STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056216	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Care and Rehabilitation Center	410 Eastwood Ave Manteca, CA 95336

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 50161 Based on observation, interview, and record review, the facility failed to ensure 1 of 25 residents (Resident 27) was assessed for the ability to independently use her prescribed inhaler (a device used to administer inhaled medication). This failure had the potential to result in an unsafe self- administration of medication by Resident 27. Findings: Review of Resident 27's Order Summary Report, indicated Resident 27 was admitted to the facility with a diagnosis which included lung cancer. Review of Resident 27's MEDICATION ADMINISTRATION RECORD, (MAR) indicated, . Budesonide-Formoterol Fumarate Inhalation Aerosol .2 puff inhale orally two times a day related to [chronic lung disease] .order date 7/10/2024 . During an observation on 7/16/24, at 11:47 a.m., Resident 27 was observed sleeping in her bed and an inhaler was observed on her bedside table. During a concurrent observation and interview on 7/16/24, at 12 p.m., in Resident 27's room, Licensed Nurse (LN) 12 confirmed Resident 27's budesonide inhaler was on her bedside table. LN 12 confirmed the inhaler did not have Resident 27's name or directions labeled on the inhaler. LN 12 stated she received the order from the physician for Resident 27 to keep her inhaler at her bedside. During a concurrent observation and interview on 7/16/24, at 12:15 p.m., in Resident 27's room, Resident 27 stated she used her inhaler (budesonide) on her own and without informing her nurse. During an interview on 7/18/24, at 10:59 a.m., the Director of Nurses (DON) stated that for residents who kept medications at their bedside, the facility needed to do an Inter-Disciplinary Team (IDT, a group of healthcare professionals from complementary fields) meeting, and check with the resident to determine their capacity and if they could properly use the medication. The DON further stated the resident should have received training for how to properly use the medication. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24, at 10:21 a.m., LN 1 stated the process for keeping a resident's medication at the bedside was to get an order from the physician and then complete an assessment to check if the resident was able to self-administer. LN 1 further stated a risk and benefit would be explained with verbal consent. LN 1 stated the resident would receive training of when the medication was due, and the LN would go through the protocol of how to administer the medication and let the resident know that it must be stored in a secured placed such as a container. During a concurrent interview and record review on 7/19/24, at 4:24 p.m., the DON stated for medications that were to be stored at the resident's bedside; a resident needed to have a physician order for self-administration of medication, a medication self-administration assessment would be performed for the resident, and the IDT would meet with the resident to discuss the information. The DON further stated that a risk and benefit would be completed to determine if it was safe for the resident to have medications stored at the bedside. The DON stated that if the IDT approved the medication to be stored at the bedside, then the resident would require a care plan and the nurse would continue to monitor the resident's use of the medication stored at their bedside. The DON confirmed during a review of Resident 27's record, an IDT meeting was not completed, and no risk and benefit was completed for Resident 27. The DON stated if these steps were not completed and the medication was allowed at the resident's bedside, then the resident could self-administer a double dose or miss a dose of medication because education and self-administration assessment was not completed. Review of a facility policy and procedure (P&P) titled, Self-Administration of Medications, indicated, . Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to so .As part of the evaluation comprehensive assessment the interdisciplinary team (IDT) assesses each residents cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .

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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. 50161 Based on interview, and record review, the facility failed to ensure the Physician Orders for Life-Sustaining Treatment [POLST- a legal document communicating the resident's medical wishes for end-of-life care] was completed accurately for 1 of 25 sampled residents (Resident 27) when Resident 27's POLST was not signed by the physician. This failed practice could result in Resident 27 not having her choices being honored. Findings: Review of Resident 27's Order Summary Report, indicated Resident 27 was admitted to the facility with diagnoses which included cancer. Review of Resident 27's Physician Orders for Life-Sustaining Treatment, dated 7/4/24, indicated, . A copy of the POLST form is a legally valid physician order . The POLST was marked in section C, .Trial period of artificial nutrition, including feeding tubes . There was no signature by the physician or their representative on the POLST. There was a printed name, signature, and date on the POLST by Resident 27. During concurrent interview and record review on 7/17/24, at 12:05 p.m., the Minimum Data Set Coordinator (MDSC) (a nurse who manages resident assessments) confirmed there was not a physician signature on Resident 27's POLST form. The MDSC stated the expectation was for the physician to sign the POLST form after the facility's admitting nurse completed the admissions paperwork with the resident or resident representative. The MDSC stated it was important for the physician to sign the POLST form because it provided a medical guideline for the care of the residents. During an interview on 7/19/24, at 10:04 a.m., Licensed Nurse (LN) 7 stated she was familiar with the POLST form and would get a signature from the resident or their responsible party and that the POLST form must be filled out completely. LN 7 stated it was important to have the physician signature because they must confirm the residents' wishes, as the physicians speak to the resident or decision makers regarding their decisions for life sustaining treatments. LN 7 stated if the doctor did not sign the POLST, it would not be a valid document. LN 7 further stated staff could not give care based on the document, so the residents' wishes may not be followed. During a concurrent interview and record review on 7/19/24, at 4:24 p.m., the Director of Nurses (DON) stated the facility expectation was for the POLST form to be filled out completely. The DON further stated if the physician did not sign the POLST, then the facility could not implement the resident or resident representative wishes regarding medical care and emergency treatment. Review of an undated facility policy and procedure (P&P) titled, Advanced Directives, indicated, . Physician Orders for Life-Sustaining Treatment (or POLST) form . a form designed to improve patient care by creating a portable medical order form that records patients treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patients current medical condition into consideration .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47369 Based on interview, and record review, the facility failed to ensure 1 of 25 sampled resident's (Resident 20) Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN-a document that provides information of the potential liability for payment of services not covered by Medicare A, a federal insurance program for specialized services requiring skilled nursing or rehabilitation services) provided the estimated cost of services Resident 20 could be held responsible for. This failure increased the risk of Resident 20 and her representative not having adequate information to make financial decisions. Findings: A review of Resident 20's ADMISSION RECORD, indicated she was readmitted to the facility in 2023. A review of Resident 20's Notice of Medicare Non-Coverage (NOMNC- a document that informs a beneficiary when their Medicare services will be ending and provides information to appeal the decision) form indicated, The Effective Date Coverage of Your Current Nursing Services Will End 1/02/24 . A review of Resident 20's SNFABN dated 12/29/2023, indicated, .Medicare doesn't pay for everything, even some care that you or your health care provider think you need .the care listed below does not meet Medicare coverage requirements . Beginning on 01/03/24, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs . Care: Skilled Nursing Services . Reason Medicare May Not Pay: Resident will be discharged back to Long-term Care . The .Estimated Cost . area of the form was blank. The SNF ABN further indicated, .Read this notice to make an informed decision about your care . During an interview on 7/19/24, at 8:41 AM, the Business Office Manager (BOM) stated when a resident was no longer eligible for Medicare A they would sign the NOMNC, and if they remained in the facility the SNF ABN. The BOM stated the SNF ABN indicated the fees the resident or their representative may be responsible for. The BOM stated typically, the document would list the private pay room and board rate and the BOM would explain to the family what their share of cost would be and make adjustments as needed. During an interview on 7/19/24, at 8:51 AM, the Minimum Data Set Coordinator (MDSC-a nurse who coordinates resident assessments) stated when it was determined that a resident was no longer eligible for Medicare A services, she would issue the NOMNC, and if needed, the SNF ABN. The MDSC further stated when she provided the SNF ABN she did not fill in the estimated cost amount. The MDSC stated she told the resident or their representative to contact the business office to find out the amount they may be responsible for. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/19/24, at 9 AM, the BOM confirmed Resident 20's SNF ABN should have included an estimated cost of services. The BOM stated it was her expectation that the form would indicate the private pay rate so the resident or their representative would know they may be responsible for a fee. A review of an undated facility procedure titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018), indicated, .The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility . Estimated Cost Section . In this section, the SNF enters the estimated cost of the corresponding care that may not be covered by Medicare .The SNF should enter an estimated cost or a daily, per item, or per service cost estimate .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 40903 Based on observation, interview, and record review, the facility failed to ensure privacy was protected for one of ten residents observed during medication pass (Resident 37), when a licensed nurse (LN) used a personal phone to take a picture of Resident 37's medication labels which displayed the drug and Resident 37's name. This failure and unauthorized photography of resident's medical information with a personal phone violated medical privacy. Findings: During a concurrent interview and observation of medication administration, on 7/16/24, at 9:24 AM, with LN 12, at Unit 1's hallway, LN 12 removed three medications bubble packs (a packet of medication with individual pills labeled with a drug's direction and resident's name) from the medication cart for Resident 37. LN 12 then put the pills into a small cup and took a picture of the bubble packs with a smart phone for the three medications. LN 12 stated she was taking a picture so she could review them later, to make sure she did not miss any medication. LN 12 stated she would delete the pictures afterward, as it was her personal phone. LN 12 then crushed the pills in a pouch and mixed it with apple sauce for administration. LN 12 marked the computer by clicking on the drug names. During an interview on 7/18/24, at 8:51 AM, with the Director of Nursing (DON) in her office, the DON stated the staff were not allowed to use personal phones to take pictures of protected resident's medical information including the label of medication products. Review of the facility's undated policy titled, Confidentiality of Information and Personal Privacy, indicated, The facility will safeguard the personal privacy and confidentiality of resident personnel and medical records. The facility will strive to protect the resident's privacy regarding his or her .Medical treatment .Written and telephone communication .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47369 Based on interview, and record review, the facility failed to protect the rights of 1 of 25 sampled residents (Resident 45), when Resident 45 informed staff he was missing 25 dollars and the loss was not investigated. This failure had the potential to cause Resident 45 to feel vulnerable and to suffer psychosocial distress. Findings: A review of Resident 45's ADMISSION RECORD, indicated, he was admitted to the facility in 2018. During an interview on 7/17/24, at 11:06 AM, Resident 45 stated he was missing 25 dollars. Resident 45 further stated the facility had not investigated his loss. A review of Resident 45's Progress Note, dated 7/15/24, at 6:38 AM, indicated, .At 5am during rounds resident reported someone stole my small bag of quarters approximately $25. Search patient room everywhere but did not find the money. This will be endorsed to next shift nurse to follow up with SS [social services]. When their office will be open . During an interview on 7/18/24, at 8:42 AM, the Social Services Director (SSD) stated when staff were informed of a missing resident item, they slipped a note under her door. The SSD further stated after receiving the note she completed a theft and loss report and initiated an investigation. The SSD stated she had not been notified of any missing items for Resident 45. The SSD further stated it was her expectation that staff would inform Social Services of any missing items that were reported to them. During a concurrent interview and record review on 7/18/24, at 9:50 AM, Licensed Nurse (LN) 1 stated staff would first try to find missing items, and if they could not, they would report to the Social Services Department by telephone call or in person during business hours. LN 1 further stated if an item was reported missing during the night shift, staff would document the missing item on the shift-to-shift endorsement form [form documenting pertinent information to be shared with the oncoming shift]. LN 1 reviewed the endorsement form for 7/14/24, 7/15/24, and 7/16/24. LN 1 confirmed Resident 45's missing money was not documented on the form. During an interview on 7/18/24, at 3:16 PM, LN 2 stated she had worked at the facility for a few months, but she did not recall any training about reporting theft and loss. LN 2 further stated she documented Resident 45's complaint of missing money in the progress notes and told the next shift to notify the Social Services department. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/2024, at 12:33 PM, the Director of Staff Development (DSD) stated if a theft or loss occurred when the Social Services offices were closed, staff would document the theft or loss in the progress notes and call the Social Services Department from home when the office was open. The DSD further stated a binder was available at each nurse's station to provide staff the details of how to report theft and loss. During a concurrent interview and record review on 7/19/2024, at 12:44 PM, on the [NAME] Nurses Station, LN 3 stated if a resident reported an item was missing, she would write a note and slide it under the Social Services Department door. LN 3 stated there was a binder at the nurse's station that provided information on what to do in a variety of situations. LN 3 reviewed the binder and confirmed it did not provide a procedure for reporting theft and loss. During an interview on 7/19/24, at 2:11 PM, the Director of Nurses (DON) stated when a resident reported an item was missing staff could access the binder at the nurse's station for a theft and loss report. The DON further stated it was important for staff to report any thefts or losses to allow residents to be reimbursed and to maintain their dignity and rights to possess their own personal property. The DON further stated it was important to report missing items to the Social Services Department so they could investigate and decide if the situation needed to be escalated if theft had occurred. The DON stated it was a big problem and needed to be reported immediately to ensure an investigation could take place. A review of a facility policy and procedure titled, Investigating Incident of Theft and/or Misappropriation of Resident Property, revised April 2021, indicated, .All reports of exploitation, theft or misappropriation of resident property are promptly and thoroughly investigated .Residents have the right to be free from exploitation, theft and/or misappropriation of personal property .Our facility exercises reasonable care to protect the resident from property loss or theft, including .promptly responding to and investigating complaints of theft or misappropriation of property .Training staff to educate them about activities that constitute and procedures for reporting abuse neglect exploitation and misappropriation of resident property .

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046 Based on interview, and record review, the facility failed to protect 1 of 25 sampled residents (Resident 62) from misappropriation (the unauthorized use of funds or other property for purposes other than that for which intended) of property and personal belongings, when Certified Nursing Assistant (CNA) 6 took Resident 62's wallet containing money, Automated Teller Machine (ATM) card, health insurance card and ID (Identity Document) without Resident 62's consent. This failure caused Resident 62 emotional distress and had the potential for continued loss and/or theft of other residents' property/money. Findings: A review of Resident 62's Admission Record, indicated Resident 62 was admitted to the facility in May 2024 with multiple diagnoses which included chronic kidney disease. A review of Resident 62's Minimum Data Set (MDS, an assessment and care screening tool) dated 5/26/24, indicated Resident 62 had the ability to understand and be understood by others with a Brief Interview for Mental Status (BIMS) score of 15 (a score of 13 to 15 suggests memory is intact). During a concurrent observation and interview on 7/16/24, at 11:10 a.m., with Resident 62, Resident 62 was observed lying in bed. Resident 62 stated CNA 6 came to her and pulled Resident 62's wallet out. Resident 62 stated her wallet had $160.00, an ATM card/debit card, health insurance card and an ID. Resident 62 stated she was very scared. During a concurrent interview and record review on 7/17/24, at 9:29 a.m., with the Director of Staff Development (DSD), the DSD stated CNA 6 was responsible for taking Resident 62' s wallet and verified Resident 62's wallet contained $160.00, ATM/debit card, insurance card and ID. The DSD stated she confirmed the stolen items with Resident 62's family member. CNA 6's personnel record was reviewed with the DSD. CNA 6 had orientation to the facility on [DATE] at which time CNA 6 received and signed an in-service for Theft and Loss. The DSD stated CNA 6 was terminated from work on 7/7/24. During an interview on 7/17/24 at 12:16 p.m. with Licensed Nurse (LN) 10, LN 10 stated he heard Resident 62 screaming for help. LN 10 stated he observed CNA 6 at the facility entrance leaving the facility. LN 10 stated he went to Resident 62's room and Resident 62 informed him CNA 6 stole her wallet. LN 10 further stated one of the housekeeping staff saw CNA 6 outside Resident 62's room when Resident 62 was screaming for help. During a concurrent interview and record review, on 7/17/24, at 2:23 P.M., with the Social Services Director (SSD), the SSD stated Resident 62's money was reimbursed. During a review of Resident 62's care plan initiated on 7/16/24, indicated, .[Resident 62] has a potential for trauma r/t [related to] theft and lost incident on 7-7-24 . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled, Identifying Exploitation, Theft and Misappropriation of Resident Property, indicated, .Exploitation, theft and misappropriation of resident property are strictly prohibited .Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without resident's consent . Examples of misappropriation of resident property include .theft of money .theft of personal belongings .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50161 Based on interview, and record review, the facility failed to report an allegation of stolen property to the facility Administrator and the Department within twenty-four hours for 1 of 25 sampled residents (Resident 22) when, Resident 22 reported to staff her suspicion that staff stole 200 dollars during the first week of July 2024, and the facility reported the incident to the Department on 7/19/24. This failure resulted in Resident 22 feeling upset by the loss, caused a delay in the facility and the Department's investigation of the alleged incident, and placed other residents at risk for abuse by the accused employee. Findings: During an interview on 7/18/24, at 12:20 p.m., Resident 22 stated that she took 200 dollars out of the bank at the end of June and kept the money in her wallet. Resident 22 further stated a certified nursing assistant (CNA) came in about a week later and asked if she had change for twenty dollars. Resident 22 stated when she pulled her purse out, she noticed her 200 dollars was gone, and she told Licensed Nurse (LN) 10. Resident 22 further stated this occurred shortly after 7/4/24. Resident 22 stated she asked LN 10 several times for information regarding a follow-up, but LN 10 never got back to her. During an interview on 7/18/24, at 2:36 p.m., Resident 22 stated having someone come into her room and go through her personal belongings made her feel terrible and very upset. Resident 22 further stated she liked to have her own money because sometimes she wanted to purchase things or go out for a pedicure. During a telephone interview on 7/18/24, at 4:22 p.m., LN 10 stated Resident 22 told him someone took money from her purse on either 7/1/24 or 7/4/24. LN 10 further stated Resident 22 told him she suspected a specific CNA because that person came into her room earlier that day and knew where her money was in her purse. LN 10 stated he notified the charge nurse and wrote a note to the social worker and left it under the social worker's office door. LN 10 further stated that he also told the night nurse to follow up with the social worker the next day. LN 10 stated that he had not followed up with the social worker regarding Resident 22. During an interview on 7/19/24, at 11:17 a.m., the Social Services Director (SSD) stated she had not received notification regarding a theft or loss for Resident 22. During a subsequent interview on 7/19/24, at 11:49 a.m., the SSD stated she was not aware Resident 22 had missing money. The SSD stated if she had known, she would have made a police report and follow up with the resident to monitor for psychosocial distress. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24, at 3:56 p.m., the Administrator (ADM) stated staff should have gone to social services as soon as they received the allegation or complaint. The ADM further stated that he was not aware of Resident 22's missing money. The ADM confirmed Resident 22's report of missing money in the amount of 200 dollars was considered abuse, and due to this it should have been reported to the police, to the Department, and ombudsman (advocate for seniors) within 24 hours. Review of the facility's undated policy and procedure titled, ABUSE PROHIBITION AND PREVENTION POLICY AND PROCEDURE AND REPORTING REASONABLE SUSPICION OF A CRIME IN THE FACILIY POLICY AND PROCEDURE, indicated, .facility staff are .Mandated Reporters [people required by law to report suspected or known instances of abuse] .all mandated reporters will report reasonable suspicion of a crime against a resident .examples of crimes that need to be reported include .theft .the Facility will report allegations of abuse .misappropriation of resident property .No later than 24 hours (actual, alleged . misappropriation of property) .To Whom .Facility Administrator, State Survey Agency, Law Enforcement, Ombudsman .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47046 Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan (an individualized plan for the nursing care) was resident centered, when 1 of 25 sampled resident's (Resident 87) care plan for refusal to wear a smoking apron (protection to prevent burns) while smoking was not revised and updated in a timely manner. This deficient practice had the potential for Resident 87 to not receive education about the risks associated with his expressed choices, and had the potential Resident 87 would be injured while smoking. Findings: A review of Resident 87's Admission Record, indicated Resident 87 was admitted to the facility with multiple diagnoses which included respiratory failure (a serious condition that makes it difficult to breathe on your own) and quadriplegia (a form of paralysis that affects all four limbs). A review of Resident 87's Minimum Data Set (MDS, an assessment and care screening tool) dated 6/27/24, indicated Resident 87 had the ability to understand and be understood by others and a Brief Interview for Mental Status (BIMS) score of 15 (suggests that memory is intact). A review of Resident 87's Care plan initiated on 7/1/24, indicated, .Resident [Resident 87] has health-risk associated with smoking .Interventions .Smoking apron use-All staff . During a review of 87's clinical record, Progress Notes, dated 7/3/24, indicated, .IDT [Interdisciplinary Team-team members from different health care disciplines discuss, identify, address, implement, and review plans to meet needs regarding the resident's care RECOMMENDATIONS .using apron for safety . During an interview on 7/16/24, at 2:06 p.m., with Resident 87, Resident 87 stated he never wore a smoking apron and facility staff never asked him to wear one. During a concurrent observation and interview on 7/18/24, at 8:26 a.m., with Activity Assistant (AA) 1 in the designated smoking area, AA 1 confirmed Resident 87 was not wearing a smoking apron. AA 1 stated Resident 87 had been refusing to wear a smoking apron. During an interview on 7/18/24, at 10:39 a.m., with the Director of Staff Development (DSD), the DSD failed to show a care plan was revised related to Resident 87's refusal to wear a smoking apron. The DSD also failed to show any documentation Resident 87 was educated about the risk of not wearing a smoking apron. During an interview on 7/18/24, at 2:18 p.m., with the Director of Nursing (DON), the DON stated Resident 87's care plan should have been updated and revised when Resident 87 refused to wear a smoking apron. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy titled, Care Plans, Comprehensive Person-Centered, indicated, .The resident has the right to refuse to participate in the development of his/her care plan .Such refusals are documented in the resident's clinical record in accordance with established policies .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 40903 Based on interview, and record review, the facility failed to ensure ongoing medication refusals were communicated to the medical doctor in a timely manner for 1 out of 25 sampled residents (Resident 16). This failure could contribute to adverse health consequences and an untreated medical condition when prescribed medication was not administered over a long period of time. Findings: During a review of Resident 16's medical record titled, Physician Progress Note, dated 5/27/24, the record indicated Resident 16 had multiple medical diagnoses including heart failure (heart does not pump well enough to meet the body's needs), atrial fibrillation (or A.Fib, a dangerous type of heart rhythm that could result in blood clot in the heart if not treated), hypothyroid (thyroid function with low hormone level), and depression. Resident 16 was taking 15 routine medications for treatment of her medical conditions. During a review of Resident 16's medical record titled, Medication Administration Record, (or MAR, a legal document that lists drugs given and monitoring done) dated for June and July of 2024, the record indicated ongoing medication refusal including critical medications related to her heart and other medical conditions as follows for select medications: Furosemide (or Lasix- drug known as a water pill used for heart failure by reducing fluid in the body or lungs) refusals documented in the MAR: *7/1, 7/2, 7/3, 7/4, 7/5, 7/7, 7/9, 7/10, 7/13,7 /15 and 7/16/24 *6/3, 6/7, 6/12, 6/14, 6/19, 6/21, 6/23, 6/24, 6/25, 6/26, 6/27, and 6/28/24 Paroxetine (or Paxil, antidepressant medication with risk of withdrawal with abrupt stop) documented refusals in the MAR: *7/2, 7/5, 7/7, 7/9, 7/10, 7/15, 7/16, and 7/17/24 *6/6, 6/18, 6/19, 6/20, 6/22, 6/23 Apixaban (Eliquis, a blood thinner used to treat and prevent blood clot formation) documented refusals in the MAR: *7/2, 7/5, 7/7, 7/9, 7/10, 7/15, and 7/16/24 *6/1, 6/3, 6/4, 6/6, 6/16, 6/18, 6/19, 6/20, and 6/22/24 Levothyroxine (or Synthroid- a thyroid hormone replacement that helps regulate many functions in body including mood and energy) documented refusals in the MAR: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*7/1, 7/2, 7/3, 7/4, 7/5, 7/7, 7/9, 7/10, 7/14, and 7/15/24 *6/3,6/7,6/12,6/14, 6/19, 6/21, 6/23, 6/24, 6/25, 6/26, 6/27, and 6/28/24 Further review of Resident 16's records and nursing notes did not show any documentation the medical doctor was notified of refusal of the heart medications, blood thinners or other drugs between 6/1/24 to 7/17/24. During an interview on 7/18/24, at 5:02 PM, with Licensed Nurse (LN) 14, when asked how a resident's medication refusal was handled, LN 14 stated the workflow was to ask the resident three different times, then document the refusal in the MAR record. LN 14 stated the doctor should be notified if medications were refused on multiple days or shifts. During a concurrent interview with LN 1 and review of Resident 16's MAR, nursing and provider notes, on 7/19/24, at 12:30 PM, the MAR and nursing notes from 6/1/24 to 7/18/24 were reviewed. The record did not show if the medical doctor was notified of refusals. Review of providers notes [include both the medical doctor and Nurse Practitioner (NP- a provider who provide medical care under supervision of a doctor] did not show any comment or notes on the ongoing medication refusal including high risk and critical medications such as blood thinner (apixaban), furosemide for heart failure, blood pressure medication including Metoprolol and Diltiazem (both used to lower blood pressure and heart rate/palpitation) and thyroid medication. LN 1 confirmed the findings and indicated blood thinner refusal put the resident at risk of blood clot, stroke or heart attack, Lasix and other heart medication refusal could worsen the heart failure, Paxil refusal could put the resident at risk for withdrawals and anxiety. During a review of Resident 16's electronic medical record for medication orders, dated 7/1/24, the record indicated the thyroid medication (levothyroxine, a hormone used to replace the low level in the body) dosage was increased from 70 mcg (mcg is microgram, a unit of measure) to 100 mcg when the blood level came back indicating the thyroid function (thyroid hormone level) was low. The record did not indicate if the medication refusal and non-compliance may have contributed to reduced thyroid function or hormone level. During an interview on 7/19/24, at 2:42 PM, with the Director of Nursing (DON) in her office, the DON stated Resident 16 had been refusing medication regularly and the nursing staff offer the medication 3 times before concluding refusal. The DON stated the nursing staff should have informed the medical doctor when refusal was more than once for critical drugs. The DON stated the doctor needed to make the assessment on what steps needed to keep the patient safe. The DON stated Resident 16 was sent to hospital earlier that day due to excessive swelling of her lower extremities (legs) since she had been refusing the Lasix. During a telephone interview on 7/19/24, at 3:15 PM, with the facility's Consultant Pharmacist (CP), the CP stated he came across the medication refusal by Resident 16 but did not put it in the report for the facility, as he did not have a solution to the refusal. The CP acknowledged the thyroid function test that resulted in increasing the dose of levothyroxine could have been a result of drug refusal, missing the blood thinner medication could have put resident at risk of blood clot, and refusing the Lasix could have worsened the heart failure symptoms. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 7/19/23, at 5 PM, with the Medical Doctor (MD) 2, MD 2 stated she asked to transfer the Resident 16 to the hospital for further care due to lower extremity swelling. MD 2 stated the nursing staff should have notified the medical doctor if essential medications were refused by the resident. MD 2 stated she relied on the consultant pharmacist to review medication irregularities. Review of Resident 16's nursing Plan of Care (a document that sets the monitoring plan for nurses to follow), dated 5/25/23, and revised on 6/7/23, indicated, Resident will not experience injury related to refusal to medication and lab (medical tests). The Care Plan on the intervention section indicated, Continue to monitor resident for changes in behavior and notify MD of any changes that might be a danger to resident. Review of the facility's undated policy, titled Administering Medications, the policy indicated, the director of nursing services supervises and directs all personnel who administer medications and/or have related functions. The policy on section 19 indicated, If a drug is withheld, refused, or given at time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. The policy did not address ongoing refusal of high-risk medications and if the medical doctor should be contacted.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 47369 Based on observation, interview, and record review, the facility failed to ensure 1 of 25 sampled residents (Resident 89) received activities that met their interests and needs, when Resident 89 did not attend group activities and in room activities were offered infrequently. This failure had the potential to adversely affect the psychosocial needs and well-being of Resident 89. Findings: A review of Resident 89's ADMISSION RECORD, indicated he was admitted to the facility in 2024 with diagnoses which included, nontraumatic intracerebral hemorrhage (bleeding in the brain/stroke) and adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition, inactivity, dehydration, and impaired immunity). During an interview on 7/17/24, at 10:48 AM, in Resident 89's room, Certified Nurse Assistant (CNA) 1 stated Resident 89 did not attend activities because he did not get out of bed. A review of Resident 89's care plan dated 6/6/24, indicated, Goal .Resident responds to sensory stimulation activities daily .The resident needs 1:1 bedside/in room visits and activities .Activities will provide stretching exercises with the hands and arms . During an interview on 7/19/24, at 7:23 AM, Activity Assistant (AA) 2 stated staff provided in room activities for residents who were unable to leave their rooms. AA 2 further stated some of the activities they provided were music, reading, videos, and conversation to make the residents laugh. AA 2 stated if a resident declined to participate in an activity they documented participation as refused. A review of Resident 89's activity attendance record for the month of June 2024, indicated, on 6/1/24, Resident 89 was provided .Social . activity at 1:59 PM, and activity paper .arts & crafts .Bingo . at 9:33 PM. On 6/15/24, Resident 89 was provided 27 different activities at 5:53 PM. On 6/27/24, Resident 89 was provided .News/paper or TV .Social . at 1:59 PM. On 6/30/24, Resident 89 was provided .News/paper or TV .Social . at 12:57 PM. There were no refusals documented for the month of June. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/18/24, at 4:16 PM, the Activities Director (AD) stated the activity participation documentation on 6/1/24, at 9:33 PM, and on 6/15/24, at 5:53 PM, were not completed by the activity department staff and Resident 89 did not participate in activities at those times. The AD confirmed the documentation indicated Resident 89 was provided activities on three days in the month of June 2024. The AD stated staff documented refused when residents declined to participate in activities. The AD confirmed there was no documentation to indicate Resident 89 refused activity participation during the month of June 2024. During an interview on 7/19/24, at 2:18 PM, the AD stated the purpose of providing activities to residents was for the residents to experience fun, socialization, and to lift their spirits. The AD further stated the residents enjoyed reminiscing, music, hand massages and gentle stretching of their arms and hands. The AD stated the resident's psychosocial well-being was enhanced during activity participation. During an interview on 7/19/24, at 2:08 PM, the Director of Nurses (DON) stated it was her expectation that activities would consistently be offered to residents who were unable to leave their rooms. The DON further stated activity participation would help Resident 89 to not feel depressed during his stay in the facility. A review of an undated facility policy titled, Activity Evaluation, indicated, .In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident .to help develop an activities plan that reflects the choices and interests of the resident .Each resident's activities care plan .reflects his/her individual needs .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50161 Based on interview, observation, and record review, the facility failed to ensure one of seven residents (Resident 38) would remain free of urinary catheter (medical device that helps drain urine from your bladder) complications, when Resident 38's urinary catheter drainage bag was on the floor in his room. This failure had the potential to cause infection and urinary complications for Resident 38. Findings: Review of Resident 38's Order Summary Report, indicated Resident 38 was admitted with a diagnosis which included, .Foley Catheter [medical device that drains urine from bladder] .Dx: [Diagnosis] URINARY RETENTION [bladder does not empty completely or at all] . During a concurrent observation and interview on 7/16/24, at 1 p.m., in Resident 38's room, Certified Nurse Assistant (CNA) 5 confirmed Resident 38's urinary bag was hanging off Resident 38's bed and was resting on the floor. CNA 5 stated the urinary catheter bag should be off the floor. CNA 5 stated the risk to the resident was infection if it was touching the floor. CNA 5 further stated Resident 38's urinary catheter bag was currently full at 1600 ml (milliliter, a unit of measurement) and stated the bag needed to be emptied. During an interview on 7/18/24 at 2:54 p.m., the Infection Preventionist (IP) stated a resident's urinary catheter bag should not be touching the floor and should be hung off the bed. The IP stated there would be an infection risk to the resident if the urinary catheter bag touched the floor. During an interview on 7/19/24 at 9:29 a.m., Licensed Nurse (LN) 7 stated that a resident's urinary catheter bag should be hung off a non-movable part of the resident's bed. LN 7 further stated if the urinary catheter bag touched the floor, then it could get caught by a wheelchair, stepped on, and there was also a risk for dislodgement. During an interview on 7/19/24 at 4:24 p.m., the Director of Nurses (DON) stated she expected residents' urinary catheter bags to be off the floor to prevent infection and other problems.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161 Based on observation, interview, and record review, the facility failed to provide appropriate care to one of ten residents (Resident 76) who received enternal nutrition (the use of a medical device called a feeding tube to provide liquid nourishment, liquids, and medications directly into the stomach) when Resident 76's enteral tube feeding liquid nourishment was not discontinued approximately five hours past its expiration This failure increased the potential for complications, including, but not limited to; nausea, vomiting, diarrhea, and stomach cramping for Resident 76. Findings: Review of Resident 76's Order Summary Report, indicated Resident 76 was admitted with a diagnosis which included a gastrostomy tube (G tube, a tube placed surgically through the skin and stomach wall and used to deliver nutrition). The report indicated, .Enteral Feed Order one time a day ADMINISTER ENTERAL FORMULA [name of feeding product] . During an observation on [DATE], at 9:15 a.m., Resident 76 was observed in his room sleeping on his bed, receiving an enteral feeding through a pump (electronic delivery system). The enteral feeding bag was labeled with a handwritten date of ,d+[DATE] and time of 0400 (4 a.m.). During a concurrent observation and interview on [DATE], at 9:28 a.m., in Resident 76's room, Licensed Nurse (LN) 3 confirmed the enteral feeding bag was labeled ,d+[DATE] at 0400. LN 3 stated the enteral feedings were good for 24 hours and Resident 76's should have been changed in the morning on [DATE] at 4 a.m. LN 3 confirmed the feeding pump was still delivering the feeding to Resident 76, and further confirmed it was five hours past the time it should have been changed. LN 3 stated the feeding and pump supplies needed to be changed and replaced so the formula did not become spoiled. LN 3 further stated that if the enteral feeding was to continue to be used for a resident over 24 hours it could place the resident at risk for infection. During an interview on [DATE], at 11:27 a.m., with LN 1, LN 1 stated the enteral feedings set-up, including the tubing, flush water, syringe, and formula should all be changed out within 24 hours of being hung. During an interview on [DATE], at 4:24 p.m., the Director of Nurses (DON) stated enteral feedings, which included formula, flush water, and tubing should be labeled with the resident's name, date, time, and flow rate. The DON further stated that if a resident was to receive an expired enteral feeding, the resident would be at risk for health infections and not have proper digestion. The DON stated the expired formula could clog the tubing and the expectation was that staff were to change the feeding out at the correct time which was within 24 hours.

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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. 50161 Based on observation, interview, and record review, the facility failed to ensure 1 of 26 residents receiving oxygen (Resident 27) received respiratory care according to professional standards when: 1. Resident 27's nasal cannula (NC- tubing that delivers oxygen into your nose) was not labeled with a date when it was changed; and, 2. Resident 27's oxygen humidifier bottle (a plastic bottle filled with water which moistens the oxygen) was not labeled when it was changed. These failures had placed Resident 27 at risk for infection. Findings: Review of Resident 27's Order Summary Report, indicated Resident 27 was admitted to the facility with a diagnosis which included lung cancer and chronic obstructive pulmonary disease (makes breathing difficult). The report indicated, .OXYGEN AT 2-5 [Liters per minute-the flow rate of oxygen] PER NASAL CANULA (NC) CONTINUOUSLY (order date 7/4/24) .CHANGE O2 [oxygen] CANNULA/MASK TUBING Q [every] 7 DAYS OR PRN [as needed] SOILAGE every night shift every Wed [Wednesday] (order date 7/4/24) . CHANGE MISTY OXYGEN HUMIDIFIER Q7 DAYS OR PRN (as needed) WATER BELOW INDICATOR LINE (order date 7/4/24) . During an observation on 7/16/24, at 11:47 a.m., Resident 27 was observed sleeping in her bed and was receiving oxygen via NC at 4.5 liters per minute, and the oxygen concentrator (medical device that extracts oxygen from the surrounding air and turns it into condensed oxygen to breathe) had an attached water humidifier. There was no date labeled on the oxygen humidifier and there was no date labeled on the oxygen tubing. During a concurrent observation and interview on 7/16/24, at 12 p.m., in Resident 27's room, Licensed Nurse (LN) 12 confirmed Resident 27's oxygen tubing had a piece of tape attached but could not identify what was written on the tape. LN 12 further confirmed there was no date written on the humidifier bottle. LN 12 stated the tubing and canister (misty oxygen humidification) should be changed out once a week and labeled. LN 12 further stated if it was not changed once a week there could be a risk of bacteria and the resident could get an infection. During an interview on 7/18/24, at 2:55 p.m., with the Infection Preventionist (IP), the IP stated the expectation was for a resident's NC oxygen tubing to be labeled with the date it was started and changed at least every 7 days and as needed. The IP further stated the NC labeling should be correct and legible. The IP stated the water canister (misty oxygen humidification) that was used to provide moisture to the oxygen should be changed every seven days and labeled with the date. The IP explained if this was not done it would be risk for infection for the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24, at 4:24 p.m., the Director of Nurses (DON) stated the expectation was for NC tubing to be labeled with the date of administration and changed every seven days and should be legible to read, and the water canister for humidification should be changed every seven days and when empty, and labeled with the date of use. The DON further stated the risk to the resident if this was not done would be infection.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50161 Based on observation, interview, and record review, the facility failed to ensure training, including a written policy and procedure (P&P) was provided for licensed staff regarding the use of continuous glucose monitoring (CGM, tracks your blood sugar levels in real time on a Reader, which captures the data from a sensor inserted under the skin) for nine of nine residents who used CGMs in the facility. This failure had the potential for staff not being competent in the implementation of CGM and increased the risk of residents with CGMs receiving improper blood glucose management and nursing care. Findings: During a concurrent observation and interview on 7/18/24, at 10:19 a.m., with Licensed Nurse (LN) 13, in Resident 14's room, LN 13 identified Resident 14's CGM Reader and stated it was for testing blood sugar. LN 13 indicated she was not sure how often the sensor was to be changed, and stated she was not sure how to change it. LN 13 stated she had not had any training on the CGM from the facility and was not provided any reading material. LN 13 further stated it would be helpful to get the training so she knew how to use it, how to change the sensor, and whether the results were equivalent to testing blood by fingerstick. During a concurrent interview and review of staff training on 7/18/24, at 12:38 p.m., the Director of Staff Development (DSD) stated she had notified the pharmacy consultant (CP) regarding staff training and education because she was concerned the LNs were having to replace resident sensors and other equipment. The DSD further stated residents had been requesting CGMs from their physician. The DSD stated if staff were not properly trained, they could get the wrong blood sugar reading. The DSD further stated she recently did a training on diabetes but there was no training on the use of the CGMs during that training. During an interview on 7/19/24, at 2:16 p.m., the DSD stated the facility started using CGMs in April of 2024. The DSD further stated when a new device came into the facility, the expectation was the facility needed to implement new policies and training so staff would know how to use them. The DSD stated residents preferred the CGM due to pain from a fingerstick (using a needle to collect blood from the finger). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 7/19/24, at 3:20 p.m., the Consultant Pharmacist (CP) stated the facility started to have CGM devices in the facility in March of 2024. The CP further stated he did not know the facility had no written policy and procedure in place for the CGM devices in March. The CP stated a nurse from the facility called him in June 2024 to ask for the procedure regarding CMGs. The CP further stated the facility was responsible for providing training for new medical devices with their staff, such as the CGM. The CP stated that he noticed the facility was having problems with the sensors of the CGMs. The CP further stated this was because the sensors were intended to be used for two weeks, but the residents were needing their sensor replaced more frequently. The CP stated the pharmacy was getting refill requests before the two weeks time frame due to the sensors falling off the residents' skin. The CP further stated the pharmacist was taking phone calls from various nurses in the facility and he was trying to assist them in the use of the CGM device. The CP stated the sensors were very expensive and the risk of nursing staff not knowing how to apply them properly was improper glucose assessments which could lead to complications of low or high blood sugar levels. The CP further stated if a blood sugar was low, the monitors/sensors sometimes would read incorrectly. The CP stated if the CGM read less than 70, the nurses should be using a fingerstick to check the blood sugar. The CP further stated if the nurse did not do this, the resident could suffer from effects of low blood sugar, such as coma (a prolonged state of unconsciousness), and seizures (sudden, uncontrolled burst of electrical activity in the brain). The CP stated his judgment as a pharmacist was that training for licensed staff and a written P&P would be in place before rolling out the use of CGMs on residents. During an interview on 7/19/24, at 4:24 p.m., with the Director of Nurse (DON), the DON confirmed there was no training given to nursing staff regarding the use of CMGs and application of the sensor. The DON further confirmed there was no training provided to residents regarding the proper use of the CGM either. The DON confirmed there was no P&P in place for the CGM device which would have ensured staff had access to the proper procedures and protocols.

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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. 40903 Based on interview, and record review, the facility failed to ensure safe use and accountability of controlled narcotic medications (prescription opioid drugs of abuse) when: Resident 91's Norco (Hydrocodone-APAP; an opioid pain medication) was removed from the Controlled Drug Record (CDR, an accountability sheet that tracks narcotic removal with the nurse's initial, date, and time) without the corresponding administration documentation in Resident 91's MAR (Medication Administration Record- a legal document that lists the drugs given to a resident). This failure could contribute to unsafe drug handling, poor pain control, and risk of drug diversion (medication taken by someone other than for whom it is prescribed). Findings: During a review of Resident 91's Controlled Drug Record (CDR) for Norco, with date range of 6/15/24 to 7/15/24, the record listed Norco removal for PRN (as needed) use. A comparative review of Resident 91's CDR with the Medication Administration Record (MAR) for the same time period, indicated the following: 6/23/24 at 5:30 PM; No MAR documentation 6/29/24 at 10 PM; No MAR documentation 7/5/24 at 10:42 PM; No MAR documentation 7/8/24 at 10:40 PM; No CDR removal documentation. During a concurrent interview and record review on 7/18/24, at 8:51 AM, with the Director of Nursing (DON) in her office, the CDR record and MAR was reviewed. The DON stated she would further research the record to clarify the missing documentation. During an interview on 7/19/24, at 2:42 PM, with the DON, in her office, the DON stated the nurse who removed the Norco from the CDR was no longer working at the facility. The DON stated she was not able to contact the nurse and ask why the removal from the CDR was not documented in the MAR. During a telephone interview on 7/19/24, at 3:21 PM, with the facility's Consultant Pharmacist (CP), the CP stated he had performed a random audit of the narcotic use and gave the report to the facility. A review of the facility's undated policy titled, Controlled Substances indicated, The facility complies with all laws, regulations, and other requirements related to handling .and documentation of controlled medications .

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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** 40903 Based on interview, observation, and record review, the facility failed to ensure the safe use of psychotropic medications (mind altering drugs) for 2 of 25 sampled residents (Resident 45 and Resident 92) when: 1. Resident 45's documented diagnosis of bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels and behavior) in the medical record for use of the mind-altering psychotropic medication called risperidone (or Risperdal, a drug used to treat mental health or behavior issues) was not reflected in the medical doctor's progress notes and assessments. 2. Resident 92's use of PRN (as needed) anti-anxiety medication called alprazolam (or Xanax, a drug used to treat anxious feelings) was not evaluated and re-assessed by the facility and medical doctor despite frequent use. These failures could contribute to unsafe use of mind-altering medications that could put Resident 45 at risk for adverse consequences and Resident 92 at risk for dependence on a medication. Findings: 1. During a review of Resident 45's medical record, Medication Administration Record, (or MAR- a legal document that lists the medications and monitoring by nursing staff) dated for July of 2024, the record indicated an order for risperidone, a mind-altering drug, for diagnosis of bipolar disorder as follows: RisperiDONE Tablet 0.5 MG .(mg is milligram, a unit of measure) by mouth at bedtime for CRYING AND VERBALIZED SADNESS related to BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED . -Order Date- 5/13/24. Further review of Resident 45's medical record admission information indicated Resident 45 was admitted to the facility in 2018 with a diagnosis of stroke (brain injury). The record further indicated the diagnosis of bipolar disorder was added to the electronic medical record on 3/22/24. During a review of Resident 45's medical record, MDS (or Minimum Data Set; a mandated federal government tool for facilities to implement standardized assessment and care provided to residents), for the second quarter of 2024 (April to May 2024), the record indicated the addition of a bipolar diagnosis in the MDS on 5/25/24 under psychiatric/Mood disorder section. During a concurrent interview with Licensed Nurse (LN) 11 on 7/19/24, at 11:58 AM, and review of Resident 45's medical record, Physician Progress Note, dated 7/2/24 and 6/3/24, written by Medical Doctor (MD) 2, the record indicated among other medical conditions, a diagnosis of Dementia with hallucinations-Depakote, Risperdal (Dementia is forgetfulness and confusion; Hallucination is when hearing unreal voices or people; Depakote and Risperdal are mind altering drugs used to treat mental health symptoms). Further review of MD 2's progress notes from 5/2/23, 5/25/23, 5/29/23, 7/26/23, and 10/4/23 did not include any bipolar diagnosis. LN 11 confirmed the electronic record documentation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/19/24, at 12:15 PM, with Resident 45 in his room, Resident 45 was observed in bed and his lunch was in a tray in front of him. Resident 45 stated he had been in the facility for 5 years after suffering a stroke that paralyzed one side of his body. Resident 45 stated he had been depressed and not happy for being bed bound and not able to do things on his own, and he became frustrated at times. During an interview on 7/19/24, at 2:24 PM, with the MDS Coordinator (MDS-C) in her office, the MDS-C stated they updated the diagnosis based on the doctor's documented records. The workflow for adding a new diagnosis was for the nurse to enter the orders and diagnosis in the electronic medical record. MDS-C stated they followed what the nurses entered in the system based on the doctor's progress notes. MDS-C further stated Resident 45's bipolar diagnosis was entered by a nurse, and they must have had a doctor's order to enter it in the computer. Review of a paper order written by Nurse Practitioner (NP) 1, dated 3/21/24, indicated Risperdal for bipolar disorder with depression as manifested by crying, and verbalized sadness. The record further indicated, Progress Notes to be Cosigned by Physician. The record did not have a physician cosignatory. The record did not indicate how the NP 1 came up with Resident 45's bipolar disorder diagnosis. During a telephone interview on 7/19/24, at 3:53 PM, with NP 1, NP 1 stated she no longer worked at the clinic and did not have access to records. NP 1 stated any orders or notes she wrote, as a consultant, should have been reviewed and approved by the primary doctor. NP 1 further stated the mental health consult records after a visit were given to the Director of Nursing and Social Services staff for review with the medical team. During a telephone interview on 7/19/24, at 4:56 PM, with MD 2, MD 2 stated her group started providing care to the facility's residents in May of 2023 and could not comment on prior documentation. MD 2 stated her progress notes were her assessments, and if there was a psychiatric consultation, it should have been shared with her. During an interview on 7/19/24, at 2:42 PM, with the Director of Nursing (DON), in her office, the DON stated the psychiatric diagnosis should have been reviewed by the medical doctor and the Interdisciplinary Team (IDT, a team of nurses, social worker and other caregivers) should have assessed the use of mind-altering medication regularly and shared the input and information with the medical provider. Review of the facility's undated policy titled, Psychotropic (mind altering drug) Medication Use, indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition .Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat specific condition that is diagnosed and documented in medical record. 2. During a review of Resident 92's medical record, Medication Administration Record, (MAR- a legal document that lists the medications and monitoring by nursing staff) dated for July of 2024, the record indicated an order for alprazolam as follows: ALPRAZolam Oral Tablet 2 MG (Alprazolam); Give 1 tablet by mouth every 24 hours as needed for RESTLESSNESS related to ANXIETY DISORDER; Start date 6/3/24. (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 the record indicated Resident 92 was given alprazolam on nearly a daily basis in the evening time, with the exception of a few days since it was started. During a concurrent interview and record review on 7/19/24, at 11 AM, with Licensed Nurse (LN) 9, Resident 92's medical record was reviewed with LN 9, the record indicated Resident 92 was admitted on [DATE] with the alprazolam order to be used as needed, and the admitting doctor did not indicate to re-evaluate the use after 2 weeks. LN 9 stated it should have had a stop date and re-evaluation after 2 weeks and had continued for more than 1.5 months. During an interview on 7/19/24, at 2:42 PM, with the DON in her office, the DON stated the PRN anti-anxiety medication alprazolam for Resident 92 should have been re-assessed with a stop date of 14 days when it was first started. During a telephone interview on 7/19/24, at 2 PM, with the facility's Consultant Pharmacist (CP), the CP stated the alprazolam order for Resident 92 should have been questioned by the pharmacy provider during the initial dispensing review. The CP stated the pharmacy had been sending 10 days supply each time they issued a refill. The CP acknowledged the PRN order was missed for 2 week re-assessments by staff and doctors. Review of the facility's undated policy titled, Psychotropic (mind altering drug) Medication Use, indicated, Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical records. PRN orders for psychotropic medications are limited to 14 days. For Psychotropic medication that are not anti-psychotic: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration of PRN order.

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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. 40903 Based on observation, interview, and record review, the facility failed to ensure safe medication labeling and storage practices for a census of 97 when: 1. The medication refrigerator contained undated medication, the sealed Emergency Kit (Ekit- a box containing medications for urgent use) contained drugs covered with white material, and the medication cart in Station 2 contained undated products; 2. Resident 27's chemotherapy medication called capecitabine (or Xeloda, a cancer treatment drug) was not properly labeled, stored, and dispensed as an identifiable hazardous (dangerous) medication; 3. Resident 27's prescribed inhaler was not properly secured or labeled with Resident 27's name or other identifier on the medication; and, 4. Resident 5 and Resident 14's continuous glucose monitoring (CGM-tracks glucose (blood sugar) levels in real time) Readers (displays glucose data collected by a sensor inserted under the skin of the upper arm and displays a current blood sugar) were not labeled with their name or another identifier. These deficient practices could contribute to unsafe medication storage, use, and handling and placed staff and residents at risk for exposure to hazardous medications. These failures also had the potential for accidental use of Resident 27's inhaler by other residents, and for improper blood sugar management if Resident 5 and Resident 14's devices were used by the wrong resident. Findings: 1. During a concurrent interview and inspection of the facility's medication room for Unit 1, on 7/16/24, at 9:40 AM, accompanied by Licensed Nurse (LN) 4, the medication refrigerator contained a liquid bottle of a medication called lorazepam (or Ativan, a controlled medication used to treat anxiety) with no marking when it was first opened. The label on the lorazepam container indicated it was dispensed in February of 2024. The outer label of lorazepam bottle had a wet looking touch. The manufacturer label on the container indicated Discard opened bottle after 90 days. LN 4 confirmed the finding. During a concurrent interview and inspection of the facility's medication room for Unit 1, on 7/16/24, at 9:40 AM, accompanied by Licensed Nurse (LN) 4, the medication refrigerator contained a packet of medication called Gvoke HypoPen (or Glucagon, a drug in shot form used in emergency to treat low blood sugar). The label on the packet and pharmacy label indicated DO NOT refrigerate or freeze. LN 4 acknowledged the finding and stated it should have been kept in the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and inspection of the facility's medication room for Unit 1, on 7/16/24, at 9:40 AM, accompanied by LN 4, the Ekit for oral medication was opened for inspection. The kit contained two small bottles of SPS Suspension (Sodium Polystyrene Sulfonate, a liquid medication used to treat dangerous high potassium level in the body) sealed in a plastic bag and had a white powdery spill or contamination around the two bottles and inside the plastic bag. LN 4 stated she would send the Ekit back to pharmacy, and was not sure if it was a leak or damage to the container. During a concurrent interview and inspection of the facility's medication Cart for Unit 2, on 7/16/24, at 10:24 AM, accompanied by LN 5, the cart contained undated test strips bottles used to measure blood sugar with a glucometer (a machine that measures blood sugar) and two undated control solutions (a testing solution used to calibrate the glucometer for accurate blood sugar testing) bottles. LN 5 stated the test strip bottle and control solution should have been dated when first opened. The label on the container of the test trip indicated Use within 6 months after first opening. The label on the container of the control solution indicated Use within 3 months after first opening. Review of the facility's undated policy titled, Medication Labeling and Storage, indicated, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 50161 2. Review of Resident 27's Order Summary Report, indicated Resident 27 was admitted to the facility with diagnoses which included cancer of the colon and lung. Review of Resident 27's MEDICATION ADMINISTRATION RECORD, (MAR) indicated, .Capecitabine Oral Tablet 500 MG (MG same as milligram, unit of measurement) .Give 3 tablet by mouth three times a day related to [colon and lung cancer] .Order date 7/4/24 . The MAR indicated Resident 27 was administered her capecitabine for 22 doses from 7/5/24 through 7/18/24. During a concurrent observation and interview on 7/18/24, at 10:45 a.m., LN 1 identified and confirmed Resident 27's medication bottle of capecitabine was stored in the top drawer of the medication cart. LN 1 stated Resident 27's capecitabine medication was a hazardous drug and should not be stored in the top drawer of the cart with the other non-hazardous medications. LN 1 further stated the capecitabine medication should be stored in a separate drawer with other hazardous medications. LN 1 confirmed the capecitabine medication bottle was not labeled with medication warnings and stated the medication should have had warning labels. LN 1 stated the medication warning labels were there so that licensed nurses were aware of the safe handling of the medication. During a concurrent interview and observation on 7/18/24, at 11:15 a.m., LN 13 confirmed Resident 27's medication bottle of capecitabine in the medication cart. LN 13 further confirmed that she had administered Resident 27's 8 a.m. dose of capecitabine on 7/18/24 and stated she did not wear gloves during the administration of Resident 27's capecitabine. LN 13 stated she was not aware of the safety precautions of the medication and was not aware that it was a hazardous medication. LN 13 further stated Resident 27's medication was stored in the top drawer of the medication cart with the rest of the non-hazardous medications. LN 13 stated there was no hazardous label on the capecitabine medication bottle, and it was not stored in a hazardous labeled bag. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/19/24, at 4:24 p.m., the Director of Nurses (DON) stated hazardous medications should be stored separately from other medications and stored in a sealed, labeled, hazardous drug bag. The DON further stated this was important, so staff were aware to wear gloves during administration. The DON stated the risk for licensed nurses if they handled a hazardous drug without wearing gloves or taking other precautions would be a potential for reproduction issues if they would touch these medications as the medication could absorb into their skin. The DON further stated hazardous medications should be labeled hazardous and labeled with associated risks. The DON further stated hazardous medications were to be administered in a separate dispensing cup and not mixed with other medications during administration. The DON stated that if these precautions were not done then this would be harmful to staff and residents. Review of an undated facility policy and procedure (P&P) titled, Hazardous Drugs, indicated, .Hazardous pharmaceutical drugs are handled according to practice standards so as to minimize staff and resident exposure, and environmental damage .Hazardous drugs handled in this facility are identified according to criteria published by the National Institute for Occupational Safety and Health (NIOSH, National Institute for Occupational Safety and Health conducts research and makes recommendations for the prevention of work-related injury and illness a federal agency sets standard of safety in health care) .Hazardous drugs are labeled, stored and transported in accordance with current .standards .Staff are trained on and required to wear personal protective equipment (PPE) specific to the risk of the exposure and activities performed . Review of the DailyMed drug information website (a U.S. Food and Drug Administration (FDA) labeling for prescription drugs) for capecitabine (or Xeloda, a cancer treatment drug), last accessed on 7/23/24, via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a1de8bba-3b1d-4c9d-ab8a-32d2c05e67c8, the drug information indicated XELODA is a hazardous drug. Follow applicable special handling and disposal procedures. Review of drug information for capecitabine (or Xeloda, a cancer treatment drug), last accessed via Lexicomp (A drug information database), on 7/23/24, the information indicated capecitabine was a hazardous drug and was categorized in group 1 hazard level (group 1 is antineoplastic drugs (cancer drugs) and group 2 and 3 were non-antineoplastic hazardous drugs). The record further referenced Hazardous Drugs Handling Considerations; Hazardous agent NIOSH -2016 (National Institute for Occupational Safety and Health conducts research and makes recommendations for the prevention of work-related injury and illness) .Use appropriate precautions for receiving, handling, administration, and disposal .Gloves should also be worn during receiving, unpacking, and placing in storage. NIOSH recommends single gloving for administration of intact tablets or capsules. NIOSH recommends double gloving, a protective gown, and (if there is a potential for vomit or spit up) eye/face protection for administration of an oral liquid/feeding tube administration. 3. Review of Resident 27's MEDICATION ADMINISTRATION RECORD, indicated .Budesonide-Formoterol Fumarate Inhalation Aerosol .2 puff inhale orally two times a day related to (for chronic lung disease) .order date 7/10/2024 . During an observation on 7/16/24 at 11:47 a.m., Resident 27 was observed sleeping in her bed and an inhaler was observed on her bedside table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/16/24, at 12 p.m., in Resident 27's room, LN 12 confirmed Resident 27's budesonide inhaler was on her bedside table. LN 12 confirmed the inhaler did not have Resident 27's name or directions labeled on the inhaler. LN 12 stated there was a room number written on the inhaler, but that it was the wrong room number because Resident 27 had changed rooms and the number written on her inhaler was her old room number. LN 12 further stated the inhaler should be labeled with the resident's name and room number. LN 12 stated that if the inhaler was unlabeled and left on the bedside table the risk could be that another resident could use it and administer the medication to themselves. LN 12 stated if someone else was to use the medication then they would be at risk for an infection or at risk of taking a medication they did not need. During a concurrent observation and interview on 7/16/24, at 12:15 p.m., in Resident 27's room, Resident 27 stated she had changed rooms about a month ago after she was released from the hospital. During an interview on 7/19/24, at 4:24 p.m., the DON stated medications should be labeled with a pharmacy label which included the resident's name and usage directions so that it was clear who the medication was for and how to administer it, along with the expiration date. The medication should also be in a locked storage in the resident's room. The DON further stated the risk if the medication was not secured in the room would be that another resident could use the medication and there could be risk of infection and other health risks from the use of the medication. Review of an undated facility policy and procedure (P&P) titled, Self-Administration of Medications, indicated, .Self-administered medication are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them . 4a. Review of Resident 5's Order Summary Report, indicated Resident 5 was admitted to the facility with diagnoses including diabetes mellitus (disease that affects how the body uses blood sugar). The report indicated, .[Brand Name of CGM] READER TO READ RESULT AS DIRECTED .order date 5/13/2024 . [Brand Name] SENSOR, APPLY TO PATIENT'S SKIN ONCE EVERY 2 WEEKS) .order date 5/13/2024 . During an observation on 7/16/24, at 11:31 a.m., in Resident 5's room, Resident 5 was not in her room and a black Reader device was observed on her bed. During a concurrent observation and interview on 7/16/24, at 11:41 a.m., in Resident 5's room, LN 12 confirmed there was no name on Resident 5's CGM Reader. LN 12 stated there were two residents in the room (Resident 5 and Resident 14) and each was using a CGM Reader. LN 12 further stated if the Readers were switched, the residents could receive an incorrect dose of insulin (medication used to lower blood sugar-too much insulin can cause dangerously low blood sugar) and this could cause serious problems. b. Review of Resident 14's Order Summary Report, indicated Resident 14 was admitted to the facility with diagnoses including diabetes mellitus. The report indicated, .[Brand Name of CGM] READER TO READ RESULT AS DIRECTED .order date 5/13/2024 .[Brand Name of CGM] SENSOR, APPLY TO PATIENT'S SKIN ONCE EVERY 2 WEEKS .order date 5/13/2024 . (continued on next page)

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	056216	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Care and Rehabilitation Center	410 Eastwood Ave Manteca, CA 95336

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/16/24, at 11:28 a.m., in Resident 14's room, a CGM Reader was observed laying on her bedside table. Resident 14 stated the Reader was hers, and that staff left it on her bedside table. Resident 14 stated her roommate (Resident 5) had a Reader too. During a concurrent observation and interview on 7/16/24 at 11:45 a.m., LN 12 stated she had worked at the facility for one month. LN 12 confirmed there was no name or other identifier on Resident 14's CGM Reader and stated the Reader should have a resident identifier because it could get mixed up with another resident. LN 12 stated if the LN used the wrong Reader, the resident could receive the wrong dose of insulin. During an interview on 7/16/24, at 4:36 p.m., Resident 14 stated no password was needed to use the Reader, and she received it while in the facility. During a concurrent observation and interview on 7/16/24, at 4:50 p.m., LN 12 explained the Reader gave a blood sugar reading when staff tapped it near the resident's upper arm where the sensor was located. LN 12 stated no password was required to use the Reader. LN 12 further stated she was not sure what the Reader would do if she was to use it on another resident's sensor. During an interview on 7/18/24, at 9:46 a.m., the DON stated nine to ten residents had CGMs in the facility. The DON further stated the expectation was for the Reader to be labeled. The DON stated the Reader was connected to the resident's sensor (meaning attached to their body). The DON further stated the benefit of the CGM for residents was less finger sticks, more accurate glucose values, and the ability to see a trend in glucose values. The DON stated that this was even more reason to make sure the Readers were patient specific. During a phone interview on 7/19/24, at 3:20 p.m., the Consultant Pharmacist (CP) stated there should be a label on the Reader with the resident's name to identify it belonged to that specific resident. The PC stated if the Reader was switched with another resident's, this could lead to a misreading of blood sugar levels.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046 Based on observation, interview, and record review, the facility failed to ensure safe food storage for 92 residents who received food service from the kitchen when: 1. Food items were not dated and were not labeled with a use-by date in the refrigerator and freezer; and, 2. Thawing bacon trays were not labeled with a pulled-out date. These failures had the potential to expose residents to food borne illnesses (illnesses caused by the ingestion of contaminated food or beverages). Findings: During an initial tour of the kitchen on [DATE], at 8:36 a.m., accompanied by the Dietary Supervisor (DS) 1, the following findings were observed: 1.a. During a concurrent observation and interview on [DATE], at 8:53 a.m., with DS 1 in the walk-in refrigerator, DS 1 confirmed an opened 2 pound (unit of weight) bottle of minced garlic had no use-by date. DS 1 stated there should have been a use-by date on the opened bottle. b. During a concurrent observation and interview on [DATE], at 8:57 a.m., with DS 1 in the walk-in refrigerator, DS 1 confirmed an opened 1 gallon (a unit of volume) bottle of barbeque sauce had no use-by date. DS 1 stated there should have been a use-by date on the opened bottle. c. During a concurrent observation and interview on [DATE], at 9:11 a.m., with DS 1 in the walk-in freezer, DS 1 confirmed an opened bag of 5 veggie patties was not labeled with a use-by date. DS 1 stated it should have been labeled with a use-by date. d. During a concurrent observation and interview on [DATE], at 9:17 a.m., with DS 1 in the walk-in freezer, one opened 30 pound box was observed with an opened bag of precut green beans that was not labeled with a use-by date. DS1 confirmed the finding and stated the box with green beans should have been labeled with a use-by date. e. During a concurrent observation and interview on [DATE], at 9:24 a.m., with DS1 and DS 2 in the kitchen, DS1 and DS 2 both confirmed a plastic spice bottle of rubbed sage was not labeled with a use-by date. DS 1 stated it should have been labeled with a use-by date. f. During a concurrent observation and interview on [DATE], at 9:26 a.m., with DS 1 and DS 2 in the kitchen, an opened 128 oz (ounce- unit of volume) bottle of vanilla extract had no use-by date. The finding was confirmed by DS 1 and DS 2. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on [DATE], at 9:08 a.m., with DS 1 in the walk-in refrigerator, DS 1 confirmed three large metal trays with thawing bacon were not labeled with a date or time when the thawing was started. DS 1 stated the trays of thawing bacon should have been labeled with the date and time the thawing was started. During an interview on [DATE], at 11:44 a.m., with the Registered Dietitian (RD), the RD stated all food products should be labeled with a use-by date to avoid serving expired food. The RD explained residents could be exposed to food borne illnesses if served expired food. The RD further stated the thawing food should be labeled with the date when the thawing process was started to prevent food borne illnesses. During a review of an undated facility policy titled, LABELING AND DATING OF FOODS, indicated, .All food items in the .refrigerator, and freezer need to be labeled and dated .Newly opened food items will need to be closed and labeled with .used by the date . Review of an undated facility procedure titled, THAWING OF MEATS, indicated, .Label defrosting meat with pull out and use by date .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49823 Based on observation, interview, and record review, the facility failed to follow infection prevention practice for a census of 97 when, 1. Staff placed a dirty cup on the same cart with the clean water pitchers; and, 2. Resident 65's urinal was not labeled with a resident identifier such as his room number or name. Findings: These failures increased the potential risk for the spread of infection to residents in the facility. Findings: During a concurrent observation and interview on 7/18/24, at 2:58 p.m., with Certified Nursing Assistant (CNA) 3 in the hallway of Station II, CNA 3 took a clean water pitcher into a resident's room. CNA 3 exited the room and placed a dirty cup on the cart with the clean water pitchers. CNA 3 stated the dirty cup should not be on the clean cart. During an interview on 7/19/24, at 8:35 a.m., with Licensed Nurse (LN) 8, LN 8 stated that if a dirty cup was disposable, it should be put in the garbage. Otherwise, she would take the dirty cup away or would put it on the resident's tray after the meal for removal. LN 8 further stated she could not put a dirty cup with the clean water pitchers due to the risk of infection (contamination with germs). During an interview on 07/19/24, at 10:07 a.m., with the Director of Nursing (DON), the DON stated when a resident gave a staff member a dirty cup, the dirty cup needed to be placed on the cart for the dirty dishes. The DON further stated that the risk was infection from cross-contamination (spreading germs from one area to another). Review of an undated facility policy titled, Water Pitchers, indicated, .Water pitchers are to be sanitized in the dishwasher in the Food & Nutrition Services Department, at least once a day. After water pitchers are sanitized, they are filled with ice and water by Food & Nutrition Services staff or Nursing and delivered to the residents . A review of an online document published by the United States Department of Agriculture (USDA) titled, Keep Food Safe! Food Safety Basics, last review dated 1/5/2024, indicated, .Guidelines to keep food safe: clean - wash hands and surfaces often, separate - don't cross-contaminate . (https://www.fsis.usda. gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/steps-keep-food-safe) 50161 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 65's Order Summary Report, indicated Resident 65 was admitted with a diagnosis which included but not limited to Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During an observation on 7/16/24, at 10:30 a.m., Resident 65 was observed sleeping in his bed with a urinal attached to the side of the bedrail. The urinal was not labeled with Resident 65's name or other identifier. During a concurrent observation and interview on 7/16/24, at 10:36 a.m., in Resident 65's room, CNA 2 confirmed that Resident 65 had a urinal attached to the side rail of his bed and the urinal was not labeled with an identifier. CNA 2 stated Resident 65's first and last name should have been written on his urinal. During a concurrent observation and interview on 7/16/24, at 10:54 a.m., in Resident 65's room, LN 6 confirmed there was no resident identifier written on Resident 65's urinal. LN 6 stated that the room number identifier should have been written on the urinal. LN 6 stated the urinal needed to be labeled due to the risk of the residents in the same room sharing the same urinal and passing an infection. During an interview on 7/18/24, at 2:58 p.m., the Infection Preventionist (IP) stated urinals must be labeled with residents' room numbers. The IP further stated the risk could be contamination and infection if the urinal was used by the wrong patient. During an interview on 7/19/24, at 4:24 p.m., the DON stated urinals should be labeled and dated with the residents' room number and date. The DON further stated this was done to prevent the risk of infection due to another resident in the same room possibly sharing the urinal.