent interview was conducted with the Central Supply Clerk. The Central Supply Clerk verified the above findings. 8. On 9/24/24 at 0906 hours, during the initial tour of the facility, Resident 89 was observed in lying in bed with continuous oxygen being administered via nasal cannula at two liters per minute. The nasal cannula tubing was observed undated. In addition, a set-up bag containing a nebulizer mask was also unlabeled and undated. Furthermore, a set-up bag containing a Yankauer suction was also unlabeled undated. Medical record review for Resident 89 was initiated on 9/24/24. Resident 89 was readmitted to the facility on [DATE]. Review of Resident 89's Order Summary Report showed the following physician's orders dated 9/26/24: - To administer oxygen at two liters per minute via nasal cannula every shift for acute hypoxic respiratory failure; - To administer albuterol sulfate solution 2.5 mg/3 ml 0.083% via nebulizer every four hours as needed for SOB; and - To administer ipratropium-albuterol inhalation solution 0.5-2.5 mg/3 ml via nebulizer every six hours as needed for SOB and/or wheezing. On 9/24/24 at 1118 hours, an observation for Resident 89 and concurrent interview was conducted with the Central Supply Clerk. The Central Supply Clerk verified the above findings. 9. On 9/24/24 at 0901 hours, during the initial tour of the facility, Resident 418 was observed lying in bed with continuous oxygen being administered via nasal cannula at two liters per minute. The nasal cannula tubing was observed undated. There was no set-up bag for the nasal cannula tubing observed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 418 was initiated on 9/24/24. Resident 418 was admitted to the facility on [DATE]. Review of Resident 418's Order Summary Report showed a physician's order dated 9/17/24, to administer oxygen at two liters per minute via nasal cannula every shift for SOB. On 9/24/24 at 1119 hours, an observation for Resident 418 and concurrent interview was conducted with the Central Supply Clerk. The Central Supply Clerk verified the above findings. 10. On 9/24/24 at 0857 hours, during the initial tour of the facility, Resident 417 was observed in lying in bed with continuous oxygen being administered via nasal cannula at two liters per minute. The nasal cannula tubing was observed undated. There was no set-up bag for the nasal cannula tubing observed. Medical record review for Resident 417 was initiated on 9/24/24. Resident 417 was admitted to the facility on [DATE]. Review of Resident 417's Order Summary Report showed a physician's order dated 9/20/24, to administer oxygen at two liters per minute via nasal cannula as needed for SOB. On 9/24/24 at 1119 hours, an observation for Resident 417 and concurrent interview was conducted with the Central Supply Clerk. The Central Supply Clerk verified the above findings. 11. On 9/24/24 at 0837 hours, during the initial tour of the facility, Resident 414 was observed in lying in bed with continuous oxygen being administered via nasal cannula at two liters per minute. The nasal cannula tubing was observed undated. There was no set-up bag for the nasal cannula tubing observed. Medical record review for Resident 414 was initiated on 9/24/24. Resident 414 was readmitted to the facility on [DATE]. Review of Resident 414's Order Summary Report showed a physician's order dated 9/12/24, to administer oxygen at two liters per minute via nasal cannula every shift for SOB. On 9/24/24 at 1119 hours, an observation for Resident 414 and concurrent interview was conducted with the Central Supply Clerk. The Central Supply Clerk verified the above findings. The Central Supply Clerk stated the nasal cannula tubing, nebulizer mask, and Yankauer suction should be with a set-up bag upon initial use. The Central Supply Clerk stated the set-up bag should be labeled with the resident's last name, initial of resident's first name, room number, and the date when it was set-up. The Central Supply Clerk stated the cannula tubing, nebulizer mask, and Yankauer suction should have a sticker with the date. The Central Supply Clerk also stated the nasal cannula tubing, nebulizer mask, and Yankauer suction, and the set-up bag should be changed weekly, every Monday. On 9/27/24 at 1100 hours, an interview was conducted with the DON. The DON verified the above findings. The DON stated the nasal cannula tubing, nebulizer mask, and Yankauer suction, and set-up bag should be changed every Monday, and as needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest physical well-being for one of five final sampled residents (Resident 108)reviewed for hemodialysis care. * The facility failed to ensure the medications scheduled to be administered to Resident 108 on the days the resident had dialysis treatments had a physician's order to be held or were rescheduled. This failure had the potential for the resident's poor health outcomes. Findings: Review of the facility's P&P titled Medication Administration - General Guidelines revised 11/21 showed medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. If a dose of a regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. Medical record review for Resident 108 was initiated on 9/24/24. Resident 108 was admitted to the facility on [DATE]. Review of Resident 108's Order Summary Report dated 9/26/24 showed the following physician's orders: - dated 9/9/24, to administer magnesium oral tablet one tablet by mouth one time a day for supplement - dated 9/10/24, for hemodialysis appointments on Mondays, Wednesdays, and Fridays - dated 9/10/24, to administer colchicine (a medication used to prevent or treat gout, a type of inflammatory arthritis) tablet 0.6 mg one tablet by mouth one time a day for gout Review of the resident's Order Summary Report did not show a physician's order to hold Resident 108's medications on dialysis days. Review of the MAR for September 2024 showed the following medications were not administered or rescheduled due to Resident 108 being absent from the facility: - colchicine tablet 0.6 mg at 0900 hours, on 9/11, 9/13, 9/16, 9/20, and 9/23; and - magnesium oral tablet at 0900 hours, on 9/11, 9/13, 9/16, 9/20, and 9/23/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 1143 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated the medication times should be adjusted on the residents' dialysis days. The DON verified there was no documented evidence the medications were given during the above listed days. The DON verified there was no documentation to show the physician was notified Resident 108 was routinely out of the facility when the medications were ordered to be administered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the resident's needs. * The facility failed to ensure the medications were available for one of six final sampled residents (Resident 564)observed and reviewed for medication administration. This failure had the potential to result in medication administration errors and poor health outcomes to the residents. Findings: Review or the facility's P&P titled Medication Administration - General Guidelines revised 11/2021 showed if a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted. On 9/24/24 at 0924 hours, a medication administration observation for Resident 564 was conducted with LVN 2. LVN 2 was observed preparing and administering Resident 564's medication. LVN 2 stated he would not be able to give the Calcium Vitamin D (dietary supplement) tablet because it was not available and was not replaced. Review of Resident 564's Order Summary Report for September 2024 showed the following physician's orders: - dated 9/11/24, to administer Calcium-Vitamin D tablet 250-125 mg one tablet by mouth one time a day for supplement. -dated 9/11/24, to administer Acidophilus Probiotic/lactobacillus (a medication to aid digestive system) oral tablet one capsule by mouth one time a day for supplement. On 9/24/24 at 1112 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 verified Acidophilus Probiotic oral tablet was ordered by Resident 564's physician. LVN 2 acknowledged he did not give Acidophilus Probiotic oral tablet to Resident 564. LVN 2 stated Resident 564's Calcium Vitamin D 250/125 mg-unit and Acidophilus Probiotic oral tablet were not available during the medication administration. LVN 2 stated he should have informed the physician that Resident 564's medications were not available. On 9/27/24 at 1158 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services for one of five final sampled residents (Resident 81) reviewed for unnecessary medications. * The facility failed to ensure the pharmacy consultant's recommendation to reduce venlafaxine (antidepressant)dosage was acted upon by Resident 81's physician. * The facility failed to ensure the Consultant Pharmacist identified the duplicate therapy for the use of acetaminophen (analgesic). These failures had the potential to negatively impact the resident's well-being. Findings: Review or the facility's P&P titled Medication Regimen Review (Monthly Report) revised 8/2019 showed the consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate, the medical director and/or the administrator. Medical record review for resident 81 was initiated on 09/26/24. Resident 81 was admitted to the facility on [DATE], and readmitted on [DATE] Review of Resident 81's MDS dated [DATE], showed Resident 81's cognition was intact. Review of Resident 81's Initial Evaluation dated 10/21/23, showed the resident had major depressive disorder (serious mood disorder). a. Review of Resident 81's Order Summary Report for September 2024 showed a physician's order dated 6/29/24, to administer venlafaxine hydrochloride (medication to treat depression) oral tablet 37.5 mg one tablet by mouth one time a day for depression manifested by verbalization of sadness. Review of Resident 81's Note to Attending Physician/Prescriber by the Consultant Pharmacist dated 5/13/24, showed the resident has been on the same dose of venlafaxine 37.5 mg every day since 9/2023. GDR (Gradual Dose Reduction) is due if medically warranted to keep the facility in compliance . Further review of Resident 81's medical record failed to show the physician responded to the Consultant Pharmacist's recommendation to reduce the dosage of venlafaxine. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 1510 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 81's venlafaxine medication dosage was not reduced since 9/2023. The DON acknowledged Resident 81's physician did not respond to the Consultant Pharmacist's recommendation to reduce the dosage of venlafaxine. b. Review of Resident 81's Order Summary Report for September 2024 showed the following physician's orders: - dated 6/29/24, to administer acetaminophen tablet 325 mg two tablets by mouth every four hours PRN for mild pain (1-3, on a 0-10 pain scale, with 0=no pain and 10=worst pain) NTE 3 grams of APAP (acetaminophen) from all sources in 24 hours. - dated 8/20/24, to administer Tylenol (brand name for acetaminophen) oral tablet 325 mg one tablet by mouth every six hours PRN for mild pain 1-3 NTE 3 grams of APAP (acetaminophen) in 24 hours. Review of Resident 81's medical record failed to show the Consultant Pharmacist identified the problem on the duplicate therapy for the use of the PRN acetaminophen. On 9/27/24 at 0958 hours, a concurrent interview and medical record review was conducted with LVN 13. LVN 13 acknowledged the Tylenol and acetaminophen orders were the same. LVN 13 further stated both medications were for mild pain. LVN 13 stated the order should have been clarified with Resident 81's physician because it was a duplicate order. On 09/27/24 at 1158 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 81) reviewed for unnecessary medications was properly monitored for the medications. * The facility failed to ensure Resident 81 had no duplicate therapy for the acetaminophen medication. * The facility failed to ensure Resident 81 was monitored for side effects of Keflex (medication used to treat bacterial infections) medication. * The facility failed to ensure Resident 81 was monitored for the side effects of hydrocodone-acetaminophen (a controlled pain medication) medication. These failures had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Unnecessary Medications revised 8/2019 showed in part, each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. An unnecessary drug is any drug used: in excessive doses, including duplicate therapy; or for excessive duration; or without adequate monitoring . Medical record review for resident 81 was initiated on 9/26/24. Resident 81 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 81's MDS dated [DATE], showed Resident 81's cognition was intact. a. Review of Resident 81's Order Summary Report for September 2024 showed a physician's order dated 8/20/24, to administer Tylenol oral tablet 325 mg one tablet by mouth every six hours PRN for mild pain, levels 1-3, NTE 3 grams of APAP (acetaminophen) in 24 hours. Further review of Resident 81's Order Summary Report for September 2024, showed a physician's order dated 6/29/24, to administer acetaminophen tablet 325 mg two tablets by mouth every four hours PRN for mild pain (levels 1-3) NTE 3 grams of APAP (acetaminophen) from all sources in 24 hours. On 9/27/24 at 0958 hours, an interview and concurrent medical record review for Resident 81 was conducted with LVN 13. LVN 13 acknowledged the Tylenol and acetaminophen orders were the same. LVN 13 further stated both medications were for mild pain. LVN 13 stated the order should have been clarified with Resident 81's physician because it was a duplicate order. b. Review of Resident 81's Order Summary Report for September 2024, showed a physician's order dated 9/23/24, to administer Keflex oral capsule 500 mg by mouth four times a day for infected wound for seven days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 81's medical record failed to show a monitoring for side effects of Keflex medication. On 9/27/24 at 0958 hours, an interview and concurrent medical record review for Resident 81 was conducted with LVN 13. LVN 13 stated Resident 81 was receiving Keflex for the skin tear on her left shin starting to get inflamed. LVN 13 verified Resident 81 had no monitoring for the side effects of the Keflex medication. LVN 13 stated Resident 81 should have been monitored for side effect such as headache, dizziness, nausea, and vomiting. LVN 13 stated she did not observe any side effect or allergic reaction on Resident 81. c. Review of Resident 81's Order Summary Report for September 2024, showed a physician's order dated 8/20/24, to administer hydrocodone-acetaminophen oral tablet 5-325 mg one tablet by mouth every six hours PRN for moderate to severe pain (levels 4-10) NTE 3 grams of APAP (acetaminophen) in 24 hours. On 09/27/24 at 0958 hours, an interview and concurrent medical record review for Resident 81 was conducted with LVN 13. LVN 13 verified there was no monitoring for Resident 81's side effect on hydrocodone-acetaminophen medication. LVN 13 stated there should be a monitoring for Resident 81's hydrocodone-acetaminophen side effects such as constipation and drowsiness. LVN 13 further stated Resident 81 did not complain of drowsiness recently. However, Resident 81 had constipation a few weeks ago and LVN 13 stated she gave her medications for bowel management. On 09/27/24 at 1158 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 75 and 566) reviewed for unnecessary medication were free from unnecessary psychotropic (medications which affect the brain and the nervous system to treat mental illness and conditions which impact behavior and emotions) drugs. * The facility failed to ensure the side effects and behaviors were monitored for Resident 566 related to the resident's use of sertraline (antidepressant medication) and quetiapine (antipsychotic medication). * The facility failed to ensure the physician's documentation of the rationale for extending the physician's order for doxepin (antidepressant medication) beyond the 14-day duration for Resident 75. In addition, the facility failed to ensure Resident 75 was monitored for behavior manifestations and side effects related to the use of doxepin medication. These failures had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Use of Psychotropic Drugs revised 10/2023 showed the residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medications is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medications(s). The P&P further showed a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics. 1. Medical record review for Resident 566 was initiated on 9/24/24. Resident 566 was admitted to the facility on [DATE]. Review of Resident 566's H&P examination dated 9/18/24, showed Resident 566 was a poor historian due to cognitive and psychiatric impairment. Review of Resident 566's Orders Summary Report dated September 2024 showed the following physician's orders dated: - 9/24/24, to administer quetiapine fumarate 50 mg one tablet by mouth in the evening for psychosis m/b visual hallucination. - 9/18/24, to administer sertraline 50 mg one tablet by mouth one time a day for depression m/b verbalization of sadness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 566's Orders Summary Report showed no documented evidence Resident 566 was monitored for side effects and behaviors related to the use of quetiapine and sertraline medications. On 9/27/24 at 1101 hours, an interview and concurrent medical record review for Resident 566 was conducted with RN 3. RN 3 verified the above findings for Resident 566. RN 3 stated Resident 566 should have orders to monitor the side effects and behaviors for quetiapine and sertraline medications. RN 3 further stated psychotropic medications could cause negative side effects leading to death if not monitored correctly and stated monitoring the residents on psychotropic medications would allow the facility to gradually increase or decrease the dosage of the medication based on the resident's reaction to the medications. On 9/27/24 at 1620 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings. 39453 2. Review of the facility's P&P titled Use of Psychotropic Drugs reviewed date 10/10/23, showed the following: -Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medications is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s); - PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days); - If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order; and - The resident's response to the medication(s), including progress towards goals and presence/ absence of adverse consequences, shall be documented in the resident's medical record. Review of the FDA black box warning for doxepin showed residents prescribed an antidepressant, such as doxepin, require careful observation due to possible increase in suicidality, and should be monitored closely for the clinical worsening of depression, suicidal ideation, and changes in behavior. Medical record review for Resident 75 was initiated on 9/24/24. Resident 75 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 75's Initial H&P examination dated 5/14/24, showed Resident 75 had the capacity to understand and make decisions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 75's Order Summary Report dated 9/26/24, showed a physician's order dated 9/4/24, to administer doxepin 3 mg one tablet every 24 hours at bedtime PRN for insomnia manifested by difficulty of falling asleep at night for 30 days. a. Review of Resident 75's medical record failed to show documented evidence of the physician's rationale for extending the doxepin medication beyond the14-day period. Review of Resident 75's MAR for September 2024 showed Resident 75 was administered the doxepin medication on 9/6/24 at 2000 hours, 9/8/24 at 2020 hours, 9/15/24 at 1950 hours, 9/18/24 at 2000 hours, 9/19/24 at 2028 hours, 9/20/24 at 2030 hours, and 9/25/24 at 2007 hours. Review of Resident 75's TAR for September 2024 showed the following: - A physician's order dated 8/30/24, to monitor for sedation, drowsiness, morning hangover, and ataxia (poor muscle control causing clumsy movements) every shift for hypnotic use until 9/4/24. Resident 75 was documented to have been monitored from day shift on 9/1/24, to day shift on 9/4/24; and - A physician's order dated 8/30/24, to monitor for insomnia target behaviors (tired, falling asleep during the day, difficulty falling asleep at desired time) and to note any symptoms present every shift. Resident 75 was documented to have been monitored from day shift on 9/1/24, to day shift on 9/4/24; and - There was no monitoring for the behavior manifestation and side effects related to the use of doxepin medication from the evening shift on 9/4/24 to 9/27/24. b. Further review of Resident 75's medical records failed to show documented evidence Resident 75 was monitored for the behavior manifestation and side effects related to the use of doxepin medication from evening shift on 9/4/24 to 9/27/24. On 9/26/24 at 1359 hours, an interview and concurrent medical record review for Resident 75 was conducted with LVN 13. When asked about the doxepin medication for Resident 75, LVN 13 stated they monitored Resident 75 for sleeping and the side effects every shift related to the use of doxepin medication and documented in the TAR. When asked to show documentation of the behavior and side effects monitoring, LVN 13 could not find documentation for Resident 75's behavior and side effects monitoring related to the use of doxepin medication. On 9/27/24 at 1100 hours, an interview and concurrent medical record review for Resident 75 was conducted with the DON. The DON was informed and verified the findings. The DON stated the licensed staff forgot to continue the monitoring of behavior and side effects for Resident 75 related to the use of doxepin medication when the physician extended the order (on 9/4/24). When asked about the physician's order for the doxepin medication for 30 days, the DON reviewed Resident 75's medical record and was unable to find documentation of the physician's rationale for extending the doxepin medication beyond the 14-day period.

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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** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate during the medication pass observation was less than five percent (5%). The facility had a cumulative medication error rate of 18.52% when five of 27 opportunities for errors were observed between three licensed nurses (LVNs 3, 8, and 9) who administered medications to three nonsampled residents (Residents 33, 51, and 65). The observed medication administration errors were: * LVN 8 added 90 ml of water to Resident 51's ClearLax (a laxative to treat occasional constipation) polyethylene glycol 3350 powder instead of four or eight ounces of beverage as per the direction on the ClearLax container. * LVN 9 failed to give instructions to Resident 65 to rinse her mouth after using fluticasone propionate/salmetrol diskus (medication to prevent asthma) inhalation powder. * LVN 9 administered one tablet of B complex (supplement) to Resident 65 instead of B complex with biotin as ordered. * LVN 3 failed to administer vitamin B6 (supplement) medication to Resident 33 as ordered by the physician. * LVN 3 administered two tablets of potassium chloride (a mineral supplement) ER (extended release) to Resident 33 instead of potassium citrate (a mineral supplement) ER as ordered. These failures had the potential to compromise the health and safety of these residents. Findings: Review or the facility's P&P titled Medication Administration - General Guidelines revised 11/2021 showed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Review of the facility's P&P titled Administration Procedures for All Medications revised 6/2021 showed to administer medications in a safe and effective manner. The Procedure section showed if unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. The Procedure also showed to check expiration date on the package/container before administering any medication. When opening a multi-dose container, place the date on the container. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Oral Inhalation Administration revised 6/2021 showed to allow correct administration of inhalers to residents, and for instruction in proper technique for those residents able to administer the medication to themselves. The Procedure section showed if receiving an inhaler containing steroid, have resident rinse his/her mouth and spit out the rinse water after the final dose. Review or the facility's P&P titled Unavailable Medications revised 8/2019 showed medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. The Procedure section showed nursing staff shall notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy (ies) that are available. The P&P showed to obtain a new order and cancel/discontinue the order for the non-available medication, and notify the pharmacy of the replacement order. 1. On 9/24/24 at 0756 hours, a medication administration observation for Resident 51 was conducted with LVN 8. LVN 8 was observed mixing ClearLax 17 gm with 90 ml of water in a cup to administer to Resident 51. LVN 8 was observed administering ClearLax 17 gm via GT to Resident 51. Medical record review for Resident 51 was initiated on 9/24/24. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's Order Summary Report for September 2024, showed a physician's order dated 7/25/23, to administer MiraLAX (brand name for polyethylene glycol, same as ClearLax) oral powder 17 gm/scoop 17 gram via GT in the morning for bowel management, mix powder in water, then give; and hold for loose stool. On 09/24/24 at 1455 hours, an interview and concurrent medical record review for Resident 51 was conducted with LVN 8. LVN 8 stated she followed the physician's order when she gave the ClearLax medication to Resident 51. LVN 8 verified she added 90 ml of water to ClearLax 17 gm. However, the direction on the ClearLax container showed to stir and dissolve in any 4 or 8 ounces of beverage (cold, hot or room temperature). LVN 8 stated she should have read the direction on the Clearlax container before giving the medication to Resident 51. 2.a. On 9/24/24 at 0756 hours, a medication administration observation for Resident 65 was conducted with LVN 9. LVN 9 was observed administering fluticasone propionate/salmetrol diskus inhalation powder 250 mcg/50 mcg and giving a cup of water to Resident 65. However, LVN 9 did not give instructions to Resident 65 to rinse mouth after use. Resident 65 drank the water and did not rinse her mouth after using the fluticasone propionate/salmetrol diskus inhalation powder. Medical record review for Resident 65 was initiated on 9/24/24. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's Order Summary Report for September 2024 showed a physician's order dated 3/19/24, to administer fluticasone-salmeterol aerosol Powder Breath Activated 250-50 mcg/dose one inhalation orally two times a day for asthma, and rinse mouth after use. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24 at 1118 hours, an interview and concurrent medical record review for Resident 65 was conducted with LVN 9. LVN 9 verified she did not give instructions to Resident 65 to rinse her mouth after using the fluticasone propionate/salmetrol diskus inhalation powder. LVN 9 stated Resident 65 usually drank water after using the inhaler. b. On 9/24/24 at 0756 hours, a medication administration observation for Resident 65 was conducted with LVN 9. LVN 9 was observed administering one tablet of B complex to Resident 65. Review of Resident 65's Order Summary Report for September 2024 showed a physician's order dated 3/19/24, to administer B-complex oral tablet (B-complex with biotin [one of B vitamin] and folic acid [a B vitamin]) 500 mg by mouth one time a day for supplement. On 09/24/24 at 1118 hours, an interview and concurrent medical record review for Resident 65 was conducted with LVN 9. LVN 9 reviewed the physician's order and the label of the B complex container. LVN 9 verified the B complex she administered to the resident did not have biotin and it was not the same medication as ordered by the physician. 3.a. On 9/24/24 at 0849 hours, a medication administration observation for Resident 33 was conducted with LVN 3. LVN 3 prepared the medications which included vitamin B6 for Resident 33. However, Resident 33's vitamin B6 medication container label showed the medication had expired on 8/2024. On 09/24/24 at 0908 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 3. LVN 3 verified Resident 33's vitamin B6 medication expired last month. LVN 3 stated he would remove Resident 33's vitamin B6 medication from the medication cart and waste it in the medication room. Resident 33 did not receive the medication as ordered by the physician because the medication supply available had expired. Medical record review for Resident 33 was initiated on 9/24/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Order Summary Report for September 2024 showed a physician's order dated 1/9/22, to administer vitamin B6 tablet 25 mg by mouth one time a day for supplement. b. On 9/24/24 at 0849 hours, a medication administration observation for Resident 33 was conducted with LVN 3. LVN 3 was observed preparing and administering two tablets of potassium chloride (a mineral supplement) ER 10 mEq medication to Resident 33. Review of Resident 33's Order Summary Report for September 2024 showed a physician's order dated 3/24/22, to administer potassium citrate (a mineral supplement) ER tablet extended release 10 mEq (1080 mg) two tablets by mouth two times a day for supplement. On 09/24/24 at 0908 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 3. LVN 3 reviewed Resident 33's physician's orders and the label on the container of the potassium medication. LVN 3 verified the physician's order was potassium citrate 10 mEq, but he gave potassium chloride ER 10 mEq to Resident 33. LVN 3 stated he would verify Resident 33's potassium with the physician and the pharmacist. (continued on next page)

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Alamitos West Health & Rehabilitation	3902 Katella Avenue Los Alamitos, CA 90720

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/27/24 at 1158 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49644 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of the medications. * The facility failed to ensure Resident 51's Artificial Tears (lubricate dry eyes and help keep moisture on the outer surface of your eyes) ophthalmic solution was not left unattended on the resident's bedside table. * Medication Room A room temperature log had multiple documentation of out-of-range room temperatures above 77 degrees Fahrenheit. * Medication Room B had no room temperature log. * Medication Cart F had two topical prescription medications that were not labeled with a specific resident name. * Medication Cart C had oral medications stored with externally used medications. * The facility failed to ensure Resident 1's Refresh (medication used to relieve dry, irritated eyes) lubricant eye solution in Medication Cart C had an open date labeled. * Medication Cart B had an expired bottle of Humulin R (insulin regular). * Medication Cart B had oral medications stored with externally used medications. These failures had the potential to negatively impact the residents' well-being, risk of unauthorized access to medications, potential for the residents to have received expired medications, and risk of undermining the efficacy of the stored medications. Findings: Review of the facility's P&P titled Administration Procedures for All Medications revised 6/2021 showed to administer medications in a safe and effective manner. The Procedure section showed if unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. The Procedure section also showed to check expiration date on the package/container before administering any medication. When opening a multi-dose container, to place the date on the container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review or the facility's P&P titled Unavailable Medications revised 8/2019 showed the medications used by the residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. The Procedure section showed nursing staff shall notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. The P&P also showed to obtain a new order and cancel/discontinue the order for the non-available medication and notify the pharmacy of the replacement order. Review or the facility's P&P titled Medication Storage (Medication Cart/Narcotics) revised 7/22/24, showed it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure temperature and security. General guidelines, Section C, showed during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Review or the facility's P&P titled Refrigerated Drugs revised 7/22/24, showed it is the policy of this facility to assure proper and safe storage of medications requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperature controls. Policy explanation and compliance guidelines section 3a showed the facility will ensure that all medications and biologicals will be stored at proper temperatures and other appropriate environmental controls according to manufacturer's recommendation to preserve their integrity. Room temperature refers to temperature maintained between 68-77 degrees Fahrenheit. Policy explanation and compliance guidelines section 6d showed to date label of any multi-use vial when the vial is first accessed (needle punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies different (shorter or longer) date for that opened vial. Review or the facility's P&P titled Storage of Medications revised 8/2019, showed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendation or those of the supplier. Procedure section D showed orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. 1. On 9/24/24 at 0813 hours, an observation was conducted with LVN 8. LVN 8 was observed leaving the Artificial Tears ophthalmic solution on top of Resident 51's bedside table while she went to the restroom to wash her hands. The door was observed not fully open when LVN 8 was washing her hands. The eye drop medication was out of LVN 8's reach and sight. On 9/24/24 at 0825 hours, an interview was conducted with LVN 8. LVN 8 acknowledged the Artificial Tears ophthalmic solution was on top of Resident 51's bedside table when she went to the restroom. LVN 8 verified the door was not fully open when she washed her hands in the restroom. 2. On 9/25/24 at 0830 hours, an observation and concurrent interview and record review was conducted with RN 3 in Medication Room A. Medication Room A had the discontinued medications, supplements, over the counter medications, excess supply of IV, and refrigerator for medications. The room temperature in Medication Room A was 74 degrees Fahrenheit. However, review of the Medication Room A Temperature Log showed the room temperature on 9/24/24, was 79 degrees Fahrenheit. RN 3 stated the room temperature should be less than 75 degrees Fahrenheit. RN 3 stated she needed to report to the supervisor and maintenance if the room temperature was higher than required. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 1336 hours, an interview and concurrent record review was conducted with the DON. Medication Room A Temperature Log-Fahrenheit for the month of August 2024 showed the following: - 78 degrees Fahrenheit on 8/3, 8/4, 8/6, 8/8, 8/9, 8/10, 8/13, 8/14, 8/17, 8/21, 8/25, 8/27, 8/30, and 8/31/24; - 79 degrees Fahrenheit on 8/1, 8/5, 8/11, 8/12, 8/15, 8/22, 8/23, 8/24, and 8/26/24; and - 80 degrees Fahrenheit on 8/2/24. Medication Room A Temperature Log-Fahrenheit for September 2024 showed the following: - 78 degrees Fahrenheit on 9/2, 9/3, 9/6, 9/7, 9/14, 9/15, 9/19, and 9/20/24; - 79 degrees Fahrenheit on 9/5, 9/8, 9/9, 9/11, 9/12, 9/13, 9/21, 9/23, and 9/24/24; and - 80 degrees Fahrenheit on 9/10 and 9/22/24 The DON verified Medication Room A Temperature Log had multiple documentation of room temperatures above 77 degrees Fahrenheit. The DON stated Medication Room A temperature should be checked every day and reported to the Maintenance Director if the room temperature was higher than 77 degrees Fahrenheit. However, there was no evidence the out-of-range room temperatures above 77 degrees Fahrenheit were reported to the Maintenance Director. The DON stated the nursing supervisor checked Medication Room A temperature daily. 3. On 9/25/24 at 0906 hours, an observation and concurrent interview and record review was conducted with RN 3 in Medication Room B. Medication Room B had the discontinued medications, supplements, over the counter medications, and refrigerator for medications. Medication Room B temperature was 72 degrees Fahrenheit. However, there was no room temperature log in Medication Room B. RN 3 verified the findings. RN 3 stated she did not know where the temperature log for Medication Room B was. On 9/25/24 at 1336 hours, an interview and concurrent record review was conducted with the DON. The DON stated RN 3 informed her that the Medication Room B temperature log was missing. The DON stated they created a new medication room temperature log yesterday. 4.a. On 9/25/24 at 0932 hours, an inspection of Medication Cart F and concurrent interview was conducted with LVN 11. A Collagenase Santyl (a topical enzyme medication) ointment 250 units/g and flucinonide (a topical steroid) cream 0.05% were observed inside Medication Cart F. The Collagenase Santyl ointment had no label to identify whose it was. LVN 11 stated they used the Collagenase Santyl ointment as a house supply. The flucinonide cream 0.05% was a prescription medication and was not labeled with a specific resident's name. LVN 11 verified the flucinonide cream 0.05% and Collagenase Santyl ointment were not labeled for specific residents. 5. On 9/25/24 at 1123 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 3. The following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A box of Bisacodyl (laxative) stimulant laxative suppository 10 mg was stored in a bin with a box of sore throat lozenges, a box of loperamide hydrochloride (medication to treat diarrhea) tablets 2 mg, a box of ferrous gluconate (iron supplement) 324 mg, and a box of calcium carbonate (dietary supplement) 500 mg. - A bottle of Refresh lubricant eye solution for Resident 1 was observed without an open date. Medical record review for Resident 1 was initiated on 9/25/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE] . Review of Resident 1's Order Summary Report for September 2024 failed to show a physician's order to administer Refresh eye lubricant solution. LVN 3 verified the above findings. 6. On 9/25/24 at 1146 hours, an inspection of Medication Cart B and concurrent interview was conducted with LVN 9. The following was observed: - A bottle of Humulin R (insulin regular-medication to lower blood sugar) with an open date of 8/21/24; - A box of Bisacodyl stimulant laxative suppository 10 mg was stored in a bin with a small plastic bag of acetaminophen (pain medication) 650 mg suppository, two small plastic bags of ondansetron (medication used to prevent nausea and vomiting) ODT (orally disintegrating tablet) 4 mg tablet, and a box of loperamide hydrochloride (medication for diarrhea) 2 mg tablet. LVN 9 verified the findings. LVN 9 stated Humulin R expired 28 days from the date when it was opened and should have been discarded. LVN 9 acknowledged the oral medications were stored with suppositories in one bin and should have been separated. On 9/27/24 at 1158 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39453 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the pureed recipes were followed for 12 of 12 residents who received pureed food from the kitchen. * The facility failed to ensure the puree recipes for chicken ala king, steamed broccoli, and brown rice were followed. This failure had the potential for not providing nutritional meals to meet the needs of residents on pureed diet. Findings: Review of the facility's document titled Diet Type Report dated 9/24/24, showed 12 residents received pureed food prepared from the kitchen, with no restrictions to chicken, broccoli, or rice. Review of the facility's diet spreadsheet titled TGG Menu #5: SNF Master for Cycle Day: 25 showed the lunch menu including chicken ala king, brown rice, and steamed broccoli for L1 pureed diet. Review of the facility's P&P titled In-service: Pureed Foods revised 9/2022 showed the following: - The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/ or swallowing; - The Pureeing Process section showed to measure out the number of portions needed and to use the fluid specified in each recipe. Water is not used since it will dilute the flavors and nutrients in the food item. Some items may not need extra fluid added to the pureeing process due to the high-water content. Foods such as fruits, vegetables, salads made to recipe with the salad dressing on it, and soups do not usually need extra fluid, but may need stabilizers to reach the desired consistency; - The Portioning section showed to always pureed food that is already prepared and portioned per the recipe to meet the need of the diet and the portion size. The spreadsheet for the food item will state the portion size to serve; and - The Handout for Pureed Foods In-service section showed the liquid specified for the food items, such as warm gravy or low sodium broth for meat, warm milk for starches, and no liquid or if needed, warm milk or low sodium broth for vegetables. Review of the facility's pureed recipe titled TGG Chicken Ala King PU dated 5/10/23, for Week 4 Day 4 - Lunch, showed to prepare the chicken ala king according to regular recipe, process until smooth, adding on tablespoon of food thickener per portion. Review of the facility's pureed recipe titled TGG Seasoned Broccoli PU dated 5/10/23, for Week 4 Day 4 - Lunch, showed to prepare the seasoned broccoli according to regular recipe, process by adding one teaspoon of food thickener per serving to reach desired consistency. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's pureed recipe titled TGG [NAME] Rice PU dated 5/10/23, for Week 4 day 4 - Lunch, showed to prepare the brown rice according to regular recipe, process until smooth, and add 2% milk gradually to achieve the right consistency. On 9/25/24 at 1014 hours, a concurrent observation of the puree preparation and interview was conducted with [NAME] 1, with the DSS present. The following was observed: a. For pureed chicken ala king, [NAME] 1 was observed preparing 15 #8 scoops (1/2 cup) of the cooked chicken ala king to the blender, and processed the chicken ala king. [NAME] 1 added a cup of milk and processed the chicken ala king. Then, [NAME] 1 added three teaspoons of thickener to the pureed chicken ala king. b. For pureed steamed broccoli, [NAME] 1 stated he already prepared the pureed steamed broccoli at 1000 hours, to which he showed a pureed steamed broccoli in a silver container. When asked how the pureed steamed broccoli was prepared, [NAME] 1 stated he prepared 15 #8 scoops (1/2 cup) of the steamed broccoli. [NAME] 1 stated he added 3/4 cup of milk, and butter to the processed steamed broccoli. [NAME] 1 also stated he added a little bit of thickener to the pureed steamed broccoli. c. For pureed brown rice, [NAME] 1 stated he already prepared the pureed brown rice at 1000 hours, to which he showed a pureed rice in a silver container. When asked how the pureed rice was prepared, [NAME] 1 stated he used a rice hot cereal, and not the brown rice prepare for regular recipe. When asked how much rice hot cereal was used, [NAME] 1 stated he used half a box, and could not identify the exact measurement. [NAME] 1 stated he added butter and 3/4 cup water to the pureed rice hot cereal. On 9/25/24 at 1037 hours, a concurrent interview and facility document review was conducted with the DSS. When asked about the pureed chicken ala king preparation, the DSS verified the recipe for pureed chicken ala king did not show to use milk. When asked about the pureed steamed broccoli preparation, the DSS verified the recipe for pureed steamed broccoli did not show to use milk nor butter. When asked about the pureed brown rice preparation, the DSS verified the recipe for pureed brown rice showed to prepare the brown rice according to regular recipe and did not show to use rice hot cereal. d. On 9/25/24 at 1038 hours, Cooks 1 and 2 stated they would prepare the pureed brown rice. A concurrent observation of the puree preparation for brown rice and interview was conducted with [NAME] 2, with [NAME] 1 present. [NAME] 2 prepared 12 #8 scoops (1/2 cup) of brown rice, then he added six cups of hot water into the blender and processed the brown rice. On 9/25/24 at 1040 hours, a concurrent interview and facility document review was conducted with the DSS. When asked about the pureed brown rice preparation, the DSS verified the recipe for pureed brown rice showed to use 2% milk, and not hot water.

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F 0806 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and facility document review, the facility failed to ensure the resident food preference was followed for one nonsampled residents (Resident 418). * Resident 418 disliked cooked carrots but was served with carrots for lunch. This failure had the potential to negatively impact the residents' well-being. Findings: Review of the facility's diet spreadsheet for TGG Menu #5: SNF Master for Cycle Day 24 showed the lunch menu including a serving of baby carrots. On 9/24/24 at 1239 hours, during the dining observation, Resident 418 was observed in bed, with his lunch tray. Resident 418 stated, Do you want to see what I have today? Look, carrots! Although I already informed them I do not like carrots! Resident 418's lunch tray included a serving of baby carrots. Review of Resident 418's meal ticket dated 9/24/24, under Allergies/Dislikes, showed no cooked carrots. On 9/24/24 at 1245 hours, a concurrent observation for Resident 418 and interview was conducted with LVN 10. Resident 418 was observed with a serving of baby carrots. LVN 10 verified the above findings. On 9/24/24 at 1300 hours, an interview was conducted with the DSS. The DSS verified the above findings. The DSS verified Resident 418 was given cooked carrots. Medical record review for Resident 418 was initiated on 9/24/24. Resident 418 was admitted to the facility on [DATE]. Review of Resident 418's H&P evaluation dated 9/16/24, showed Resident 48 was cognitively intact. Review of Resident 418's Order Summary Report showed a physician's order dated 9/15/24, for regular renal focus diet. Level 4 texture, regular/thin consistency, no eggs, no bell peppers, and no cooked carrots.

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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. 39453 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements in the kitchen were followed. * The facility failed to ensure the dietary staff and non-dietary staff inside the kitchen wore hair restraints. * The facility failed to ensure proper labeling and dating of food items in the kitchen. * The facility failed to ensure kitchen equipment and plates were clean. The facility failed to ensure the microwave utilized to warm up the residents' food was in sanitary condition and the plates used in trayline were free of food residue. * The facility failed to ensure pan and cutting boards were in sanitary condition. * The facility failed to air dry plates and insulated domes for plates. * The facility failed to ensure the scoop was stored properly. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's document titled Diet Type Report dated 9/24/24, showed 116 of 121 residents receiving food prepared from the kitchen. 1. According to Food Code of 2022, 2-402.22, Hair Restraints, showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hairs that are designed and worn to effectively keep their hair contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service and single-use articles. a. On 9/25/24 at 1038 hours, [NAME] 2 was observed for pureed food preparation. [NAME] 2 was observed with exposed hairs on his arms. [NAME] 2 was not observed using any hair restraint to cover the exposed hairs. b. On 9/25/24 at 1155 hours, a concurrent observation and interview was conducted with Dining Assistant 2. During the trayline observation, a non-dietary staff went inside the kitchen without a hair restraint. Dining Assistant 2 verified the above findings. On 9/27/24 at 1203 hours, an interview was conducted with the DSS. The DSS verified the above findings. The DSS stated the kitchen staff should a hair restraint for any exposed hair, beard, and body hairs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled Inservice: Labeling and Dating revised 8/2018 showed the following: - It is important to label all food items in the kitchen with product name, received date, and open date; - All items must be labeled with the food product name. This includes all items prepared in the facility or transferred to a new container after opening, even if the food is visible in a clear container; - Food items need to have multiple dated including different situations. Be sure to state the type of date labeled - received, open, or use by; and - Open date is the date the product was opened for use. Label all products when opened, including condiments, and the exception would be milk. On 9/24/24 at 0805 hours, during the initial tour of the kitchen, the following was observed with [NAME] 1 present: - An opened container of Montreal chicken seasoning was no opened date; - A clear container of red-colored powder was unlabeled and undated; and - A clear container of brown-colored powder was observed unlabeled and undated. Cook 1 verified the above findings. 3. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, showed materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. a. On 9/24/24 at 0805 hours, during the initial tour of the kitchen, the following was observed with [NAME] 1 present: - The microwave was observed with food debris on the inner panel of the microwave door, and food debris and rust were observed on the inner upper panel of the microwave. - A corroded and worn-out pan was observed hanging with the other pots and pans ready to be used for food preparation. Cook 1 verified the above findings. b. On 9/25/24 at 1155 hours, a concurrent observation and interview was conducted with [NAME] 1. During the trayline observation, plates ready to be used for trayline were observed with food debris. [NAME] 1 verified the fiindings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, showed surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. On 9/24/24 at 0805 hours, a concurrent observation and interview was conducted with [NAME] 1. During the initial tour of the kitchen, two green cutting boards were observed heavily marred with kitchen marks and with brown discoloration. [NAME] 1 verified the findings. 5. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. On 9/25/24 at 1155 hours, a concurrent observation and interview was conducted with [NAME] 1 and Dining Assistant 1. During the trayline observation, the following was observed: - The plates to be used for trayline were observed wet. [NAME] 1 verified the findings. - The insulated domes for the plates to be used for trayline were observed wet. Dining Assistant 1 verified the findings. 6. Review of the facility's P&P titled Storage of Food and Supplies dated 2023 showed dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.) should be stored in seamless metal or plastic containers with tight covers or in bins which are easily sanitized. If using plastic bags for dry bulk food storage, food grade must be used. Scoops should not be left in the containers. On 9/24/24 at 0805 hours, a concurrent observation and interview was conducted with [NAME] 1. During the initial tour of the kitchen, a scoop was observed inside the bin containing oatmeal. [NAME] 1 verified the findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 39453 Based on observation, interview, facility document review, and facility P&P review, the facility failed to follow the facility's P&P regarding the use and storage of food brought to the residents by the family or visitors. In addition, the facility failed to ensure the staff were aware of the facility's P&P on safe food handling of outside food. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consume food brought from outside sources. Findings: Review of the CMS S&C-09-39 Food Procurement, and Self-Determination and Participation, dated 5/29/09, showed the following: - The residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices; and - The facility has the responsibility under the food safety regulation to help visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Review of the facility's P&P titled Food Brought in by Family/ Visitors with reviewed date 8/10/23, showed the following: - It is the right of the residents of this facility to have foods brought in by family or other visitors, however, the food must be handled in a way to ensure safety of the resident; - All food items that are not in original containers brought in by the family member or visitor must be labeled with use by date; - The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator; - Food not in its original container must be consumed by the resident within four days; and - If the food is not consumed within four days, the food will be thrown away by facility staff. On 9/24/24 at 1550 hours, an interview was conducted with RN 3. When asked if the staff provided the visitors information on safe handling and storage of food from outside sources, RN 3 stated the facility did not have a refrigerator used for food from outside sources, and the visitors were encouraged not to bring excess food. RN 3 stated if the visitors brought food from outside sources, they were informed to eat the food from outside sources right away. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 1405 hours, an interview was conducted with LVN 13. When asked if the staff provided the visitors information on safe handling and storage of food from outside sources, LVN 13 stated they checked the food brought in by the visitors from outside sources, and the staff had to toss the unfinished food from the outside sources. LVN 13 stated the facility did not have a refrigerator for resident food from outside source so the staff told the visitors that the facility could not keep any unconsumed food. On 9/26/24 at 1414 hours, an interview was conducted with LVN 14. When asked if the staff provided the visitors information on safe handling and storage of food from outside sources, LVN 14 stated the facility did not have a refrigerator for resident food so when the visitors brought food from outside sources, the staff told the visitors and/or the resident to eat the food, and they could not leave any food from outside sources at bedside. LVN 14 stated cookies or chocolates were allowed to be left at bedside, but those should be in a Ziploc bag or container. On 9/27/24 at 1100 hours, an interview was conducted with the DON. When asked if the staff provided the visitors information on safe handling and storage of food from outside sources, the DON stated the visitors were not allowed to leave any unconsumed food from outside sources as the facility did not have a refrigerator for resident food from outside sources. The DON was informed of the facility's P&P regarding the use and storage of food brought to the residents by the family or visitors and the DON verified the findings. On 9/27/24 at 1203 hours, an interview was conducted with the DSS. When asked if the staff provided the visitors information on safe handling and storage of food from outside sources, the DSS stated the visitors were not allowed to leave any unconsumed food from outside sources as the facility did not have a refrigerator for resident food from outside sources. The DSS was informed of the facility's P&P regarding the use and storage of food brought to the residents by the family or visitors and the DSS verified the findings.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 39453 Based on observation, interview, and facility P&P review, the facility failed to ensure trash was disposed in a sanitary manner. * The facility failed to ensure three of four dumpsters were properly covered. This failure had the potential to harbor pests. Findings: According to the US Food Code 2022, Section 5-501.113, Covering Receptacles, showed receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids. Review of the facility's P&P titled Miscellaneous Areas for Garbage and Trash dated 2023 showed the following: - All food waste must be placed in a sealed leak-proof, non-absorbent, tightly closed containers (i.e. plastic bags) and shall be disposed of as necessary to prevent nuisance or unsightliness; - Adequate, clean, vermin-proof areas must be provided for storage of garbage and rubbish; - Garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed; and - The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean. On 9/24/24 at 1500 hours, an observation of the trash disposal and concurrent interview was conducted with the Maintenance Director. The following was observed: - The green food waste dumpster was observed overflowing with trash which prevented the lid from closing. An untied black garbage bag was observed open and food waste was observed dripping to the ground. Flies were observed flying over the green food waste dumpster; - The blue recycling dumpster with boxes was observed fully open; and - One gray trash dumpster was observed with the lid not fully closed. The Maintenance Director verified the above findings.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 47476 Based on interview and medical record review, the facility failed to ensure the medical record was accurate for one of 24 final sampled residents (Resident 564). This failure had the potential for not able to properly obtaining consent or providing information related to care needs for this resident. Findings: Medical record review for Resident 564 was initiated on 9/24/24. Resident 564 was admitted to the facility on [DATE]. Review of Resident 564's H&P examination dated 9/12/24, under the section for the resident's decision making capability, showed Resident 564 did have and did not have the capacity to understand and make decisions. Additionally, the document showed there was a surrogate decisionmaker listed. Review of Resident 564's Consent For Treatment dated 9/12/24, showed Resident 564 signed the document consenting to be admitted and treated in the facility. However, there was no documented evidence of clarification with the physician regarding the resdient's capacity to understand and make decisions. On 9/27/24 at 1138 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed and verified the above findings. The DON stated the physician would assess the resident for the resident's capacity to make decisions. The DON verified Resident 564's H&P examination decision making capabilities should have been clarified with the physician, and stated she would need to have the physician reevaluate Resident 564.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to ensure one of three final sampled residents (Resident 59) reviewed for hospice services attained and maintained their highest practicable well-being. * The facility failed to communicate with the hospice agency regarding missing hospice aide visitations for Resident 59. This had the potential of a delay in hospice care for Resident 59. Findings: Review of the facility's P&P titled Hospice Services Facility Agreement reviewed date 1/11/24, showed the following: -The facility has a designated staff person to be responsible for working with hospice representatives to coordinate care to the resident provided by facility and hospice staff. This designee (a) has a clinical background, (b) functions within their state's scope of practice, and (c) has the ability to assess the resident or have someone that has a skill and capabilities to assess the resident; and -The designated member of the facility working with hospice representative is responsible for communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family. Review of the facility's contract with Hospice Provider A dated 3/30/19, showed the following: - Under Article II, Responsibilities of Hospice, Coordination of Services section, showed for each hospice resident in the facility, the hospice interdisciplinary group shall maintain responsibility for directing, coordinating, and supervising the hospice care and hospice services provided under this agreement, and require all care and services provided to hospice resident shall be provided in accordance with the hospice plan of care, based on all hospice assessments of the resident and family needs; - Under Article III, Responsibilities of Facility, Administration section, showed the facility shall designated a member of the facility's IDT who is responsible for working with hospice to coordinate care provided by facility staff and hospice staff to any hospice resident. Such IDT member must have a clinical background, functions within their state's scope of practice, and has the ability to assess the hospice resident or have someone that has a skill and capabilities to assess the hospice resident; and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Under Article V, Records, Maintenance and Retention of Records section, showed the facility and hospice shall each prepare and maintain complete and appropriate clinical records concerning each hospice resident in the facility in accordance with prudent record keeping procedures, their own P&P, applicable federal and state law regulations, and applicable Medicare and Medicaid program guidelines. Medical record review for Resident 59 was initiated on 9/24/24. Resident 59 was admitted to the facility on [DATE]. Review of the Order Summary Report showed the following physician's orders dated: - On 1/11/24, for Resident 10 to be admitted to hospice services under routine level of care; - On 7/26/23, for hospice aide visits twice per week for ADL cares; and - On 8/2/23, for CNA staff and hospice CNA to offer exercises during care for comfort and maintenance as tolerated daily. Review of the facility's document titled Master Calendar 7/10/24, showed for the week of 6/30 to 7/6/24, the hospice aide was scheduled to visit on 7/2 and 7/4/24. Review of the facility's document titled Client Calendar Report dated 7/17/24, showed the following: - For the week of 8/11 to 8/17/24, the hospice aide was scheduled to visit on 8/13 and 8/15/24; - For the week of 9/8 to 9/14/24, the hospice aide was scheduled to visit on 9/10 and 9/12/24; and - For the week of 9/15 to 9/21/24, the hospice aide was scheduled to visit on 9/17/24. Review of the facility's document titled Client Calendar Report dated 9/17/24, showed for the week of 9/15 to 9/21/24, the hospice aide was scheduled to visit on 9/18/24. Review of the facility's document titled Coordination of Care showed the following: - For the week of 6/30 to 7/26/24, the hospice aide visited Resident 59 on 7/2/24 (one hospice aide visit was missing); - For the week of 8/11 to 8/17/24, the hospice aide visited Resident 59 on 8/15/24 (one hospice aide visit was missing); - For the week of 9/8 to 9/14/24, there was no documentation the hospice aide visited Resident 59 (two hospice aide visits were missing); and - For the week of 9/15 to 9/21/24, there was no documentation the hospice aide visited Resident 59 (two hospice aide visits were missing. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 59's medical record did not show any other documentation the facility coordinated with the hospice agency regarding the missing hospice aide visits for Resident 59. On 9/26/24 at 0827 hours, an interview and concurrent medical record review for Resident 59 was conducted with RN 1. When asked about the hospice aide visits for Resident 59, RN 1 stated the hospice aide documented in the Coordination of Care form when they visited Resident 59. RN 1 stated the social services department coordinated the care with the hospice agency. RN 1 verified there was only one hospice aide visit to Resident 59 during the weeks of 6/30 to 7/26/24, and 8/11 and 8/17/24. RN 1 also verified there was no hospice aide visit for Resident 59 during the weeks of 9/8 to 9/14/24, and 9/15 to 9/21/24. On 9/26/24 at 1327 hours, an interview for Resident 59 was conducted with the SSD. When asked about Resident 59's hospice services, the SSD stated he was the hospice coordinator but had never met the resident. When asked about the hospice aide visits for Resident 59, the SSD stated the nursing department checked on the hospice aide visits. On 9/27/24 at 1100 hours, an interview for Resident 59 was conducted with the DON. The DON verified the findings. When asked if the facility's designated hospice coordinator had a clinical background, functions within their scope of practice, and was able to assess the resident, the DON stated the IP was the hospice coordinator. When asked about the hospice aide visits for Resident 59, the DON stated the facility conducted a weekly IDT meeting but did not discuss the missing hospice aide visits for Resident 59. On 9/27/24 at 1145 hours, an interview for Resident 59 was conducted with the IP. The IP stated she was one of the facility's designated hospice coordinators. When asked about the hospice aide visits for Resident 59, the IP stated if there were missing hospice aide visits, then they would have to call the hospice agency. When asked if she had followed up regarding the missing hospice aide visits for Resident 59, the IP answered no.

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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 P&P review, and facility document 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 show documentation of the Legionella (a bacteria that can cause a serious type of lung infection) facility risk assessment, control measures, and Legionella testing protocols. * CNAs 11 and 12 failed to wear proper PPE before providing care to Resident 34 in his room who was in EBP. In addition, CNAs 11 and 12 failed to perform hand hygiene before providing care to Resident 34. * The facility failed to ensure employee personal items were not stored in the clean laundry area. * The facility failed to ensure the visitors observed contact isolation precaution practices while inside Resident 109's room. * The facility failed to ensure CNA 14 changed gowns in between two residents These failures had the potential to result in the transmission of infection to a vulnerable population of residents in the facility. Findings: 1. 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 7/6/18, 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Water Management dated 3/31/22, showed it was the policy of the facility to establish water management plans for reducing the risk of Legionella and other opportunistic pathogens (e. g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) in the facility's water system. Further review of the P&P showed following: - Assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facilities water system. Based on the risk assessment control points will be identified. - Control measures will be applied to address potential hazards at each control point. A variety of [NAME] may be used, including physical controls, temperature management, disinfectant level control, visual inspection, or environmental testing for pathogens: - Testing protocols and control limits will be established for each control measure: a. Individuals responsible for testing or visual inspection will document findings. b. When control limits are not maintained, collective actions will be taken and documented accordingly. c. Protocols and corrective actions will reflect current industry guidelines (i.e., ASHRAE, OSHA, CDC). On 9/26/24 at 1629 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the facility did not conduct a facility risk assessment for Legionella and other opportunistic waterborne pathogens. The Maintenance Supervisor verified the facility did not have documented evidence if the facility had control measures and testing protocols for the prevention of Legionella and other opportunistic waterborne pathogens. The Maintenance Supervisor further stated the facility had two decorative water fountains and he used chlorine tablets to disinfect the decorative water fountain. When the Maintenance Supervisor was asked if he had any documentation and record of using chlorine on the decorative water fountain, he was not able to provide. On 9/26/24 at 1635 hours, an interview was conducted with the Administrator. The Administrator verified and acknowledged the above findings. 2.a. Review of the CMS's QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes dated 3/20/24 and effective 4/1/24, showed, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The QSO further showed EBP recommendations now include use of EBP for the residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CDC guidance titled Frequently Asked Questions about Enhanced barrier Precautions in Nursing Homes dated 6/6/24, showed the presence of an indwelling device is a major risk factor for being colonized with or acquiring MDRO. Therefore, the safest practice would be to wear a gown and gloves for any care (e.g. dressing changes) or use of the indwelling medical device. Further review of the CDC guidance showed EBP should be followed when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, especially when anticipating close physical contact while assisting with transfers and mobility. On 9/26/24 at 1234 hours, CNAs 11 and 12 were observed entering the room of Resident 34. CNAs 11 and 12 were observed wearing gloves and providing care to Resident 34. CNAs 11 and 12 were observed not wearing gown before providing care to Resident 34. The signage outside Resident 34's room showed EBP. On 9/26/24 at 1240 hours, an interview was conducted with CNAs 11 and 12. CNAs 11 and 12 verified the above observations. CNA 12 stated she and CNA 11 entered the room to reposition Resident 34 in bed to prepare him for lunch. CNAs 11 and 12 verified Resident 34 was in EBP. When CNAs 11 and 12 were asked regarding PPEs required before providing care to the resident in EBP, CNA 12 stated gown and gloves were required to provide direct care to Resident 34. CNA 12 further stated repositioning resident in bed was not direct care, so she and CNA 11 did not wear gown before providing care to Resident 34. Medical record review for Resident 34 was initiated on 9/26/24. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's Order Summary Report for September 2024 showed a physician's order dated 9/16/24, for Foley catheter to drainage bag for urinary retention. On 9/27/2 at 1212 hours, an interview was conducted with the DON. T he DON was informed of the above findings. The DON stated the staff should have worn gown in addition to the gloves while repositioning Resident 34 in his room to prepare him for lunch. The DON stated Resident 34 had a Foley catheter, so he was in EBP. The DON further stated when repositioning the residents in their room, the staff came in close contact with the residents; therefore, repositioning was considered as a high contact resident care. b. Review of the facility's P&P titled Hand Hygiene dated 10/21/23, showed healthcare community will take every precaution to prevent the spread of infection by using proper hand hygiene techniques at all times. Transmission of healthcare acquired pathogens from one person to another via the hands of the healthcare worker required four elements: - Organisms present on the resident skin or shed onto inanimate objects immediately surrounding the resident. - Organisms must be capable of surviving for at least several minutes on the hands of healthcare workers. - Hand hygiene or hand antisepsis must be inadequate or omitted altogether. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Contaminated hands of the caregiver must come in direct contact with another resident or with an inanimate object that will then come in contact with the resident. Further review of the facility's P&P showed hand hygiene requirement which included before and after contact with residents, before performing a resident care ADL procedure, and after removal of gloves if worn. On 9/26/24 at 1234 hours, CNAs 11 and 12 were observed entering the room of Resident 34. CNAs 11 and 12 were observed wearing gloves and providing care to Resident 34. CNAs 11 and 12 were not observed performing hand hygiene before donning gloves and providing care to Resident 34. On 9/26/24 at 1240 hours, an interview was conducted with CNAs 11 and 12. CNAs 11 and 12 verified the above observations. CNAs 11 and 12 acknowledged they should have performed hand hygiene before donning gloves to provide care to Resident 34. On 9/26/24 at 1254 hours, an interview was conducted with the IP. The IP was informed of the above findings. The IP stated the CNAs should have performed hand hygiene before donning gloves to provide care to Resident 34. The IP further stated gloving did not replace hand hygiene. 3. Review of the facility's P&P titled Handling Clean Linen Policy dated 10/19/23, showed the facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. Further review of the P&P showed linen can become contaminated with pathogens from contact with intact skin or body surfaces, or from environmental contaminants or contaminated hands. On 9/6/24 at 1316 hours, an observation of the laundry area and concurrent interview was conducted with the Housekeeping Supervisor. A laundry aid was observed folding linens on the table in the clean laundry area with employee personal items, including two water bottles and two employee purses on the table. The Housekeeping Supervisor verified the observations and was observed instructing the laundry aid to remove employee personal items from the clean laundry area. On 9/26/24 at 1339 hours, an interview was conducted with the IP. The IP was informed of the above observations. The IP stated the employee should not have stored their personal items in the clean laundry area. The IP acknowledged the above findings. On 9/27/24 at 1212 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39453 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. According to CDC, for Precautions to Prevent Transmission of Infectious Agents, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), contact precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. Review of the facility's document titled Contact Precautions (undated) showed anyone entering this room must follow the following precautions: - Hand hygiene before and after entering/exiting the room; - Gloves prior to entering the room; and - Gown prior to entering the room. Medical record review for Resident 109 was initiated on 9/24/24. Resident 109 was admitted to the facility on [DATE]. Review of Resident 109's Order Summary Report for September 2024 showed a physician's order dated 9/23/24, to place resident on contact isolation precaution every shift for ESBL (extended-spectrum beta-lactamase, enzymes found in strains of bacteria that are resistant to common antibiotics) in urine. On 9/27/24 at 1035 hours, a contact precaution signage was observed posted outside Resident 109's room alerting everyone to clean hands before room entry and when exiting, and to wear gown and gloves on room entry. A hand sanitizer dispenser and a cart containing gowns and gloves were observed outside the room. Two visitors without any PPE were observed inside Resident 109's room. On 9/27/24 at 1038 hours, an observation for Resident 109 and concurrent interview was conducted with the IP. The IP verified the two visitors without PPE were inside Resident 109's room. The IP stated the visitors did not have to wear PPE because they were not touching Resident 109. On 9/27/24 at 1100 hours, an interview was conducted with the DON. When asked about their contact isolation practices, the DON stated when the staff only answered the call light with no direct contact with the resident, the staff did not need to wear PPE, because it was only for a few minutes. The DON stated the visitors, however, needed to wear gown and gloves when inside the room on contact isolation, because they stayed in the room longer and there was a possibility for them to touch the resident. 5. According to CDC's The Basics of Standards Precautions (undated) showed to wear a gown when contact between clothing or skin with resident blood or body substances is expected, and to not wear the same gown between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/24 at 0953 hours, an EBP signage was observed posted outside Room A alerting everyone to clean hands before entering and when leaving the room. The signage also showed the providers and staff to also wear gloves and gown for high-contact resident care activities. A yellow sticker was observed by Resident 414's name (on Bed B) on the wall. CNA 14 was observed inside Room A wearing a mask, gown, and gloves, and was changing linen of Bed A. After changing the linen, CNA 14 was observed doffing her gloves and donning new pair of gloves and went to assist Resident 414. CNA 14 was observed using the same gown. On 9/27/24 at 1020 hours, an observation for Room A and concurrent interview was conducted with CNA 14. CNA 14 verified the above findings. CNA 14 acknowledged she only changed her gloves but used the same gown to change the linen of Bed A, then assisted Resident 414. On 9/27/24 at 1023 hours, an interview was conducted with the IP. The IP stated the yellow sticker meant the resident in the room was on EBP. The IP stated the staff needed to do hand hygiene when entering the room. The staff cannot wear the same gown in caring for different residents and should change their gown in between the residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, facility P&P review, and facility document review, the facility failed to monitor and address the use of antibiotics when the resident's condition did not meet the McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) for two of five nonsampled residents reviewed for infection prevention (Residents 40 and 64). This failure 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 Antimicrobial Stewardship dated 10/25/23, under the Actions section showed the facility specific procedures to improve antibiotic use according to the best practice, assess resident timely as symptoms appear utilizing McGeer's criteria for infection, perform appropriate diagnostic testing for a specific infection if indicated, and if resident is asymptomatic contact provider to discuss stopping of antimicrobial. a. Medical review for Resident 40 was initiated on 9/27/24. Resident 40 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility's document titled Infection Control Surveillance dated August 2024 showed Resident 40 was prescribed Keflex (antibiotic) 500 mg every eight hours for five days. Further review of the Infection Control Surveillance showed Resident 40 had no urinary symptoms and did not meet the McGeer's criteria for infection. Review of the Resident 40's McGeer's criteria for Urinary Symptoms dated 8/25/24, showed no symptoms. Further review of the document showed the infection did not meet the McGeer's criteria. Under the section for the medical physician's signature showed no entry. Further review of the medical record for Resident 40 failed to show the physician was notified of the infection that did not meet the McGeer's criteria. b. Medical record review for Resident 64 was initiated on 9/27/24. Resident 64 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility's document titled Infection Control Surveillance dated August 2024 showed Resident 64 was prescribed cefpodoxime (antibiotic) 100 mg two times a day for seven days. Further review of the Infection Control Surveillance showed Resident 64 had no urinary symptoms and did not meet the McGeer's criteria for infection. Review of the Resident 64's McGeer's criteria for Urinary Symptoms dated 8/23/24, showed no urinary symptoms. Further review of the document showed the infection did not meet the McGeer's criteria. Under the section for the medical physician's signature showed no entry. Further review of the medical records for Resident 64 failed to show the physician was notified of the infection that did not meet the McGeer's criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 0907 hours, an interview was conducted with the IP. The IP was asked about the facility's antibiotic stewardship program. The IP stated the facility used the McGeer's criteria. The IP stated if a resident did not meet the criteria for an infection using McGeer's criteria, the physician would be notified. On 9/27/24 at 1009 hours, a concurrent interview and medical record review for Residents 40 and 64 was conducted with the IP. The IP verified the above findings. When asked for the IP to show the documentation if the physician had been notified when the infection criteria were not met for Residents 40 and 64, the IP reviewed the medical records for Residents 40 and 64 and stated she was unable to provide the documentation. On 9/27/24 at 1212 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five residents reviewed for immunization (Resident 50) received the influenza vaccine and failed to ensure the risks and benefits of the influenza vaccination were reviewed with the resident and/or resident representative when influenza vaccine was refused. These failures had the potential for the resident and/or their representative not being informed of influenza vaccine, the benefits and risks of influenza vaccination to make an informed decision. Findings: Review of the facility's P&P titled Influenza Vaccination dated 10/22/23, showed it is the facility policy to offer residents, staff member, and volunteer worker annual immunization against influenza. Annually during influenza season, residents staff members and volunteer workers will be offered an influenza vaccination unless such immunization is medically contraindicated, or the individual has already been immunized during this time period. Further review of the P&P showed individuals being offered the influenza vaccine, or their legal representative, will be required to sign a consent form or declination form prior to the administration or refusal of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record. Medical record review for Resident 50 was initiated on 9/27/24. Resident 50 admitted to the facility on [DATE]. Review of the Resident 50's H&P examination dated 11/30/23, showed Resident 50 did not have the capacity to understand and make decisions. Review of Resident 50's Immunization Informed Consent dated 9/5/24, showed Resident 50's representative was contacted on 9/5/24, and refused influenza vaccination for Resident 50. Further review of the document did not show the signature of Resident 50 and/or resident representative, the time when the resident representative was contacted, and if risk and benefit of influenza vaccination was provided. There was no entry under the section to document how the consent was obtained. Review of the Resident 50's Progress Notes showed the following: - On 11/27/23 at 1224 hours, the resident representative for Resident 50 was contacted regarding flu vaccine, but the call was not answered and left a voice message. - On 3/6/24 at 1400 hours, the resident representative for Resident 50 was contacted again to obtain consent for flu vaccine, but the call was not answered and left a voice message. Review of Resident 50's medical record failed to show if Resident 50 and/or their resident representative was provided with the risk and benefits of influenza vaccination for flu season 2024/2025, when the resident representative refused influenza vaccination for Resident 50 on 9/5/24. Furthermore, the medical record did not show if the facility had further followed up with the resident representative to provide influenza vaccination for Resident 50 for influenza season 2023/24. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 0827 hours, a concurrent interview and medical record review for Resident 50 was conducted with the IP. The IP verified the above findings. The IP was not able to show documented evidence if Resident 50 received influenza vaccine for influenza season 2023/24. The IP stated she should have followed up more with the resident representative to provide influenza vaccination for Resident 50 for influenza season 2023/24. The IP further stated she was not able to show if the resident representative of Resident 50 was provided with the risk and benefits of influenza vaccination when the resident representative refused influenza vaccination for Resident 50 for influenza season 2024/25. On 9/27/24 at 1212 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and facility document review, the facility failed to maintain essential kitchen equipment in safe operating condition. * The facility failed to ensure the dish machine in kitchen was working. * The facility failed to ensure the digital thermometers used in the kitchen were calibrated. These failures had the potential for the equipment to not function in the way it was intended, which could cause food borne illnesses for the residents. Findings: Review of the facility's Diet Type Report dated 9/24/24, showed 116 of 121 residents residing in the facility received foods prepared in the kitchen. According to USDA Food Code 2022, Section 4-501.11, Good Repair and Proper Adjustment, showed the proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. Review of the facility's P&P titled Dishwashing dated 2023 showed the following; - All dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order; - The dish machine is to be serviced on a regular basis by a technician to ensure accurate measurements of sanitizing agents; - A temperature log and chlorine log for low-temperature machines will be kept and maintained by the dishwashers to assure that the dish machine is working properly. This log will be completed each meal prior to any dishwashing; and - For low temperature machine: if the facility does not have the manufacturer's recommendations, use the machine at a range of 120 degrees F to 140 degrees F. The chlorine should read 50-100 ppm on dish surface in final rinse. The proper chlorine level is crucial in sanitizing the dishes. If the proper temperature or chlorine level is not achieved, resort to the manual method of dishwashing. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 9/26/24 at 0926 hours, an observation of the dish machine and concurrent interview were conducted with Dining Assistant 3 and the DSS. When asked to perform the chlorine test for the dish machine, Dining Assistant 3 was observed dipping the chlorine test strip into the dish surface on the final rinse. The testing strip color changed into a very light purple, and only read 10 ppm (parts per million). Dining Assistant 3 repeated the steps several times to different parts of the dish surface, and the strip color still changed into a very light purple, and the strip only read 10 ppm. The DSS was observed checking the hoses connected to the bottles of detergent and sanitizer. The DSS verified the dish machine was not working and would have to call the technician. When asked when the last chlorine test for the dish machine was done, Dining Assistant 3 stated he performed the chlorine test for the dish machine in the morning. When asked where it was documented, Dining Assistant 3 stated he did not document because the log was missing. When asked what the chlorine test reading for the dish machine in the morning, Dining Assistant 3 stated it was a light purple, and about the same color as the chlorine test now. When asked if he reported the result of the light purple chlorine test for the dish machine in the morning, Dining Assistant 3 answered no. Review of the facility's document titled Culinary Operations for Dish Machine Temperature Log for September 2024 showed the temperature and chlorine levels were not documented on 9/25/24 in PM, and on 9/26/24 in AM. The DSS verified the above findings. On 9/26/24 at 0955 hours, an observation of the dish machine and concurrent interview was conducted with the RD. The RD was informed of the findings. The RD was observed dipping the chlorine test strip into the dish surface on the final rinse, and the testing strip color changed into a very light purple, and still read 10 ppm. The RD verified the dish machine was not working properly. The RD stated the DSS would have to call the technician to fix the dish machine. 2. Review of the facility's P&P titled Thermometer Use and Calibration dated 2023 showed the following: - Food thermometers are to be used properly and calibrated to ensure accurate temperature reading; - Food thermometers are to be calibrated each week, after one is dropped, or when a thermometer is new. It is recommended to put thermometer calibration on a cook's duties/ sanitation list; and - For digital thermometers, follow manufacturer's instructions. There is generally a reset button on the face of the thermometer that when pressed will recalibrate to 32 degrees F. If the thermometer cannot be reset to read 32 degrees F, then discard the thermometer. Review of the manufacturer's manual for Powlaken Instant Read Meat Thermometer dated 2/2021 showed the following: - Thermometers should be calibrated regularly to ensure accurate temperatures; - The ice-point method is the most widely used method to calibrate a dial and digital thermometer; and (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For digital thermometers, with the thermometer still in ice water, push the reset button and adjust to read 32 degrees F. If there is no reset or calibration button, try changing the battery or replacing the thermometer. Review of the manufacturer's manual for [NAME] 9840 instant digital thermometer dated 5/11/24, under the Frequently Asked Questions section, showed the [NAME] 9840 instant digital thermometer typically does not have connectivity features, however, if there are issues with temperature readings, ensure the thermometer is properly calibrated and positioned. On 9/25/24 at 1139 hours, an interview was conducted with [NAME] 1 and the DSS. When asked to perform a thermometer calibration, [NAME] 1 and the DSS stated they did not have to perform a thermometer calibration because they used digital thermometers to check the food temperatures, to which they showed the Powlaken digital thermometer and [NAME] digital thermometer. On 9/26/24 at 0925 hours, an interview was conducted with the DSS. The DSS acknowledged the digital thermometers needed to be calibrated.