STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056214	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramona Rehabilitation and Post Acute Care Center	485 W. Johnston Avenue Hemet, CA 92543

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to treat resident with respect and dignity when the staff failed to cover the urinary bag, for one of one resident reviewed for dignity (Resident 53). This failure increased the potential to negatively affect Resident 53's psychosocial wellbeing. Findings: On October 21, 2024, at 3:30 p.m., Resident 53 was observed with Licensed Vocational Nurse (LVN) 1. Resident 53's urinary bag was observed attached to the resident and was filled with 300 ml (millimeter-unit of measurement) yellow liquid. The urinary bag was observed hanging below the level of Resident 53's bed. In a concurrent interview with LVN 1, she stated the staff did not cover the urinary bag with a dignity bag (used to cover urine collection bag) and was exposed. She further stated, it should have been covered, I will feel embarrassed if that bag was mine and not covered. On October 23, 2024, Resident 53's record was reviewed. Resident 53 was admitted to the facility on [DATE], with diagnoses which included obstructive uropathy (blockage in urinary tract). A review of Resident 53's History and Physical, dated March 15, 2024, indicated Resident 53 had no capacity to understand and make decisions. A review of Resident 53's Order Summary, dated July 31, 2024, indicated, .Foley catheter (tube that drains urine) 16fr/10ml (french-unit of measurement), to closed drainage system for Obstructive uropathy . On October 24, 2024, at 12:20 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated residents should be treated with respect and dignity all the time. The ADON further stated leaving the urinary bag uncovered will cause psychosocial effect to resident. She stated, it should have been covered with dignity bag. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Dignity, dated February 2021, indicated, .Residents are treated with dignity and respect at all times .The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs .Staff are expected to promote dignity and assists residents .keep urinary catheter bags covered . A review of the facility's policy and procedure titled, Resident [NAME] Of Rights, dated December 2012, indicated, .Dignity .The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure an assessment was conducted, for three of six residents (Resident 20, 30, and 33) reviewed for safe self-administration of medication when: 1. One 30 ml (milliliters - unit of measurement) cup of powder medication was found on the bedside table of Resident 20; 2. One opened tube of Desitin (brand of ointment used to prevent and treat rash) 57 GM (gram-unit of measurement) ointment was found on bedside table of Resident 30; and 3. One opened bottle of 15 ml eyedrops (medication that relieves eye irritation) was found on the overbed table of Resident 33. These failures had the potential for Residents 20, 30, and 33 to receive multiple doses of medication without proper monitoring, which could lead to harmful effects. Findings: 1. On October 21, 2024, at 9:13 a.m., during a concurrent observation and interview with Resident 20 in her room, one 30 ml cup of powder medication was observed on top of her bedside table. In a concurrent interview with Resident 20, she stated the nurse placed the medication on her bedside table this morning and then left the room. Resident 20 further stated, she put it on my bedside so I can apply it later. On October 24, 2024, Resident 20's ADMISSION RECORD, was reviewed. Resident 20 was admitted on [DATE], with diagnoses which included cerebrovascular disease (brain disease), and dysphagia (difficulty in swallowing). A review of Resident 20's Order Summary, dated August 8, 2024, indicated, Nystatin External Powder 100000 UNIT/GM (medicine used to treat skin infection), for under breast redness A review of Resident 20's Minimum Data Set (MDS - a resident assessment tool), dated August 26, 2024, indicated Resident 20 had a BIMS (Brief Interview of Mental Status) score of 14 (cognitively intact). Further review of Resident 20's medical record indicated there was no documented evidence that a self-administration assessment was conducted. On October 21, 2024, at 9:20 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 2, she stated the powder medication was Nystatin External Powder and stated, it should not be left on bed side table. LVN 2 further stated Resident 20 should have had an assessment for self-administration of Nystatin External Powder. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 23, 2024, at 9:07 a.m., Registered Nurse (RN) 2 was interviewed. RN 2 stated there was no assessment for self-administration of medications for Resident 20. RN 2 stated there was no physician order for Resident 20 to self-administer medications. RN 2 further stated if Resident 20 will continue to self-medicate, then it could lead to further issues like skin irritation or adverse effect of the medication. 2. On October 21, 2024, at 10:22 a.m., during a concurrent observation and interview with Resident 30 in his room, one opened tube of Desitin 57 GM was on bedside table. In a concurrent interview with Resident 30, he stated he administered the medication himself when he wanted to be relieved from rash. On October 24, 2024, Resident 30's ADMISSION RECORD, was reviewed. Resident 30 was admitted on [DATE], with diagnoses which included chronic kidney disease (long -term kidney damage). A review of Resident 30's History and Physical, dated May 9, 2024, indicated Resident 30 was mentally capable of understanding. Further review of Resident 30's medical record indicated there was no documented evidence that a self-administration assessment was conducted. In addition, there was no physician order for the use of the Desitin ointment. On October 21, 2024, at 10:40 a.m., during a concurrent interview and review of Resident 30's medical records with LVN 2, she stated Resident 30 had an one open tube of Desitin 57 GM at the bedside without a physician order. LVN 2 stated medication should not be kept at the bedside. LVN 2 further stated the Desitin ointment should not be applied without a physician's order and a self-administration assessment should have been made. 3. On October 21, 2024, at 10:15 a.m., during a concurrent observation and interview with Resident 33 in her room, one opened bottle of 15 ml eyedrops was found on the overbed table. Resident 33 stated she administered the medication herself when she wanted to relief from her eye irritation and itching. On October 24, 2024, Resident 33's ADMISSION RECORD was reviewed. Resident 33 was admitted on [DATE], with diagnoses which included hypertension (elevated blood pressure). A review of Resident 33's History and Physical, dated July 23, 2024, indicated Resident 33 was mentally capable of understanding. Further review of Resident 33's medical record indicated, there was no documented evidence that a self-administration assessment was conducted. In addition, there was no physician order for the use of the eyedrops. On October 21, 2024, at 10:25 a.m., during a concurrent interview and review of Resident 33's medical records with LVN 2, she stated Resident 33 did not have a physician's order for the eyedrop solution. LVN 2 further stated the eyedrop solution should have had a physician's order, and a self-administration assessment should have been completed. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 23, 2024, at 12:28 p.m. during an interview with the Assistant Director of Nursing (ADON), she stated her expectation for licensed nurses was to follow the policy and procedure regarding self-administration assessment and administration of medications for all residents. The ADON further stated if the policy and procedures were not followed, there was a potential for residents to not receive medications according to the physician's order, and to not be monitored for any adverse (negative) effects. A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, . Residents may self-administer their own medications per Self Administration Policy and Procedure . A review of the facility's policy and procedure titled, Self Administration of Medications, dated February 2021, indicated, .Residents have the right to self-administration .The resident is able to safely and securely store the medication .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge .The nursing staff routinely checks self-administered medications .

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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** 49113 Based on interview and facility policy review the facility failed to answer the call light within a reasonable time, for one of 95 residents (Resident 34). This failure had the potential to not meet the resident's needs. Findings: On October 21, 2024, at 10:05 a.m., an interview with Resident 34 was conducted. Resident 34 stated on the he could not get help for up to an hour usually during the morning shift. A review of Resident 34's electronic medical record indicated Resident 34 was admitted to the facility on [DATE], with diagnoses which include fusion of the spine (surgical process that joins vertebrae in the spine), wedge compression fracture (fracture when the front of a vertebrae collapses) of T7-T8 vertebrae, and ankylosing spondylitis (inflammatory arthritis) of thoracic region. A review of Resident 34's History and Physical, dated September 28, 2024, indicated Resident 34 was mentally capable of understanding. On October 24, 2024, 12:40 p.m., an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated everyone was responsible for answering the call lights and they should not be ignored. The ADON further stated the resident could fall if basic needs such as bowel movement, transferring, or reaching out for something were not met if call light was not answered in a timely manner. On October 23, 2024, at 12:50 p.m., an interview with the family representative (FR) was conducted. The FR stated Resident 34 was transferred to the facility on [DATE], with a fractured back, a punctured lung and was there for rehab. The FR stated Resident 34 called her and complained that the nurses do not come when he would call. The FR stated the only time the staff responded to Resident 34 was when she would call the nurse's station from home. The FR stated the husband calls for assistance with using the restroom and repositioning. The FR stated this had frustrated him. On October 24, 2024, at 3:10 p.m. observed call light in room [ROOM NUMBER] on while several staff were talking at the nurse station and Certified Nursing Assistant (CNA) 1 was walking from room to room looking in and out and did not answer the call light in room [ROOM NUMBER]. On October 24, 2024, at 3:17 p.m., an interview with CNA 1 was conducted. CNA 1 stated call lights should be answered as soon as possible, and it was everyone's responsibility to answer the call lights. CNA 1 further stated it is important to answer the call lights as soon as possible to prevent accidents. The CNA stated she heard the call light going off and she should have answered it. A review of the facility's policy and procedure titled, Call System, dated December 2016, indicated, .It is the policy of this facility to provide each resident with a call system to enable them to request assistance .Answer all call bells promptly .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on observation, interview, and medical record review, the facility failed to manage the pain, for one of three residents reviewed for pain (Resident 137), when the pain medication was not administered according to the physician's order. This failure resulted in Resident 137 not receiving the pain medication as ordered by the physician and had the potential for Resident 137 to experience pain not to be managed appropriately and affect overall health condition. Findings: On October 21, 2024, at 9:22 a.m., a concurrent observation and interview was conducted with Resident 137. Resident 137 was observed wearing a neck brace sitting at bedside and grimacing while repositioning himself. Resident 137 stated he arrived at the facility on October 16, 2024, around 5 p.m., and did not receive pain medication until the next day around 7 a.m. Resident 137 further stated he asked for pain medicine at 2 a.m., in the morning of October 17, 2024, and the nurse replied, We don't have your doctor's orders and the pain medication was not available. On October 22, 2024, at 6 p.m., during a follow up interview with Resident 137, he stated he had a pain level of nine out of 10 the previous night and was given Norco (medicine to relieve pain) 7.5-325 mg (milligram - unit of measurement) instead of Norco 10-325 mg. Resident 137 further stated the nurse told him Norco 10-325 mg was not yet delivered to the facility, and he could not get any more from the Cubix (smart cabinet holds and dispense medication) reserve. Resident 137 stated he felt his needs were not being met. On October 23, 2024, at 8:45 a.m., in a follow up interview with Resident 137, he stated his pain was not managed through the night. Resident 137 stated his order for Norco 10-325 mg for severe pain was not available to him. Resident 137 stated the night nurse told him the doctor would sign the order today. A review of Resident 137's electronic record indicated Resident 137 was admitted to the facility on [DATE], with diagnoses which included displaced fracture of second cervical vertebra (a break in the bones of the neck), contusion (injury to the skin and underlying tissue of an area of the body) left hand, fibromyalgia (widespread musculoskeletal pain), and pain in the left shoulder and left upper arm. A review of Resident 137's physician's order indicated the following orders dated October 17, 2024: - Norco 7.5-325 mg one tab by mouth every four hours as needed for moderate pain (rate of 4 to 6); and - Norco 10-325 mg one tab by mouth every four hours as needed for severe pain (rate of 7 to 10). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 137's care plan, dated October 17, 2024, indicated, .at risk for pain and discomfort r/t (related to) DX (diagnosis) .cervical fracture .fibromyalgia .Evaluate and document severity of pain and response to interventions .Medications per MD (physician) order . A review of Resident 137's Medication Administration Record, for the month of October 2024, indicated Norco 7.5-325 mg was administered to Resident 137 with a pain rating of severe pain on the following dates and times: - October 20, 2024, at 2:05 p.m.; pain rate of 8; - October 20, 2024, at 11:53 p.m.; pain rate of 9; - October 21, 2024, at 4:25 p.m.; pain rate of 7; - October 21, 2024, at 8:25 p.m.; pain rate of 7; - October 22, 2024, at 9:57 a.m.; pain rate of 9; and - October 22, 2024, at 10:20 p.m.; pain rate of 10. A review of the pharmacy document indicating the times Norco 10-325 mg was pulled out from the Cubix reserve for Resident 137 did not indicate Norco 10-325 mg was taken from the Cubix on the above dates when the resident's pain level was severe (7 to 10 pain rate). On October 23, 2024, at 8:37 a.m., LVN 2 was interviewed. LVN 2 stated Resident 137 had stated to her that his pain was not being managed effectively in the facility, and he did want to experience severe pain while in the facility. LVN 2 stated she did not offer any alternative pain management measures and was not able to administer any Norco 10-325 mg to the resident throughout her shift on October 22, 2024, since the resident's medication supply had not yet been delivered. LVN 2 stated the medication should have been available, and the resident not having his pain medication could prevent him from resting and being comfortable. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 23, 2024, at 3:35 p.m., an interview with Licensed Vocational Nurse (LVN) 3 was conducted. LVN 3 stated she cared for Resident 137 since October 21, 2024. After assessing Resident 137, she gave him Norco 10-325 mg around 8:30 a.m. LVN 3 stated at the end of the shift, she endorsed to the oncoming night nurse that there was one Norco 10-325 mg available for the resident, and she had submitted an electronic refill order to the pharmacy for the medication. LVN 3 stated she returned to work on the morning of October 22, 2024, and at the change of shift, the outgoing night nurse endorsed to her that there was no more Norco 10-325 mg available for Resident 137. LVN 3 stated Registered Nurse (RN) 1 was able to request a code from the pharmacy to pull the Norco 10-325 mg from the Cubix at the end of the shift, which LVN 3 used to remove the medication and administer to Resident 137. LVN 3 stated she passed on the code to the next shift because there was still one dose available for the resident. When asked about the facility's process for pain management, LVN 3 stated staff would assess the resident's pain level and offer medication according to the physician's order, then re-assess within the hour to see if the medication was effective. LVN 3 stated she would contact the physician if the pain medication was ineffective. LVN 3 stated Resident 137 had mentioned to her that the Norco 7.5-325 mg was ineffective and required the Norco 10-325 mg dose instead for better pain control. LVN 3 stated Resident 137's pain should be managed, but it was not currently being managed appropriately. On October 23, 2024, at 4:19 p.m., a concurrent review of Resident 137's MAR was conducted with RN 1. RN 1 stated Norco 7.5-325 mg (moderate pain) was administered to Resident 137 for severe pain instead of administering Norco 10-325 mg. RN 1 stated Resident 137 should have received Norco 10-325 mg for severe pain. RN 1 stated residents with orders for narcotics were entered into the electronic system and the orders faxed to the pharmacy. RN 1 stated the pharmacy would then verify with the physician and obtain the physician's signature to authorize the pharmacy to dispense the narcotic medication. RN 1 stated medications were usually filled within six to eight hours and if the medication was not delivered within 24 hours, the licensed staff would follow up with the pharmacy. RN1 stated further stated the pharmacy could also provide a code for the licensed staff to access the Cubix and remove the narcotic medication from the reserve storage when the medication is still not available. RN 1 stated she did not know why Resident 137 was not medicated with the Norco 10-325 mg when it was available in the Cubix. RN 1 further stated Resident 137's pain should have been managed. A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated, .Medications are administered in accordance with the prescriber orders, including any required time frames . A review of facility's policy and procedure titled, Pain Assessment and Management, revised dated March 2020 indicated, . the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of plan, based on professional standards of practice, the comprehensive care plan and the resident's choices related to pain management .Implementing Pain Management Strategies . Implement the medication regimen as ordered, carefully documenting the results of the interventions

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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** 49113 Based on observation, concurrent interview, and record review, the facility failed to monitor for anticoagulant (medication that treats blood clots) use, for one of two residents reviewed (Resident 138), when Resident 138 was observed to have multiple bruises on both arms. This failure resulted in Resident 138 not being monitored for potential harmful side effects of anticoagulants. Findings: On October 22, 2024, at 2:45 p.m., a concurrent observation and interview with Resident 138 was conducted. Resident 138 was observed with multiple scattered purple and red discolorations on both arms. Resident 138 stated he was on blood thinner and was not given instructions or teaching on monitoring for signs and symptoms of bleeding. On October 22, 2024, a review of Resident 138 electronic medical record indicated Resident 138 was admitted to the facility on [DATE], with diagnoses which included acute embolism and thrombosis of deep veins (condition blocking blood flow in veins and arteries) of the left lower extremity, and history of long term use of anticoagulants. A record review of Resident 138's Order Summary Report, included a physician's order, dated October 17, 2024, which indicated Resident 138 was on apixaban (blood thinner) 5 (five) mg (milligram - unit of measurement) 1 (one) tablet by mouth 2 (two) times a day. A record review of Resident 138's Nursing Admission Screening/History, dated October 17, 2024, indicated no skin issues. A record review of Resident 138's care plan, initiated on October 18, 2024, indicated Resident 138's skin integrity was at risk related to anticoagulant use. A record review of Resident 138's Progress Notes, dated October 18, 2024, indicated Licensed Vocational Nurse (LVN) 7 did a follow up skin assessment. LVN 1 documented Resident 138 had purple discoloration to left inner arm, right elbow, redness to the abdominal fold and both wrist. On October 24, 2024, at 8:45 a.m. an observation, concurrent interview, and record review with LVN 8 was conducted. LVN 8 stated Resident 138 was on apixaban 5mg. Stated she did not notice the bruising on Resident 138's arms. LVN 8 further stated there was no monitoring of Resident 138 for anticoagulant use. LVN 8 stated there should be monitoring for adverse affects from anticoagulant use. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 24, 2024, at 9:05 a.m., an observation, concurrent interview, and record review with Registered Nurse (RN) 1 was conducted. Observed Resident 138's right upper arm with purple and red discolorations on both lower arms. RN 1 stated Resident 138 did not have an order to monitor for signs and symptoms of bleeding nor was baseline labs ordered. RN 1 further stated Resident 138 should be monitored for signs and symptoms of bleeding or bruising. Stated nursing should monitor residents on anticoagulants because they need to know if they were experiencing any signs or symptoms of bleeding such as nose bleeds or bruising. RN 1 stated the licensed nurse who identifies the change in skin condition would be responsible for initiating a change of condition and notifying the physician. RN 1 stated there was no change of condition documented. RN 1 stated the Certified Nursing Assistant (CNAs) and licensed nurses are responsible for daily assessing the residents. On October 24, 2024, at 12:01 p.m. an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated the facility's process was to identify patient with anticoagulant therapy and verify the order. The ADON stated licensed nurses make sure there is a care plan regarding the order and the importance and reason for the care plan was if a patient is at risk; skin discoloration could be from bleeding if on anticoagulants. The ADON further stated the CNA was responsible for monitoring all patient for change in skin condition when doing Activities of Daily Living (ADL) and showers by looking for skin discolorations, any breakdown, or any tears. The CNA must notify the licensed nurse of any skin changes. The ADON stated the licensed nurse must assess and do an SBAR if it was a new issue. The ADON stated the licensed nurse must notify the doctor for further orders. On October 24, 2024, at 12:18 p.m. a follow up interview with Resident 138 was conducted. Resident 138 stated no one has reassessed his skin. On October 24, 2024, at 12:18 p.m. a follow up interview with the ADON was conducted. The ADON stated there was no new skin changes documented on shower days since October 18, 2024 for Resident 138. The ADON stated there was no documented information of new bruising was noted for Resident 138. The ADON stated no prior labs was ordered and there were no current orders. The ADON stated Resident 138 should have been monitored for any adverse effects of anticoagulant use. A review of the facility's policy and procedure titled, Anticoagulation - Clinical Protocol, revised and dated November 2018, indicated, .As a part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulant; for example, those with recent history of deep vein thrombosis (DVT), . Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications .The staff .will monitor for possible complications in individuals who are being anticoagulated and will manage related problems .If an individual on anticoagulant therapy shows signs of excessive bruising, hematuria, hemoptysis (blood mixed with sputum), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next schedule dose of anticoagulant .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40988 Based on observation, interview, and record review, the facility failed to ensure expired, discontinued, and unlabeled medications and intravenous (IV- into the vein) fluids were not readily available for use. These failures have the potential for the residents to receive wrong, contaminated, expired, or ineffective medication therapy. Findings: 1a. On October 23, 2024, beginning at 3:27 p.m., an inspection of the Station 4 Medication Cart (Med Cart) was conducted with Licensed Vocational Nurse (LVN) 9. The following medications were found expired and kept stored in the second left drawer of Med Cart 4: - One tablet ondansetron (medication for nausea/vomiting) 4 mg (milligrams- unit of measurement) tab (tablet), labeled for Resident 31, with an expiration date of March 18, 2024; - Eight tablets of Clonidine (a blood pressure medication) 0.1 mg tab, labeled for Resident 12, with an expiration date of October 2, 2024; - 25 tablets of ondansetron tab 4 mg, labeled for Resident 19, with an expiration date of October 1, 2024; - Three tablets hyoscyamine (medication that reduces secretions) 0.125 tab SL (sublingual- under the tongue), labeled for Resident 19, with an expiration date of October 10, 2024; - 29 tablets of Chest Conges Tab (medication for nasal drip) 400 mg, labeled for Resident 3, with an expiration date of April 26, 2024; and - Four tablets ondansetron tab 4 mg, labeled for Resident 1, with an expiration date of September 17, 2024. In a concurrent interview, LVN 9 stated the medications were expired and should have already been removed from the cart, to prevent the medications from being incorrectly given to residents and cause potential harm to them. LVN 9 stated expired medications have decreased efficacy after their expiration dates. LVN 9 further stated it was the nurses' responsibility to ensure all expired medications were removed from the Med Cart, and discarded in the incinerator bin following facility protocol. 1b. On October 23, 2024, beginning at 4:57 p.m., an inspection of the Station 3 Med Cart was conducted with LVN 10. The following medications were found expired and kept stored in the second left drawer of Med Cart 3: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Two capsules dicyclomine (medications for stomach cramps) 10 mg, labeled for Resident 2, with an expiration date of August 20, 2024; and - Nine tablets ondansetron tab 4 mg, labeled for Resident 2, with an expiration date of October 6, 2024. In a concurrent interview and review of Resident 2's electronic health record, LVN 10 stated she thought Resident 2 was not receiving dicyclomine anymore. LVN 10 verified the medication was expired and discontinued, and stated the medication should have been taken out of the Med Cart. LVN 10 verified ondansetron was expired, had also been discontinued, therefore the medication should not have been in the Med Cart. LVN 9 further stated expired and discontinued medications got wasted (discarded) in the medication storage room. LVN 10 stated the medication stickers are to be removed and pasted on the medication disposition form in the binders, and all these medication got popped out, and put in the incinerator box to be wasted. On October 24, 2024, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated it was her expectation that anything expired should be removed from the Med Carts and the nurses were responsible for checking their own carts to make sure there were no expired medications available in the carts. The ADON stated expired and discontinued medications should not have been in the Med Carts and should have been removed from the carts and destroyed (discarded). A review of the facility's undated policy and procedure titled, FACILITY AUDITING AND REMOVAL OF EXPIRED AND DISCONTINUED MEDICATIONS, indicated, .The medication nurses will remove expired medications from the drug storage areas so that they are not administered to residents .The facility staff will remove expired medications from the medication storage areas on a regular schedule and when encountered .At least once monthly the nurse responsible for the medication cart for each station will inspect the medication cart and medication room for expiring medications . A review of the facility's policy and procedure titled, Storage of Medications, dated November 2020, indicated, .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed . 41459 2a. On October 24, 2024, at 11:30 a.m., an inspection of the Station 1 Medication Storage Room was conducted with Registered Nurse (RN) 1. The following was found: - One bag of 1000 ml (milliliter- unit of measurement) of Dextrose (a sterile solution used to provide your body with extra water and calories from sugar)10% IV was unlabeled and readily available for use. In a concurrent interview, RN 1 stated there should be a label on the IV bag. 2b. On October 24, 2024, at 11:39 a.m., an inspection of the Station 2 Medication Storage Room was conducted with Registered Nurse (RN) 1. The following was found: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One multi-dose vial of Tubersol injection (aids in the diagnosis of tuberculosis [a bacterial infection that affects the lungs]), with an open date of September 20, 2024, was found stored in the small medication refrigerator, four days over the expiration date, readily available for use. In a concurrent interview with RN 1, RN 1 stated medication multi-dose vials were to be disposed of 30 days after opening. RN 1 further stated the medication vial of Tubersol was labeled with an open date of September 20, 2024, and should not have been in the refrigerator for continued use, since it was over the 30 day timeframe. A review of the facility's policy and procedure titled, Storage of Medication revised November 2020, indicated, .Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for prober labeling before storing . A review of the policy and procedure titled, Administering Medications, revised April 2019, indicated, .The expiration beyond use date on the medication label is checked prior to administering. When opening a mulit-dose container, the date opened is recorded on the container .the medication nurse will remove expired medications from the drug storage areas so that they are not administered to residents .the facility staff will remove expired medications from the medication storage areas on a regular schedule and when encountered . According to the webarticle published by DailyMed, indicated, .STORAGE .A vial of TUBERSOL which has been entered and in use for 30 days should be discarded .

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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. 41459 Based on observation, interview, and record review, the facility failed to ensure safe storage practices were followed in the kitchen when: - One seven-pound (lb- unit of measurement) can of cranberry jelly was found in the dry storage area undated; - Two stalks of celery in a plastic bag were found in the walk-in refrigerator with the bag open exposing the celery to air; and - Five three-lb bars of chopped spinach were found in the freezer not dated. These failures had the potential to cause food-borne illnesses in a highly susceptible resident population. Findings: On October 21, 2024, at 9:00 a.m., an initial kitchen tour was conducted with the Dietary Manager (DM). The following were observed: - One seven-lb can of cranberry jelly was found in the dry storage area undated; - Two stalks of celery in a plastic bag were found in the walk-in refrigerator with the bag open exposing the celery to air; and - Five three-lb bars of chopped spinach were found in the freezer not dated. On October 21, 2024, at 9:22 a.m., a concurrent interview was conducted with the DM. The DM stated all food items should be dated prior to placing the items in the pantry or other storage areas. The DM stated no food should be open to air, and all food items should be dated when received. A review of the facility's policy and procedure titled, Labeling and Dating of Food, revised 2023, indicated, . food delivered to the facility needs to be marked with a received date .Newly opened food items will need to be closed and labeled with an open date and use by the date .Produce is to be dated with received date .

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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** 50204 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Certified Nursing Assistant (CNA) 2 did not use personal protective equipment (PPE - equipment use to protect against infection or illness) when providing care to a resident requiring enhanced barrier precautions (EBP-an infection control intervention to reduce transmission of multidrug-resistant organisms [MDRO-bacteria that have become resistant to multiple antibiotics]); 2. The Laundry Staff (LS) failed to follow proper handling and storage of clean linens; 3. The Certified Occupational Therapy Assistant (COTA - healthcare provider who performs physical movement) did not conduct proper handwashing before and after providing therapy treatment to a resident; 4. The facility staff failed to ensure the nebulizer treatment tube (a plastic device that delivers air and medicine through a tube for breathing treatment) was changed according to the physician's order; and 5. Two direct care staff were observed wearing long artificial nails while providing care to the residents. These failures increased the potential for the spread of infection to an already medically compromised resident population of 95 residents. Findings: 1. On October 21, 2024, at 3:45 p.m., a resident's room was observed to have a sign by the door indicating instructions to wear appropriate PPE (gown and gloves) before entering the resident's room (Resident 76). CNA 2 was observed to enter Resident 76's room and provided care to the resident who was in the bathroom without wearing gown and gloves. In a concurrent interview with CNA 2, she stated she forgot to wear PPE. CNA 2 further stated she should have worn PPE when she provided care to Resident 76 to prevent the spread of germs and protect the residents from infection. On October 21, 2024, at 3:57 p.m., during an interview with Licensed Vocational Nurse (LVN) 1, she stated the staff should wear gown and gloves when providing direct care to Resident 76. LVN 1 stated appropriate PPE should be worn to prevent the spread of germs and protect the residents from infection. LVN 1 further stated a sign was to be posted by the wall to remind staff to wear proper PPE while doing direct care such as changing briefs, assisting in the bathroom. On October 22, 2024, at 10:07 a.m., during an interview with the Infection Prevention (IP) nurse, she stated Resident 76 had an indwelling catheter and was on enhance barrier precaution. The IP further stated CNA 2 should have worn PPE before providing care to Resident 76 to prevent the spread of infection to other 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 October 23, 2024, Resident 76's record was reviewed. Resident 76 was admitted to the facility on [DATE], with diagnoses which included obstructive uropathy (urinary tract disorder) and pressure-induced deep tissue damage of sacral region (wound at the back area). A review of Resident 76's Order Summary, dated September 21, 2024, indicated, .Enhanced Barrier Precautions (a type of Transmission Base Precautions [TBP] - measures use to prevent the spread of infections) .staff to wear gloves and gown for high contact resident care activities . On October 24, 2024, at 12:39 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated the expectation was for the staff to follow the facility infection control policy and procedure. The ADON further stated CNA 2 should have worn PPE to prevent the spread of infection to the residents. A review of the facility's undated policy and procedure titled, Enhanced Barrier Precautions, indicated, . focuses on preventing transmission of multidrug-resistant organism (MDRO) infections via staff hands and clothing .staff need to use gloves and gown with certain residents during high-contact resident care activities . when .transferring .providing hygiene .assisting with toileting . 2. On October 23, 2024, at 10:30 a.m., during a concurrent observation and interview with the Laundry Staff (LS), the LS was observed taking out clean linens from the clothes dryer and stacking them in the rolling carts, using his body without gown to prevent the linen falling out of the cart. The LS proceeded to push the cart against the wall, allowing the linen to come in contact with the wall. In a concurrent interview, the LS stated there were no extra carts to use so he stacked the rolling cart high with the linens. The LS further stated it could spread infections if the clean linens were not handled and stored properly. On October 23, 2024, at 10:55 a.m., the Housekeeping/Laundry Supervisor (HS) was interviewed. The HS stated the clean linens should not touch surfaces on the wall and should be kept in a clean storage bin. The LS further stated, it could spread infections. On October 23, 2024, at 11:41 a.m., the IP was interviewed. The IP stated laundry staff should practice proper handling and storage of clean linens. The IP further stated if laundry staff did not follow infection control policies, and practiced improper handling and storage of clean linens, it could cause cross contamination and spread of infection. On October 23, 2024, at 12:15 p.m., during an interview with the ADON, she stated clean linens should be kept in a clean environment and not touching or leaning to the walls. The ADON stated the wall was considered dirty and the contaminated linen could transmit the infection to the residents. A review of the facility's policy and procedure titled, Departmental (Environmental Services)-Laundry and Linen, dated January 2014, indicated, .the purpose of this procedure is to provide a process for the safe and aseptic handling, washing and storage of linen .clean linen will remain hygienically clean (free of pathogens [infectious agents]) .to cause human illness .designed to protect it from environmental contamination, such as covering clean linen carts . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On October 22, 2024, at 11:27 a.m., during a concurrent observation and interview with the Certified Occupational Therapy Assistant (COTA), the COTA was observed providing therapy to a resident and brought the resident back to the room. The COTA was then observed to assist another resident in the therapy room and did not perform hand washing or hand hygiene before and after therapy treatment in between residents. The COTA stated, I forgot to wash my hands. The COTA further stated he should have washed his hands before and after providing therapy to prevent spread of infection to other residents. On October 22, 2024, at 12:20 p.m., the Director of Rehab (DOR) was interviewed. The DOR stated the COTA should have washed his hands before touching the resident, otherwise the COTA could spread the infection to other residents. On October 22, 2024, at 2:21 p.m., the IP was interviewed. The IP stated, Staff should wash their hands before and after therapy procedures. The IP further stated if staff did not wash their hands, it could lead to the spread of infections. On September 23, 2024, at 12:04 p.m., the ADON was interviewed. The ADON stated staff members were supposed to perform hand washing before and after therapy procedures. The ADON further stated unwashed hands could transmit and spread infection to other residents. A review of the facility's policy and procedure titled, Departmental-Therapy/Rehabilitation-Prevention of Infection, dated September 2010, indicated, .Wash hands or use hand sanitizer before direct resident care . Therapist must wash their hands between residents . A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated August 2019, indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors . 4. On October 23, 2024, at 8:27 a.m., during a concurrent observation and interview with Registered Nurse (RN) 2, the nebulizer tubing of Resident 50 was observed with white colored build up at the edge of the nebulizer mask. The nebulizer tubing was dated and labeled 10/17/24 (October 17, 2024) .CHANGED TUESDAY . In a concurrent interview with Registered Nurse (RN) 2, she stated the nebulizer tubing was soiled, and it should have been changed yesterday. A review of Resident 50's ADMISSION RECORD, indicated Resident 50 was admitted to the facility on [DATE], with diagnoses which included pneumonia (respiratory infection). A review of Resident 50's Order Summary, dated September 10, 2024, indicated, .Change and date O2 (oxygen) and nebulizer tubing .every Tue (Tuesday) . On October 23, 2024, at 11:07 a.m., during an interview with the IP, the IP stated the licensed nurses should change the soiled nebulizer tubing and should follow the schedule of the facility to change tubings every Tuesday. The IP further stated if the nebulizer tubing was not changed, it could lead to bacterial (germ) growth, the resident might inhale it and cause respiratory illness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 23, 2024, at 12:24 p.m., an interview was conducted with the ADON. The ADON stated her expectation for licensed nurses were to follow the standard of practice for infection control. She further stated if the nebulizer tubing was soiled, it should had been changed, and the schedule to change it every Tuesday should have been followed. A review of the facility's policy and procedure titled, Oxygen Administration, dated October 2010, indicated, . to provide guidelines for safe oxygen administration .change tubing per manufacturer guidelines . A review of the facility's policy and procedure titled, Specific Medication Administration Procedures, dated October 2012, indicated, .Rinse and disinfect the nebulizer equipment .change equipment and tubing every seven days . 5a. On October 22, 2024, at 1:57 p.m., an observation was conducted with LVN 11. LVN 11 was observed to have long artificial nails (approximately 1/2 inch from tip of fingers) when providing care to residents. On October 22, 2024, at 2:20 p.m., an interview was conducted with LVN 11. LVN 11 stated she was involved in the care of residents and I am considered as direct care staff handling residents. LVN 11 stated she was capable of helping residents in their care, passing food trays in residents' rooms, and helping to feed residents. LVN 11 stated that she had artificial nails made of gel, that was attached and extended to her natural fingernails. LVN 11 further stated she was not aware of the facility's policy for employees' nails. On October 22, 2024, at 2:27 p.m., an interview was conducted with the IP. The IP stated the facility's policy indicated nails must have appropriate length, and the nails should not be too long specially for direct care staff. The IP further stated if staff had long nails, these could potentially scratch the skin of the residents, which could lead to skin breakdown and cause infection. On October 23, 2024, at 12:07 p.m., an interview was conducted with the ADON. She stated long artificial nails could accumulate germs underneath the nails. The ADON further stated, Direct care staff should follow facility's policy regarding infection control, and staff should not have artificial long nails. 40988 5b. On October 23, 2024, beginning at 8:50 a.m., a medication administration observation was conducted with LVN 2. LVN 2 was observed wearing gel nails (a type of artificial fingernails similar to acrylic nails) while providing direct care to the residents. On October 23, 2024, at 3:20 p.m., LVN 2 was interviewed. LVN 2 stated she was wearing gel nails and the facility's policy regarding use of artificial nails was not clarified with staff, and so was not sure if it was prohibited. When asked about the length of her nails, LVN 2 stated as long as it was not too long, as she currently had it (LVN 2's nails were measured to be approximately 1/4 inch in length from the tip of the fingers), then she stated it was ok to have it. When asked what was considered too long, LVN 2 stated it was up to her judgement, since the facility had not clarified with staff what an acceptable nail length was for direct care staff to wear. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 24, 2024, at 3:59 p.m., the IP was interviewed. The IP stated the use of gel nails was a preference, but asked to confer with the Administrator (Adm) regarding the facility's policy regarding artificial nails. After consulting with the Adm, the IP stated the facility policy indicated nails should be neat and clean, and the employee handbook indicated a length of 1/4 inch. The IP further stated neither mentioned about the use of nail polish or gel nails. On October 24, 2024, at 4:46 p.m., the Adm was interviewed. The Adm stated the facility's Hand Hygiene policy at number 11 indicated nails should be clean and tidy and strongly recommended no acrylic for direct care staff. The Adm further stated in the employee handbook there is a mention of 1/4 inch length for the nails. The Adm stated he expected direct care staff to adhere to facility policy. According to the web article titled, Guideline for Hand Hygiene in Health-care Settings (MMWR 2002, volume 51) published by the Centers for Disease Control and Prevention (CDC - a leading national public health institute in the United States), .even after careful handwashing, HCWs (health care workers) often harbor substantial numbers of potential pathogens (disease causing viruses, fungi, and bacteria) in the subungual (under the nails) spaces .HCWs who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than those who have natural nails, both before and after handwashing . According to the web article titled, WHO (World Health Organization) Guidelines on Hand Hygiene in Health Care, published by the World Health Organization, .Long, sharp fingernails, either natural or artificial, can puncture gloves easily .Each health-care facility should develop policies on the wearing of .artificial fingernails or nail polish by HCWs. These policies should take into account the risks of transmission of infection to patients .recommendations are that HCWs do not wear artificial fingernails or extenders when having direct contact with patients . A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated August 2019, indicated, .Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and is prohibited among those caring for severely ill or immunocompromised residents .The infection preventionist maintains the right to request the removal of artificial fingernails at any time if he or she determines that they present an unusual infection control risk . A review of the facility's employee handbook titled, Personal Appearance, dated 2024, indicated, .natural nail tips should be kept to 1/4 inch in length .A growing body of evidence suggests that wearing artificial nails may contribute to transmission of certain healthcare-associated pathogens (germs that cause disease) .