STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056225	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute	4840 E.Tulare Avenue Fresno, CA 93727

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on observation, interview and record review, the facility failed to ensure residents were treated with respect and dignity for two of three sampled residents (Resident 14 and Resident 67) when: 1. Licensed Vocational Nurse (LVN) 2 did not address Resident 14 by her name. This failure had the potential for Resident 14 to feel disrespected. 2. Resident 67' foley catheter (an indwelling urinary catheter (a thin tube placed in the bladder to drain urine into a bag) drainage bag was without a dignity cover (a cover used to cover and hold the catheter drainage bag so it is not visible). This failure violated Resident 67's right to dignity and privacy and had the potential to affect the self-esteem, self-worth, and quality of life of Resident 67. Findings: 1. During an observation on 7/24/24 at 8:57 a.m. in Resident 14's room, LVN 2 addressed Resident 14 by calling her mama and honey while obtaining Resident 14's blood pressure (the pressure of blood on the walls of your arteries as your heart pumps blood around your body). During a concurrent observation and interview on 7/24/24 at 9:03 a.m., near Resident 14's room entrance, Resident 14 was seated in her wheelchair. Resident 14 stated she wanted to be addressed by her name and not being called 'mama or honey because it did not sound right. During a review of the clinical record for Resident 14, the Minimum Data Set (MDS- assessment of healthcare and functional needs) assessment dated [DATE], Section C indicated Resident 14's Brief Interview for Mental Status (BIMS) score was of 8 of 15 possible points (0-7: severe impairment, 8-12: moderately impaired, 13-15: cognitively intact). Resident 14 was moderately impaired. During an interview on 7/24/24 at 9:32 a.m. with LVN 2, LVN 2 validated addressing Resident 14 by calling her mama and honey. LVN 2 stated residents should be addressed by their name. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/26/24, at 4:03 p.m., with the Director of Nursing (DON), the facility policy titled, Dignity dated 2/2021 was reviewed. The policy indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs Staff are expected to treat cognitively impaired residents with dignity and sensitivity . The DON stated residents should be addressed by their name unless specified otherwise in their care plan. 48739 2. During a concurrent observation and interview on 7/22/24 at 7:33 a.m. with Resident 67 in Resident 67's room, Resident 67 was observed in bed with his urinary catheter bag uncovered, hanging on the side of his bed. Resident 67 stated staff did not put his urinary catheter bag in a cover. Resident 67 stated when he was transferred to the hospital, people could see Resident 67's urine. Resident 67 stated his urine was red with blood. During an interview on 7/22/24 at 7:51 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 67's urine bag should have been covered for Resident 67's privacy. During a concurrent interview and record review on 7/25/24 at 10:33 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 67's Progress Notes, dated 7/20/24 were reviewed. The progress notes indicated Resident 67 was sent to the hospital after reinsertion of Resident 67's foley Catheter, red tinged urine was observed inside Resident 67's catheter bag. LVN 1 stated Resident 67 should have had a privacy bag over his urine catheter bag when he was transferred to the hospital. LVN 1 stated the catheter privacy bag was used to preserve Resident 67's dignity. During an interview on 7/26/24 at 3:09 p.m. with the Director of Nursing (DON), the DON stated Resident 67's urine catheter bag should have been covered in a dignity bag to preserve Resident 67's dignity. The DON stated her expectation was all staff should watch for residents with urine catheters to have covers on the catheter bags to preserve resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 12/2016, indicated, . employees shall treat all residents with kindness, respect, and dignity . these rights include the resident's right to: . a dignified existence . be treated with respect, kindness, and dignity . During a review of professional reference retrieved from https://www.researchgate.net/publication/229538320_The_impact_of_urological_conditions_on_patients'_dignity titled, The Impact of Urological Conditions on Patient's Dignity, dated March 2007, indicated, . patients with urological conditions are particularly vulnerable to a loss of dignity . staff promoted dignity by providing privacy .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview and record review, the facility failed to ensure physician obtained informed consents (a process in which residents are given important information of the possible risk and benefits of the use of medications) for the use of psychotropic medication (medication capable of affecting mind, emotions, and behavior) and antipsychotic medication (a medication used to treat certain types of mental health problems) were completed for one of six sampled residents (Resident 31) when Resident 31 received Citalopram hydrobromide (an antidepressant medication used to treat a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and Resident 31 received Quetiapine (an antipsychotic medication that can treat several mental health conditions such as bipolar disorder [a disorder associated with episodes of mood swings ranging from depressive lows to manic highs]) without a signed informed consent. These failures resulted in Resident 31 to receive psychotropic and antipsychotic medications without being fully informed of the risk and benefits of the medications being administered; preventing them from making an informed choice which placed the resident at risk of negative side effects. Findings: During an observation on 7/22/24 at 8:02 a.m. in Resident 31's room, Resident 31 was observed sleeping in her bed. During a review of Resident 31's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 7/25/24, the AR indicated Resident 31 was admitted on [DATE] with diagnoses of major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). During a review of Resident 31's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/28/24, the MDS section C indicated Resident 31 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 31 was cognitively intact. During a concurrent interview and record review on 7/25/24 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 31's Medication Administration Record (MAR), dated 7/26/24 was reviewed. The MAR indicated Resident 31 was taking Citalopram and Quetiapine. LVN 1 stated Resident 31 started taking Citalopram on 6/15/24. LVN 1 stated Resident 31 started taking Quetiapine on 6/15/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/25/24 at 10:51 a.m. with LVN 1, Resident 31's Informed Consent - Psychoactive Medication (IC), dated 6/14/24 was reviewed. The IC indicated Resident 31 was taking antidepressant and antipsychotic medications. LVN 1 stated Resident 31 did not sign the IC. LVN 1 stated the physician signed Resident 31's IC, without dating his signature. LVN 1 stated two nurses initialed Resident 31's IC without dating their initials. LVN 1 stated Resident 31's IC was electronically signed by the Director of Nursing (DON) on 7/19/24. LVN 1 stated Resident 31 was admitted on [DATE]. LVN 1 stated Resident 31 should have signed the IC on admission when she started taking the antidepressant and antipsychotic medications. During a concurrent interview and record review on 7/26/24 at 2:34 p.m. with the Pharmacy Consultant (PC), Resident 31's IC, dated 6/14/24 was reviewed. The IC indicated Resident 31 was taking antidepressant and antipsychotic medications without signing her IC. The PC stated she first saw Resident 31 and reviewed Resident 31's records on 7/10/24. The PC stated she gave a recommendation on 7/10/24 to get dated signatures on Resident 31's consents. The PC stated Resident 31 needed to sign the consents before taking the antidepressant and antipsychotic medications. During an interview on 7/26/24 at 3:09 p.m. with the DON, the DON stated residents on antidepressant or antipsychotic medications should have a signed IC for the medications. The DON stated the IC was not valid if the physician did not sign and date the IC. The DON stated antidepressant and antipsychotic medications should not be started without valid ICs. During a review of the facility policy and procedure (P&P) titled, Informed Consent Policy (IC), dated 4/2017, indicated . the physician will provide education to the resident or responsible party to include the risks, benefits, and alternatives of a given procedure or intervention . During a review of the facility P&P titled, Behavior Management, dated 12/31/15, indicated, . whenever an order is obtained for psychotropic medication(s), the licensed nurse verifies that informed consent has been obtained . During a review of the facility P&P titled, Antipsychotic Medication Use, dated 7/2022, indicated, . residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind .

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 40641 Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for one of five sampled residents (Resident 59) when Certified Nursing Assistant (CNA) 8 stood over Resident 59 while spoon feeding her breakfast while lying in bed. This failure resulted in Resident 59 not being provided a respectful and dignified dining experience which could further enhance resident's quality of life. Findings: During an observation on 7/22/24 at 8:25 a.m. in Resident 59's room, Resident 59 was lying in bed with head of the bed elevated and bed was in the highest position. Bedside table on the side of the bed and CNA 8 was standing on the side of Resident 59's bed while spoon feeding her breakfast. During a review of Resident 59's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information) dated 7/25/24, the AR indicated, Resident 59 was admitted to the facility with diagnoses which included intervertebral (between) disc degeneration (breakdown) lumbar region (lower back) and muscle weakness. During an interview on 7/24/24 at 10:10 a.m. with CNA 8, she stated Resident 59 was dependent on staff to meet all her activities of daily living (ADL-related to personal care like bathing, dressing, transfers, eating and toileting). CNA 8 stated she was assisting Resident 59 with breakfast on 7/22/24. CNA 8 stated she was standing on the side of the bed while spoon-feeding Resident 59 and it was wrong. CNA 8 stated, . I should have been sitting next to her [Resident 59] while I was assisting her [Resident 59] during breakfast because it was a dignity issue . During an interview on 7/25/24 at 10:40 a.m. with CNA 9, CNA 9 stated the practice when assiting residents with meals in bed was to lower resident's bed, elevate the head of the bed and sit next to resident bed and at eye level with resident. CNA 9 stated it was a dignity issue standing over resident while assiting during meals. During an interview on 7/26/24 at 11:15 a.m. with the Director of Nursing (DON), the DON stated staff should be sitting on a chair next to the resident when assisting during meals. The DON stated staff should not be standing next to resident when assisting during meals because it was a dignity issue. The DON stated CNA 8 should have lowered Resident 59's bed and sat on a chair to spoon-feed Resident 59. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2/2021, the P&P indicated, . Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self worth and self-esteem . (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Resident Rights, dated 2/2021, the P&P indicated, . Federal and state laws guarantee certain basic rights to all residents of this facility . be treated with respect, kindness and dignity .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to provide a homelike environment for three of eight sampled residents (Residents 19, 44 and 137) when meals were served on plastic trays. This failure did not enhance or promote the rights of the residents to live and experience dining in a manner or environment that was homelike. Findings: During a concurrent observation and interview on 7/22/24 at 12:01 p.m. in the dining room, staff served Residents 19, 44 and 137 their meals on a plastic trays. Staff placed the entire tray in front of each resident, but did not remove the food plates, beverage glass, utensils, and napkins from the plastic tray. Residents 19, 44 and 137 did not answer any questions asked. During a review of Resident 19's Admission Record dated 7/25/24, the AR indicated, Resident 19 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body). During a review of Resident 44's AR dated 7/25/24, the AR indicated, Resident 44 was admitted to the facility on [DATE], with diagnoses which included hemiplegia, unspecified affecting right dominant hand. During a review of Resident 137's AR dated 7/25/24, the AR indicated, Resident 137 was admitted to the facility on [DATE], with diagnoses which included displaced fracture (bone snaps into two or more parts and moves so that the two ends are not lined up straight) of left femur (thigh bone). During an interview on 7/22/24 at 12:25 p.m. in the dining room with Center Scheduler (CS), the CS stated she was also a Certified Nurse Assistant. The CS stated, the food plates, drinks and utensils should have been removed from the plastic tray and placed in front of residents. The CS stated the practice had always been to remove the plates, drinks and utensils from the plastic tray and placed on the table in front of resident because of homelike environment. During an interview on 7/22/24 at 12:35 p.m. in the dining room with Rehabilitative Nursing Assistant (RNA)2, RNA 2 stated, . The practice was to make sure food plates are removed from the plastic tray, placed in front of residents and remove lids . RNA 2 stated it was not acceptable to leave food plates, drinks and utensils in the plastic tray because it was not a homelike environment. RNA 2 stated the facility was the residents's home and therefore they should eat like they were eating in their own homes. During an interview on 7/25/24 at 8:19 a.m. with the Certified Dietary Manager (CDM), the CDM stated her area of concern was only the kitchen and nursing staff were responsible in the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dining room. The CDM stated food plates, utensils, water and juice glasses were removed from the plastic tray and placed in front of residents for a homelike environment. During an interview on 7/25/24 at 2:45 p.m. with Licensed Vocational (LVN) 4, LVN 4 stated she did not really know what was going on in the dining room. LVN 4 stated staff needed to make sure food was checked by licensed nurse before serving to residents making sure they were served the correct food consistency. LVN 4 stated food needed to be removed from the plastic tray and served in front of residents to make it more like homelike environment. During an interview on 7/26/24 at 10:25 a.m. with the Director of Nursing (DON), the DON stated food should not be left in the plastic tray when serving to residents because it was not homelike environment. The DON stated the facility was the residents home so they [residents] should eat like they were in their own home. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/21, the P&P indicated, . 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences . 3. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutionalized, institutional setting .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to meet the required timelines for encoding, completion and transmission of Minimum Data Set (MDS) assessments (evaluation of cognition, care needs and functional abilities) for one of five sampled residents (Resident 55) when the Minimum Data Set Nurse (MDSN) did not complete or transmit discharge and readmit MDS tracking assessment for Resident 55. This deficient practice resulted in the potential harm of residents' needs upon discharge going unmet. Findings: During a concurrent observation and intervention on 7/22/24 at 8:45 a.m. in Resident 55's room, Resident 55 was sitting up in bed eating breakfast. Resident 55 refused to answer question stated, .Why are you picking on me . During a review of Resident 55's Admission Record (AR), dated 7/25/24, the AR indicated, Resident 55 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (high blood sugar) and psychosis (mental disorder characterized by a disconnection from reality). During a concurrent interview and record review, on 7/25/24 at 11:07 a.m. with the MDSN, the MDSN reviewed the MDS assessment dated [DATE] and submission for Resident 55. The MDSN stated the last MDS assessment for Resident 55 was dated 7/9/24. The MDSN stated Resident 55 was sent out to acute hospital on 12/15/23 and readmitted to the facility on [DATE]. MDSN stated she did not find a completed and transmitted MDS discharge assessment tracking for Resident 55 when Resident 55 was sent out to acute on 12/15/23. MDSN stated she did not find a completed and transmitted MDS admitted assessment tracking for Resident 55 when Resident 55 was admitted back in the facility on 12/18/24. The MDSN stated it was a mistake on her part, she should have made sure she opened an assessment for the transfer and readmission of Resident 55. The MDSN stated the RAI (core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) manual recommendation was to open assessment on discharges and re-admissions, I did not follow the RAI guideline when I did not open assessments for the discharge and readmission. The MDSN stated it was important to open MDS assessment to identify any improvement or decline of Resident 55. During an interview on 7/26/24 at 10:25 a.m. with the Director of Nursing (DON), the DON stated, . I do not know what was going on in MDS . The DON stated she was not trained on MDS and did not have anything to do with MDS when she was working as a charge nurse on the floor. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/24 at 4:55 p.m. with the Administrator (ADM), the ADM stated his expectations when it came to MDS was for MDS to be complete and accurate. The ADM stated the MDSN was new but she could have asked question if she was not sure. During a review of facility's policy and procedure titled, MDS Assessment Coordinator, dated 11/2019, the P&P indicated, . Each individual who completes a portion of the assessent (MDS) must certify the accuracy of that portion of the assessment . Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action . During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.18.11 Manual (RAI- core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) dated 10/23, indicated, .Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds: . Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record). Resident has a hosptal observation stay greater than 24 hours, regardless of whether the hospital admits the resident Entry of a term used for both admission and reentry and requires completion of an Entry tracking record .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for one of three sampled residents (Resident 59) when Resident 59's functional limitation in range of motion was inaccurately coded on the quarterly MDS assessment dated [DATE] and 5/23/24. This failure had the potential to result in Resident 59's care needs not met. Findings: During observation on 7/22/24 at 8:25 a.m. in Resident 59's room, Resident 59 was lying in bed and was assisted by Certified Nursing Assistant (CNA) 8 with breakfast. CNA 8 was spoon-feeding Resident 59. During a concurrent observation and interview on 7/24/24 at 12:35 p.m. in the dining room, Resident 59 was seated on her wheelchair, left hand holding a rolled towel and right hand was observed with weakness. CNA 8 was sitting next to Resident 59 and spoon-feeding her lunch. CNA 8 stated Resident 59 was dependent on staff to meet all her activities of daily living (ADL-activities related to personal care which includes bathing/shower, dressing, transfers, walking, toileting and eating) needs. CNA 8 stated Resident 59 was not able to move her upper extremities and needing assistance during meals. During a review of Resident 59's Admission Record (AR), dated 7/25/24, the AR indicated, Resident 59 was admitted to the facility on [DATE] with diagnoses which included hereditary (passed from parent to child) and idiopathic (unknown cause) neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). During a concurrent interview and record review on 7/24/24 at 2:45 p.m. with Minimum Data Set Nurse (MDSN), Resident 59's quarterly assessments dated 2/22/24 and 5/23/24, section GG were reviewed. The MDSN stated Resident 59 was coded as no impairment of upper extremity (shoulder, elbow, wrist, hand) on the MDS assessment. MDSN stated she completed the assessment on Resident 59 but did not perform bedside assessment. MDSN stated she pulled the information in collaboration with the CNA charting, therapy and Director of Nursing (DON). MDSN stated the quarterly assessments dated 2/22/24 and 5/23/24 were inaccurate. MDSN stated Resident 59 should have been coded with impairment on her upper extremities because she has contractures. MDSN stated she will review the RAI manual on how to assess the functional limitations to avoid inaccurate assessments. MDSN stated the facility follows the Long Term Care Facility Resident Assessment Instruction (RAI-core set of screening, clinical, and functional status elements, including common definition and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing home certified to participate in Medicare or Medicaid) guideline. (continued on next page)

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	056225	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute	4840 E.Tulare Avenue Fresno, CA 93727

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/26/24 at 10:45 a.m. with the DON, the DON stated she assumed the position as DON in June 2024. The DON stated she did not know what was going on in MDS. DON stated she did not get oriented on MDS yet and she did not do any MDS assessment when she was working as a charge nurse on the floor. During an interview on 7/26/24 at 4:55 p.m. with the Administrator (ADM), the ADM stated MDSN is new in her position. The ADM stated his expectation was for the MDS assessment to be complete and accurate. The ADM stated MDSN should have asked question if she was not sure. During a review of facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, dated 11/19, the P&P indicated, . Any healthcare professional who participates in the assessment process is qualified to assess the medical, functional and/or psychosocial status of the resident . The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment . During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.18.11 Manual (RAI- core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) dated 10/23, indicated, .With resident seated on a chair, instruct them to reach with both hands and touch palms to back of head . touch each shoulder with the opposite hand . Code 1, impairment on one side: if resident has an upper- and/or lower-extremity impairment on one side that interferes with daily functioning .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan (CP -a detailed approach to care customized to an individual resident's needs) for five of six residents (Residents 25, 31, 58, 67, and 74) when Residents 25, 31, 58, 67 and 74 did not have a baseline care plan for the monitoring of anti-platelet medication (medication that prevents blood clots from forming). These failures placed Residents 25, 31, 58, 67, and 74 at risk for complications resulting from not having care needs planned by licensed nurses to determine if nursing interventions needed to be added, changed, or completed. These failures placed Residents 25, 31, 58, 67, and 74 at risk for bleeding and signs of bleeding to go unidentified. Findings: a. During a concurrent observation and interview on 7/22/24 at 11:14 a.m. with Resident 25 in Resident 25's room, Resident 25 was observed dressed sitting in a chair in her room. Resident 25 stated she had been in the facility for four months. No bleeding or bruising observed on Resident 25. During a review of Resident 25's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 7/25/24, the AR indicated Resident 25 was admitted on [DATE] with diagnoses of venous insufficiency (a condition where the veins have trouble sending blood from the limbs back to the heart, causing blood to pool in the veins of the legs), lymphedema (a buildup of fluid in the tissues that causes swelling), and hyperlipidemia (a condition where fats build up in the arteries, increasing the risk of a stroke [a condition when a blood vessel that carries oxygen and nutrients to the brain is either blocked or ruptures] or heart attack [a condition with the blood flow that brings oxygen to the heart is severely reduced or blocked]). During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/9/24, the MDS section C indicated Resident 25 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 25 was cognitively intact. During a concurrent interview and record review on 7/25/24 at 10:42 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 25's Order Summary Report (Report), dated 7/25/24 was reviewed. The Report indicated Resident 25 was ordered Aspirin 81 mg daily on 1/6/24. LVN 1 stated Resident 25 was on Aspirin for prophylaxis (an attempt to prevent disease). LVN 1 stated there were no orders for anticoagulation monitoring in place for Resident 25. LVN 1 stated Resident 25 should have had orders for monitoring Resident 25 for signs and symptoms of bleeding or bruising. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/25/24 at 10:44 a.m. with LVN 1, Resident 25's Care Plan (CP), dated 7/25/24 was reviewed. The CP indicated Resident 25 was . at risk for DVT (deep vein thrombosis [clot] . medication as ordered . LVN 1 stated there was no CP in place for anticoagulation monitoring for Resident 25. LVN 1 stated Resident 25 should have had a CP for monitoring Resident 25 for signs and symptoms of bleeding or bruising. LVN 1 stated Resident 25 did not have an individualized CP. LVN 1 stated nurses were responsible for CPs being initiated. LVN 1 stated she was responsible for follow up to verify CPs were accurate. b. During an observation on 7/22/24 at 8:02 a.m. Resident 31 was observed in bed sleeping. No bleeding or bruising was observed on Resident 31. During a review of Resident 31's AR, dated 7/25/24, the AR indicated Resident 31 was admitted on [DATE] with diagnoses of joint replacement surgery (a procedure in which a surgeon removes a damaged joint and replaces it with a new, artificial part), cirrhosis of the liver (permanent scarring that damages the liver and interferes with its functioning), hyperlipidemia, and personal history of transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) . During a concurrent interview and record review on 7/25/24 at 10:50 a.m. with LVN 1, Resident 31's Order Summary Report (Report), dated 7/25/24 was reviewed. The Report indicated Resident 31 was ordered Aspirin 81 mg daily for DVT prophylaxis on 6/14/24. LVN 1 stated Resident 31 did not have orders for monitoring Resident 31 for signs and symptoms of bleeding. LVN 1 stated Resident 31 should have orders for anti-coagulant monitoring for signs and symptoms of bleeding. During a concurrent interview and record review on 7/25/24 at 10:52 a.m. with LVN 1, Resident 31's CPs, dated 7/24/24 were reviewed. There was no CP in place for monitoring Resident 31 for bleeding or bruising. LVN 1 stated Resident 31 did not have a CP for Aspirin monitoring for bleeding or bruising. LVN 1 stated Resident 31 did not have an individualized CP. c. During a concurrent observation and interview on 7/22/24 at 11:29 a.m. with Resident 58, in Resident 58's room, Resident 58 was observed in bed. No bleeding or bruising was observed on Resident 58. Resident 58 stated she had an abdominal wound from a removed feeding tube (a flexible plastic tube placed into the stomach to provide nutrition when a person cannot eat or drink safely by mouth) that was not healing. During a review of Resident 58's AR, dated 7/25/24, the AR indicated Resident 58 was admitted on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body)and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction, cerebral aneurysm (a bulging, weakened area in the wall of an artery in the brain), non-ruptured (not broken), and hyperlipidemia. During a review of Resident 58's MDS, dated [DATE], the MDS section C indicated Resident 58 had a BIMs score of 12, which indicated Resident 58 was moderately impaired. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/25/24 at 10:16 a.m. with LVN 1, Resident 58's Summary Order Report (Report), dated 7/25/24, the Report indicated Resident 58 was ordered Aspirin 81 mg, one tablet daily on 9/1/23. The Report indicated Resident 58 had orders to . observe for signs or symptoms of bleeding (2nd to anticoagulant use) every shift . order date 9/1/23 . LVN 1 stated Resident 58 was taking Aspirin for prophylaxis as ordered by the physician. During a concurrent interview and record review on 7/25/24 at 10:17 a.m. with LVN 1, Resident 58's CP, dated 7/25/24 was reviewed. The CP indicated, no CP was in place to monitor Resident 58 for signs or symptoms of bleeding. LVN 1 stated Resident 58 did not have a CP for anti-coagulation monitoring. LVN 1 stated Resident 58 should have had a CP for anti-coagulation monitoring. LVN 1 stated Resident 58 did not have an individualized CP. d.During a concurrent observation and interview on 7/22/24 at 7:33 a.m. with Resident 67 in Resident 67's room, Resident 67 was observed in dressed in bed. No bleeding or bruising was observed on Resident 67. Resident 67 stated he came back from the hospital yesterday. Resident 67 stated he was in the hospital for bleeding after staff changed his urinary catheter (a thin tube placed in the bladder to drain urine into a bag). During a review of Resident 67's AR, dated 7/25/24, the AR indicated Resident 67 was admitted on [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis and hyperlipidemia. During a review of Resident 67's MDS, dated [DATE], the MDS section C indicated Resident 67 had a BIMs score of 15, which indicated Resident 67 was cognitively intact. During a concurrent interview and record review on 7/25/24 at 10:27 a.m. with LVN 1, Resident 67's Order Summary Report (Report), dated 7/25/24 was reviewed. The Report indicated resident 67 was ordered Aspirin 81 mg, one tablet daily on 5/29/24. LVN 1 stated Resident 67 was taking Aspirin for CVA (Cerebral Vascular Accident [stroke]) prophylaxis. LVN 1 stated Resident 67 did not have orders for anticoagulation monitoring. LVN 1 stated Resident 67 should have had orders for anticoagulation monitoring. During a concurrent interview and record review on 7/25/24 at 10:30 a.m. with LVN 1, Resident 67's CP, dated 7/25/24 was reviewed. The CP indicated no CP was in place for monitoring for bleeding or bruising. LVN 1 stated Resident 67 did not have a CP for anticoagulation monitoring for signs or symptoms of bleeding or bruising. LVN 1 stated Resident 67 should have had a CP for anticoagulation monitoring. LVN 1 stated Resident 67 did not have an individualized CP. e.During an observation on 7/22/24 at 8:00 a.m. in Resident 74's room, Resident 74 was observed in bed. No bruising observed. During a review of Resident 74's AR, dated 7/25/24, the AR indicated Resident 74 was admitted on [DATE] with diagnoses of cerebral infarction, TIA, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and hyperlipidemia. During a review of Resident 74's MDS, dated [DATE], the MDS section C indicated Resident 74 had a BIMs score of 10, which indicated Resident 74 was moderately impaired. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/25/24 at 11:11 a.m. with LVN 1, Resident 74's Order Summary Report (Report), dated 7/25/24 was reviewed. The Report indicated Resident 74 was ordered Aspirin 81 mg, one tablet daily on 5/11/24. LVN 1 stated Resident 74 was taking Aspirin for prophylaxis. LVN 1 stated there were no orders for monitoring for side effects of Aspirin. LVN 1 stated Resident 74 should have orders for anticoagulation monitoring for bleeding and bruising. During a concurrent interview and record review on 7/25/24 at 11:14 a.m. with LVN 1, Resident 74's CP, dated 7/25/24 was reviewed. The CP indicated no CP was in place for anticoagulation monitoring. LVN 1 stated Resident 74 did not have a CP for anticoagulation monitoring for bleeding and bruising. LVN 1 stated Resident 74 should have had a CP for anticoagulation monitoring for bleeding and bruising. LVN 1 stated Resident 74 did not have an individualized CP. During an interview on 7/25/24 at 11:15 a.m. with LVN 1, LVN 1 stated all residents on Aspirin should have had orders and CPs for anticoagulation monitoring for bleeding and bruising. LVN 1 stated it was important to monitor residents for bleeding and bruising. LVN 1 stated licensed nurses will put monitoring into resident's CP. LVN 1 stated anticoagulant monitoring was entered into resident's CP as a standard of practice. LVN 1 stated nurses, the Unit Manager, the MDS coordinator, Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were responsible for verifying CPs were accurate for each resident. LVN 1 stated CPs should have been individualized for each resident. LVN 1 stated each resident was different. LVN 1 stated the CPs were important to help make sure the residents' needs were met and helped improve the residents' goals of care. During an interview on 7/26/24 at 2:34 p.m. with the Pharmacist Consultant (PC), the PC stated Aspirin was considered an anti-platelet medication. The PC stated resident CPs should have had monitoring for bleeding and bruising for residents who were taking Aspirin daily. During an interview on 7/26/24 at 3:09 p.m. with the DON, the DON stated CPs should have been individualized for each resident. The DON stated each resident was different and each resident had different diagnoses. The DON stated the CP planned the resident's care according to the goals and interventions for each resident. The DON stated her expectation was for residents on anticoagulation or antiplatelet medications be monitored for bleeding and bruising. During a review of the facility policy and procedure (P&P) titled, Care Plans - Baseline, dated 3/2022, the P&P indicated, . the baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care . the baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission) . that includes, but is not limited to . the stated goals and objectives of the resident . any services and treatments to be administered by the facility . During a review of the facility P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, indicated, . the care plan interventions should be derived from . the comprehensive assessment . describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for three of 22 sampled residents (Resident 55, 47, and 387) when: 1. Resident 55 did not have a care plan for diagnosis of psychosis (mental disorder characterized by a disconnection from reality). This failure placed Resident 55 at a potential risk for not monitoring behavior which could lead to psychotic breakdown. 2. Resident 47's use of hearing aids was not care planned. This failure had the potential to cause staff to be unaware of Resident 47's need for the usage of hearing aids and resulted in Resident 47 not wearing her hearing aids. 3. Resident 387 did not have a care plan for communication for a foreign language. This failure had the potential for Resident 387's needs to go unmet. Findings: 1. During a review of Resident 55's Admission Record (AR- a document which provides resident contact details, a brief medical history level of functioning, preferences, and wishes), dated 7/25/24, the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses which included psychosis . onset date: 1/5/22. During a review of Resident 55's Psychologist Consultation/follow-up, (PC) dated 1/3/24 and 3/20/24, the PC indicated, . Diagnostic Impression: Depressive Episode . Anxiety Disorder . Psychosis . During observation on 7/22/24 at 8:35 a.m. in Resident 55's room, Resident 55 was sitting up in bed eating breakfast and appropriately dressed. Resident 55 answered simple questions then stated, . Why are you picking on me . Resident did not answer any more questions. During a review of Resident 55's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 6/9/24, indicated the Brief Interview for Mental Status (BIMS) score was 13 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 55 was cognitively intact. During an interview on 7/24/24 at 9:10 a.m. with Certified Nursing Assistant (CNA) 12, CNA 12 stated she was familiar with Resident 55. CNA 12 stated Resident 55 has a behavior of yelling out at staff and non compliant with activities of daily living (ADL-activities related to personal care, including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/25/24 at 9:20 a.m. with Licensed Vocational Nurse (LVN) 1, she reviewed Resident 55's clinical record and stated Resident 55 was admitted on [DATE] with diagnosis of psychosis. LVN 1 stated she was not able to find a care plan for Resident 55's diagnosis of psychosis and there should have been a care plan. LVN 1 stated licensed nurses were responsible in initiating a care plan. LVN 1 stated she was not sure when a comprehensive care plan should have been initiated. During a concurrent interview and record review on 7/25/24 at 2:15 p.m. with LVN 4, she reviewed Resident 55's clinical record and stated Resident 55 was admitted to the facility with diagnosis of unspecified psychosis. LVN 4 stated she was not able to find a care plan for psychosis and there should have been a care plan. LVN 4 stated Resident 55 had a behavior of striking out and spitting at staff. During an interview on 7/26/24 at 10:35 a.m. with the Director of Nursing (DON), the DON stated she was not sure why Resident 55 did not have a care plan for her diagnosis of psychosis. DON stated there should have been a care plan for Resident 55's psychosis diagnosis to monitor behavior and adjust intervention as needed. DON stated she was not sure what the expectation was with comprehensive care plans. DON stated she thinks comprehensive care plans should be done within 72 hours of admission. During a review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Cemtered, dated 3/22, the P&P indicated, . The comprehensive person-centered care plan should be developed within the seven (7) days of the completion of the required MDS assessment . The comprehensive person-centered care plan should: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing . The interdisciplinary team should review and updates the care plan: When there has been a significant change . readmitted to the facility from a hospital stay . 48424 2. During a review of Resident 47's Admission Record (AR- a document which provides resident contact details, a brief medical history level of functioning, preferences, and wishes), dated 12/20/23, the AR indicated, Resident 4's admitting diagnoses included: encephalopathy (term for any brain disease that alters brain function), muscle weakness, chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), and epilepsy (condition which causes recurrent involuntary movements of the muscles). During a review of Resident 47's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive (mental) abilities), dated 6/21/24, the MDS indicated a BIMS (brief interview for mental status- assessment used to determine the cognitive ability of a resident) score of 10 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 47 had moderate cognitive impairment. During a concurrent observation and interview on 7/2/24 at 8:25 a.m. with Resident 47, in Resident 47's room, Resident 47 was walking using a front wheel walker with no hearing aids in place. Resident 47 stated she was hard of hearing. Resident 47 stated her hearing aids went missing and she had difficulty hearing without them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/24/24 at 8:42 a.m. with Certified Nursing Assistant (CNA) 6 outside of Resident 47's room, Resident 47 was seen in her room without her hearing aids . CNA 6 stated Resident 47 was hard of hearing, and she needed hearing aids to properly hear. CNA 6 stated staff members had to raise their voices when speaking with Resident 47 if she did not have hearing aids on. CNA 6 stated she had seen Resident 47's hearing aids in the past and staff were aware she used them. During an interview on 7/25/23 at 4:38 p.m. with CNA 1, CNA 1 stated nurses were responsible for creating resident care plans and CNAs could view the care plan after it was created. CNA 1 stated it was important to have updated and accurate care plans to communicate resident conditions to care staff. CNA 1 stated Resident 47's hearing aids should have been care planned. CNA 1 stated if Resident 47's hearing aid use was not care planned, staff members would be unaware on Resident 47's need to use hearing aides. During a concurrent interview and record review on 7/26/24 at 11:04 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 47's care plan, dated 12/20/23 was reviewed. No preexisting care planning for Resident 47's use of hearing aid was found prior to 7/24/24. LVN 1 stated Resident 47 use of hearing aids should have been care planned upon admission. LVN 1 stated care plans were important because the care plans contain details for the individual care needs, goals, and interventions for the resident. During a concurrent interview and record review on 7/26/24 at 2:57 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 47's care plan, dated 12/20/23 was reviewed. The care plan indicated hearing aid use was added to the care plan on 7/24/24. The MDSC stated Resident 47 should have had her hearing aids care planned prior to 7/24/24. The MDSC stated Resident 47's hearing aides should have been care planned because it helped to accurately reflect and communicate Resident 47's care needs to staff. During an interview on 7/26/24 at 3:33 p.m. with the Director of Nursing (DON), the DON stated Resident 47's hearing aid use should have been care planned. The DON stated it was important to have the hearing aids care planned because it helped set goals and interventions staff members needed to implement when caring for Resident 47. During a review of the facility's LPN [Licensed practical nurse]/LVN job description, dated 11/2018, the job description indicated, . Review care plans daily to ensure that appropriate care is being rendered Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs. Ensure that your assigned certified nursing assistants are aware of the resident care plans. Ensure that the CNA's refer to the resident's care plan prior to administering daily care to the resident . (continued on next page)

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Orchard Post Acute	4840 E.Tulare Avenue Fresno, CA 93727

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/22, the P&P indicated, . A comprehensive, person centered care plan should include measurable objectives and timetables to meet the residents physical psychosocial and functional needs . 3. The care plan interventions should be derived from the information obtained from the resident and his/ her family/ responsible party, with possible discretionary modifications resulting from the comprehensive assessment . 6. The comprehensive, person-centered care plan should: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level physical, mental, and psychosocial well-being that the resident desires or that is possible . 8. The interdisciplinary team should review and updates the care plan: a period when there has been a significant change in the residence condition; b. When the resident has been readmitted to the facility from a hospital stay; and c. At least quarterly, in conjunction with the required quarterly MSD assessment . 49949 3. During a review of Resident 387's Admission Record (document containing resident demographic information and medical diagnosis) dated 7/24/24, the admission record indicated Resident 387 was admitted to the facility on [DATE]. The admission record indicated, Resident 387 diagnoses included muscle weakness, dysphagia (difficulty swallowing), hypertension (high blood pressure), atrial fibrillation (abnormal heartbeat). The admission record indicated primary language [NAME]. During a concurrent observation and interview on 7/22/24 at 9:32 a.m., Resident 387 was lying in his bed. Resident 387 had no picture board (a board to communicate needs). Family Member (FM) FM 1 stated, she had to provide translation for staff member. During an interview on 7/24/24 at 10:19 a.m., with Certified Nursing Assistant (CNA) 6, CNA 6 stated she worked for the facility for three years. CNA 6 stated she did not know what language Resident 387 spoke. CNA 6 stated she was not sure if the facility provided a language line. CNA 6 stated, a picture board and language line was important for residents to communicate their needs. During a concurrent interview and record review on 7/24/24 at 3:30 p.m., with License Vocational Nurse (LVN) 7, Resident 387's care plans were reviewed. LN 7 stated, Resident 387 was admitted on [DATE] and there was no care plan for communication. LVN 7 stated, Resident 387 was identified as speaking a different language. LVN 7 stated, Resident 387 was admitted on [DATE] and there was no care plan for communication. LVN 7 stated, a care plan for communication should have been developed when Resident 387 was admitted to the facility. During an interview on 7/26/24 at 3:49 p.m., with the Director of Nursing (DON), the DON stated a communication care plan was not done. The DON stated the admission nurse was responsible for creating care plans upon admission. The DON stated a communication board was important for residents to communicate their needs. The DON stated, a comprehensive person-centered care plan should include communication. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person Centered, dated 2001 indicated, A comprehensive person center care plan should include .resident's physical, psychosocial and functional needs .2. A comprehensive person-center care plan should be developed within the seven (7) days of the completion of the required MDS assessment .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review the facility failed to revise and implement a person centered comprehensive care plan for one of four sampled residents (Resident 34) when Resident 34 had a decrease in meal intake and care plan interventions were not revised. This failure had the potential for Resident 34's nutritional needs to go unmet. Findings: During a review of Resident 34's Admission Record (AR-document containing resident demographic information and medical diagnosis) undated, the AR indicated Resident 34 was admitted to the facility on [DATE]. Resident 34's diagnosis included unspecified cerebrovascular disease (a condition that affects blood flow to the brain), type two diabetes mellitus (condition in the way body regulates and uses sugar as a fuel) hypertension (high blood pressure), heart failure (when the heart is failing and cannot supply enough blood to the body) gastroesophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). During an observation on 7/22/24 at 12:41 p.m., in Res 34's room, Resident 34 was lying in bed. Resident 34 stated, he was not hungry and did not like his lunch. Resident 34 ate less than 25% of his lunch. During a review of Resident 34's Minimum Date Set (MDS-an evaluation of a resident's cognitive and functional status), dated 7/17/24, the MDS indicated the Brief Interview for Mental status (BIMS assessment of a resident's cognitive status for memory recall) score of three out of 15 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment) which indicated Resident 34 had severe cognitive impairment During an interview on 7/23/24 at 1:22 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated Resident 34 refused breakfast and lunch. CNA 8 stated Resident 34 was on regular diet and regular fluids. During an interview at 7/26/24 at 11:52 a.m., with CNA 9, CNA 9 stated, Resident 34 refused breakfast and sometimes lunch. CNA 9 stated Resident 34 was able to feed himself and at times needed help with meals. CNA 9 stated she notified the charge nurse when Resident 34's refused meals. CNA 9 stated Resident 34 did not eat as much as he used to. During an interview on 7/26/24 at 2:00 p.m. with License Vocational Nurse (LVN) 3, LVN 3 stated Resident 34 lost his appetite and had a decreased in meal intake within the last two weeks. LVN 3 stated he offered Jello, pudding, and fluids when Resident 34 refused his meals. LVN 3 stated a decreased in meal intake was considered a changed in condition. LVN 3 stated Resident 38's nutritional care plan was not revised for the decreased in meal intake and should have been. LVN 3 stated the nutritional care plan had not been revised since 6/28/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/24 at 3:33 p.m., with the Director of Nursing (DON), the DON stated, Resident 34's decreased in food intake should have been updated in the care plan. The DON stated, the care plan should have interventions to address Resident's decrease in meal intake. During a review of the facility's policy and procedure (P&P) titled, Care plans, Comprehensive Person-Centered, dated revised 3/2022, the P&P indicated, .A comprehensive, person-centered care plan should include measurable objective and timetable to meet the resident's physical, psychosocial and functional needs . Describes the services that are to be furnished in an attempt to assist the resident attained or maintain that level of physical, mental, and psychosocial wellbeing .the interdisciplinary team should review and update the care plan .there has been a significant change in the resident's condition .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of quality for five of 15 sampled residents (Resident 19, Resident 24, Resident 38, Resident 40 and Resident 337) when: 1. Resident 40 was administered 2.5L/min (two point five liter- unit of measurement)/min (minute) oxygen via nasal cannula (NC- plastic device used to deliver supplemental oxygen) instead of 3L/min of oxygen per physician's order. This failure resulted in Resident 40's oxygen needs going unmet and caused Resident 40 received oxygen at different rate. 2. Resident 38 was started on antibiotic (medicines that fight bacterial infections in people) without obtaining a wound (an injury to the skin) culture (a test to find germs such as bacteria, a virus, or a fungus). This failure had the potential to result in Resident 38 receiving unnecessary antibiotic and had the potential for placing Resident 38 at risk for adverse effects (an undesired harmful effect resulting from a medication or other intervention) and increased antimicrobial (substance that kills bacterial, mold or stops them from growing) resistance. 3. Resident 337 was administered 5L/min oxygen via NC instead of 2L/min per physician's order. This failure had the potential to put Resident 337 at risk for oxygen toxicity (lung damage that can occur from breathing in too much extra [supplemental] oxygen. Symptoms include coughing, trouble breathing, dizziness and death). 4. Oxygen tubing for Resident 337 was not labeled with the date it was changed and the oxygen humidifier (a device designed to increase the moisture level by emitting water droplets or steam into the air) water tank was not labeled with the date the tank was changed. These failures had the potential to put Resident 337 at risk for infection from contaminated oxygen tubing and oxygen humidifier water tank. 5. Resident 24's responsible party (RP-person who can make medical decisions for a resident) was not contacted for updates regarding his low air loss mattress (mattresses designed to distribute the patient's body weight over a broad surface area to help prevent skin breakdown). This failure caused Resident 24's RP to not be informed of changes regarding Resident's 24's care. 6. Resident 19 was listed as her own responsible party (RP-person designated to make decisions and be informed regarding the care of a resident) when she had a Brief Interview of Mental Status (BIMS-assessment which determines the cognitive [the ability to think, learn, and memorize] impairment of a person) score of 11 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment.). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This failure resulted in the facility not following their own practices of having an RP in place for Residents with a BIMS score under 13. Findings: 1. During a review of Resident 40's Admission Record (AR-a document containing resident profile information) dated 7/26/24, the AR indicated Resident 40 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD-a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and chronic(long term) respiratory failure with hypoxia (absence of enough oxygen in the tissue to sustain bodily functions). During a concurrent observation and interview on 7/22/24 at 9:55 a.m. in Resident 40's room, Resident 40 laid in bed with oxygen via nasal cannula receiving 2.5L/min. Resident 40 stated she was getting 3L/min of oxygen and had been using oxygen for a long time to help her breath. During observation on 7/23/24 at 12:10 p.m. in Resident 40's room, Resident 40 laid in bed watching TV. Resident 40's oxygen was set at 2.5L/min via NC. Resident 40 stated she was supposed to be receiving 3L/min of oxygen to help with her breathing problem. During a concurrent observation and interview on 7/23/24 at 12:15 p.m. with Licensed Vocational Nurse (LVN) 8 in the hallway, LVN 8 checked Resident 40's oxygen and stated Resident 40's oxygen was set at 2. 5L/min. LVN 8 stated the oxygen should be set at 3L/min if it was the order. LVN 8 stated Resident 40's oxygen order was not being followed per physician's order. LVN 8 stated Resident 40 was not receiving the amount of oxygen ordered which could lead to respiratory distress. During a concurrent interview and record review on 7/23/24 at 12:25 p.m. with LVN 4, LVN 4 reviewed Resident 40's oxygen order and stated Resident 40 should be recceiving 3L/min of oxygen via NC as ordered by the prhysician. LVN 4 stated she did not checked the oxygen setting in the morning at the start of her shift and she should have. LVN 4 stated all the licensed nurses should have been checking the oxygen setting of residents' receiving oxygen. LVN 4 stated Resident 40 not receiving the correct amount of oxygen could lead to respiratory issues which could result to more serious problem. During an interview on 7/26/24 at 11:03 a.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses checking the oxygen settings and comparing with the order to ensure residents are receiving the correct amount of oxygen. DON stated licensed nurses should be checking residents's oxygen at the start of their shift and throughout their shift making sure residents' were receiving the correct amount of oxygen to prevent respiratory distress. Durimg a review of facility's policy and procedure titled, Oxygen Administration dated 10/10, the P&P indicated, . Verify that there is a physician's order . Review the physician's orders or facility protocol for oxygen administration . After completing the oxygen setup or adjustment, the following informatio should be recorded . The rate of oxygen flow . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49949 2. During a concurrent observation and interview on 7/22/24 at 12:28 p.m., in his room, Resident 38 was lying in bed. Resident 38 stated he was taking an antibiotic and did not know the reason he was taking it. Resident 38 stated he had a wound. During a review of Resident 38 's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 38 was admitted to the facility on [DATE]. Resident 38's diagnosis included muscle weakness, muscle wasting, pressure ulcer (an injury that breaks down the skin and underlying tissue), dysphagia (difficulty swallowing), atrial fibrillation (irregular heartbeat) and hypertension (high blood pressure). During a review of Resident 38's Minimum Date Set (MDS-an evaluation of a resident's cognitive [mental function] and functional status), dated 6/14/24, the MDS indicated the Brief Interview for Mental status (BIMS assessment of a resident's cognitive status for memory recall) score of 11out of 15 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment) indicating Resident 38 was cognitively intact. During a concurrent interview and record review on 7/25/24 at 2:27 p.m., with License Vocational Nurse (LVN) 1, Resident 38's [Facility name] Order Summary Report (OSR), dated 7/25/24 was reviewed. The OSR indicated, .Wound culture today 7/25/24 r/t [related to] DTI [a type of tissue damage beneath the skin that results from an external pressure] right 1st toe . LVN 1 stated the wound culture was ordered on 7/25/24. LVN 1 stated Resident 38 started on doxycycline (antibiotic) for deep tissue injury) to the right toe on 7/19/24. During a review of [Facility name] Progress Note (PN) dated 7/19/24, the PN indicated .wound bed has 100% eschar (dead tissue that sheds or falls off from the skin) with no drainage noted, moderate odor present. Peri-wound (tissue surrounding a wound) does not exhibit [display] s/s [signs and symptoms] of infection or complication. Received new order on 7/19/24 doxycycline hyclate [a medication used in the management and treatment of a variety of infections.] tablet 100 mg [milligram-unit of measure] give 1 table via G-tube [a tube inserted through the belly that brings nutrition directly to the stomach]. twice a day for PPX [prophylactically] for 10 days of 1st (first) toe right foot . The PN indicated, no wound culture was ordered on 7/19/24. During an interview on 7/25/24 at 3:13 p.m., with the Infection Preventionist (IP- professionals who make sure staff, residents and visitors are doing all the things they should to prevent infections), the IP stated, she worked as an IP for six months. The IP stated, It is not standard of practice to start antibiotic for DTI. The IP stated she was notified that Resident 38 started on antibiotic on 7/19/24. The IP stated the wound culture was obtained on 7/25/24. During an interview on 7/26/24 at 3:49 p.m., with the Director of Nursing (DON), the DON stated, a wound culture should have been done the same day the antibiotic was started. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcome, Dated revised 12/2016, the P&P indicated, .The IP [infection preventionist] or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consist with the appropriate use of antibiotics .4.Thearpy [a form of treatment] was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics . During a review [NAME] the University of Florida Drug and Therapy title Article, Collect before you treat: obtaining cultures before antibiotic treatment dated 12/2006, retrieved from: chrome extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ufhealth.org/assets/media/Professionals-Bulletins/1006-drugs-therapy-bulletin.pdfthe, the article indicated, .Obtaining appropriate cultures before initiating antimicrobial therapy plays an important role in patient [residents] care . Obtaining culture after antimicrobial therapy has been started can cause inconclusive results because organisms that would otherwise be detected may not necessarily grow after exposure to an antibiotic agent Appropriate antibiotic therapy plays an import role in of antibiotic resistance . The Centers for Disease Control and Prevention (CDC) outlines that in order to help control antibiotic resistance and effectively diagnose and treat infection, it is very important to obtain cultures in order to target antimicrobe therapy to susceptibility results . 48739 3. During an observation on 7/22/24 at 9:56 a.m. in Resident 337's room, Resident 337 was observed dressed, in bed with a nasal cannula in his nostrils. Resident 337 stated he had been in the facility for two weeks. Resident 337's oxygen concentrator (a device that produces high levels of oxygen from the air in the room to supply an oxygen-enriched product gas stream) was observed to be infusing oxygen through Resident 337's nasal cannula at five liters per minute. During a review of Resident 337's Admission Record (AR), dated 7/2/24, the AR indicated Resident 337 was admitted on [DATE] with diagnoses of pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), acute respiratory failure with hypoxia (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), and acute pulmonary edema (a buildup of fluid in the lungs). During a concurrent interview and record review on 7/25/24 at 9:57 a.m. with Licensed Vocational Nurse (LVN) 1, a photograph dated 7/22/24 at 9:56 a.m. of Resident 337's oxygen concentrator was reviewed. LVN 1 verified the photograph indicated Resident 337's oxygen was delivering oxygen at 5 liters per minute. Resident 337's Order Summary Report (Report), dated 7/25/24 was reviewed. The Report indicated Resident 337 had admission orders dated 7/2/24 for oxygen to be administered at 2 liters per minute, via nasal cannula, as needed. LVN 1 stated Resident 337 was admitted on [DATE]. LVN 1 stated there were no physician orders for oxygen to be administered at five liters per minute to Resident 337 prior to 7/22/24 at 11:10 a.m. LVN 1 stated Resident 337's oxygen orders were changed on 7/22/24 at 11:10 a.m. to administer oxygen at five liters per minute. LVN 1 stated on 7/22/24 before 11:10 a.m., Resident 337 should have been receiving oxygen at 2 liters per minute. LVN 1 stated if a resident was given too much oxygen, it could blow out the resident's lungs. LVN 1 stated it was very important for staff to follow physician's orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/26/24 at 3:09 p.m. with the Director of Nursing (DON) the DON stated, it was very important for staff to follow physician's orders. The DON stated if staff did not follow physician's orders, it could cause harm to the residents. The DON stated if staff did not follow physician orders for oxygen, it could cause shortness of breath or harm to the resident. The DON stated her expectation was for staff to follow physician's orders. During a review of professional reference retrieved from https://my.clevelandclinic.org/health/treatments/25187-nasal-cannula, dated 8/4/23, indicated, . oxygen therapy has some risks. These risks include: . lung damage or pulmonary oxygen toxicity. This is damage to your lungs and airways from too much oxygen . During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 10/2010, indicated, . verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . adjust the oxygen delivery device so . the proper flow of oxygen is being administered . 4. During an observation on 7/22/24 at 9:56 a.m. in Resident 337's room, Resident 337 was observed dressed, in bed with an undated nasal cannula in both his nostrils, infusing oxygen at five liters per minute. Resident 337's oxygen humidifier tank was observed to be undated, with water inside the tank. Resident 337 stated he had been in the facility for two weeks. Resident 337 stated he had pneumonia. During a concurrent observation and interview on 7/22/24 at 10:04 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 337's room, Resident 337's oxygen tubing and oxygen humidifier tank were observed. CNA 3 stated the oxygen tubing and oxygen humidifier tank were not dated. CNA 3 stated the oxygen tubing and oxygen humidifier tank should be dated with the date they were last changed. During an interview on 7/25/24 at 2:26 p.m. with LVN 1, LVN 1 stated Resident 337's oxygen tubing should have been dated with the date the tubing was changed. LVN 1 stated Resident 337's oxygen humidifier tank should have been dated with the date the tank was changed. LVN 1 stated dated oxygen tubing and dated humidifier tanks were important for resident infection prevention. LVN 1 stated if the oxygen tubing or the oxygen humidifier tank was not changed, they could have dust or mold growth inside the tank or tubing which could cause infection to Resident 337. During an interview on 7/26/24 at 3:09 p.m. with the DON, the DON stated nurses were responsible for making sure the residents' oxygen tubing and humidifier tanks were changed weekly and dated. The DON stated it was important to change the oxygen tubing and oxygen humidifier tank weekly. The DON stated residents were at an increased risk of infection if the oxygen tubing or oxygen humidifier tank were not changed weekly. During a review of Resident 337's Order Summary Report (Report), dated 7/25/24, the Report indicated, . change humidifier bottle/tubing every day shift every Sun Date & Initial . order date 7/2/24 . During a review of professional reference retrieved from https://www.ucsfhealth.org/education/your-oxygen-equipment, titled, Patient Education Your Oxygen Equipment, dated 2022-2024 indicated, . the nasal cannula should be changed every week . if you are using a humidifier, empty it at least once a day . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	48424 5. During a review of Residents 24's Admission Record (AR), dated 1/12/24, the AR indicated, Resident 24 was not his own RP. Resident 24's admitting diagnoses included the following: muscle wasting and atrophy (condition which causes the muscles to diminish and weaken), and muscle weakness. During a review of Resident 24's Minimum Data Set (MDS), dated [DATE], the MDS indicated BIMS score of ten (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 24 had moderate cognitive impairment. During an observation on 7/22/24 at 8:14 a.m. in Resident 24's room. Resident 24 was observed lying on a low air loss mattress. During an interview on 7/25/24 at 4:22 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated a change to Resident 24's low air loss mattress should have been communicated to the RP. CNA 1 stated low air loss mattresses were doctor's orders and doctor's orders needed to be communicated to the RP. CNA 1 stated it was important to communicate to the RP in order to have a cognitively intact person consent to treatments needed. During concurrent interview and record review on 7/26/24 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 24's progress notes, dated 07/22/24 were reviewed. The progress note indicated, . Received new LAL [low air loss mattress] but noted low pressure . ADON [assistant director of nursing] notified. Resident is self RP and made aware. Will [continue] to monitor . LVN 1 stated Resident 24 was not supposed to act as his own RP. LVN 1 stated staff should have contacted his actual RP regarding his mattress. LVN 1 stated it was important to contact Resident 24's RP so appropriate decisions could have been made by a cognitively intact person. During a concurrent interview and record review on 7/26/24 at 2:38 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 24's MDS, dated [DATE] was reviewed. The MDS indicated Resident 24 had a BIMS score of 10. The MDSC stated residents with a BIMS score less than 13 could not serve as their own RP. The MDSC stated Resident 24's BIMS was 10 which indicated he had moderate cognitive impairment. The MDSC stated Resident 24's RP should have been contacted. The MDSC stated if a residents RP was not contacted, the resident would receive inaccurate care. During an interview on 7/26/24 at 3:33 p.m. with the director of nursing (DON), the DON stated Resident 24's RP should have been contacted regarding his mattress. The DON stated the RP would have been unaware of any changes occurring with Resident 24 if he was not contacted. During a review of the facility's policy and procedure (P&P) titled, Informed Consent Policy, dated 4/17, the P&P indicated, . Resident or responsible party will be provided an informed consent whenever applicable . 6. During a review of Resident 19's Admission Record (AR), dated 6/28/24, the AR indicated Resident 19 was her own RP. Resident 19's admitting diagnoses included: Major Depressive Disorder (a mental health disorder characterized by persistently sad mood or loss of interest in activities), Alzheimer's disease (condition which causes memory loss), psychotic disorder with hallucination (condition which causes false beliefs such as hearing or seeing things that are not there). (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 19's Minimum Data Set (MDS), dated [DATE], the MDS indicated a BIMS score of 11 indicating Resident 19 had moderate cognitive impairment. During an interview on 7/25/24 at 4:31 p.m. with CNA 1, CNA 1 stated residents with impaired cognitive abilities and confusion could not sign their own consents or serve as their own RP. CNA 1 stated if Resident 19 had a low BIMS score it meant she could not act as her own RP. CNA 1 stated residents with lower BIMS scores should not serve as their own RP because they could have signed consents they would not have understood. During an interview on 7/26/24 at 11:04 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents with a BIMS score between 8-12 were cognitively impaired. LVN 1 stated MDSC was the person who calculated the BIMS scores and determined if residents were able to act as their own RP. During a concurrent interview and record review on 7/26/24 at 2:42 p.m. with the MDSC, Resident 19's MDS Section C, dated 6/1/24, was reviewed. The MDS Section C indicated Resident 19 had a BIMS score of 11. The MDSC stated it was the facility's practice that residents with a BIMS score under 13 could not serve as their own RP. Resident 19 should not have been her own RP with a BIMS score of 11. The MDSC stated a different RP should have been selected at the time of her admission on 6/28/24. The MDSC stated having an appropriate RP was important in order to adequately provide care for residents . During a review of the facility's policy and procedure (P&P) titled, Informed Consent Policy, dated 4/17, the P&P indicated, . Resident or responsible party will be provided an informed consent whenever applicable .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 41119 Based on observation, interview, and record review, the facility failed to safely store, and label drugs and supplies in accordance with acceptable standards of practice when: 1. One medication cart (out of four) was left unlocked and unattended by Licensed Vocational Nurse (LVN) 3. This failure resulted in a potential for residents and staff to have unauthorized access to medications. 2. One emergency kit (E-kit- emergency medication stored in container) was found without second zip tie in the medication storage room. This failure had the potential for unauthorized access to medication and missing medication. 3. A package containing hearing aid batteries were stored with medication in the medication cart number 4. This failure had the potential for medications and hearing aid batteries to be mixed together. 4. Medications were found in one unlabeled bag, one cup containing multivitamin pill in medication cart number 3. A cup containing medications with applesauce was found in the medication cart number 4. This failure had the potential for residents receiving wrong medication because they were unlabeled. 5. Insulin pen (medication used to control high blood sugar) was not labeled with resident name and open date. This failure had the potential for insulin given to wrong residents. 6. One treatment wound cart was unattended with the keys left in the lock. This failure had the potential to harm residents to access to treatment supplies. Findings: 1. During an observation on 7/26/24 at 1:51 p.m., medication cart three was located next to the nurses' station against the wall, the medication cart drawers were facing the hall. The medication cart was unlocked and unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/26/24 at 1:54 p.m., LVN 3 Walked out of the nurses' station and placed a bag of spoons on the side of the medication cart three. LVN 3 walked back into the nurses' station without locking the medication cart three. During an observation on 7/26/24 at 1:55 p.m., LVN 3 walked out of the nurses' station and proceeded down the hall towards the main entrance. The medication cart three was unlocked and unattended. During an observation on 7/26/24 at 1:57 p.m., medication cart three remained unlocked and unattended. During a concurrent observation and interview on 7/26/24 at 1:59 p.m. medication cart three was located next to the nurses' station against the wall. Central Supply (CS) walked by the medication cart and pushed the locking mechanism in place, locking the cart. CS stated she spotted the unlocked medication cart and locked it. During a concurrent observation and interview on 7/26/24at 2:00 p.m. in the facility hallway, LVN 3 walked back to the medication cart. LVN 3 stated the medication cart should be locked for safety so no unauthorized person can access it. During a concurrent interview and records review on 7/26/24 at 4:00 p.m. with the Director of Nurses (DON), the facility policy and procedure titled Storage of Medications dated 2019 was reviewed. The policy indicated . Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications .are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access . The DON stated the medication cart should be locked when unattended to prevent unauthorized access. 49949 2. During a concurrent observation and interview on 7/24/24 at 11:09 a.m., with LVN 1 in the medication storage room, an emergency kit was found in the refrigerator with a missing zip tie. LVN 1 stated, there should be two zip ties on the emergency kit. During an interview on 7/26/24 at 9:14 a.m., with the Pharmacist Consultant (PC), the PC stated the E-kit needed to have two zip ties on it. The PC stated, if an emergency kit was missing a zip tie, the staff need to notify the pharmacy right away. The PC stated, the E-kit needed to be replaced as soon as possible. The PC stated it was important for the E-kit to have two zip ties to prevent tampering. The PC stated someone can access the E-kit with a missing zip tie. During an interview on 7/26/24 at 3:49 p.m., with the DON, the DON stated, E-kit needed two zip ties to ensure it was sealed. During a review of the facility's policy and procedure titled, Storage of Medication dated revised 11/2022, the P&P indicated, .The facility stores all drugs and biological in a safe, secure and orderly manner .Drugs containers that have missing, incomplete, or incorrect labels are returned to the pharmacy for proper labeling before storing . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During a concurrent observation and interview on 7/25/24 at 10: 47 a.m., with LVN 5, the medication cart three had hearing aid batteries stored with the medications. LVN 5 stated, Hearing aid batteries should not be stored with medications. During an interview on 7/26/24 at 9:14 a.m. with the PC, the PC stated, hearing aid batteries should not be stored in the same compartment as medications. The PC stated it was important to stored hearing aid in a different compartment to prevent giving hearing aid batteries as medications. During an interview on 7/26/24 at 3: 49 p.m., with the DON, the DON stated hearing aid batteries should not be stored in the medication compartment. The DON stated hearing aid batteries needed to be stored and separated away from the medications. During a review of the facility's policy and procedure titled, Medication Storage dated 2019, the P&P indicated, . Potentially harmful substance (such as urine test reagent tablets, household poison, cleaning supplies, disinfectant are clearly identified and stored in a lock area separately from medications . 4. During a concurrent observation and interview on 7/25/24 at 10:02 a.m., with LVN 3 in the hall, medication cart three had one multivitamin pill in a cup. LVN 3 stated, the multivitamin was for Resident 77. LVN 3 stated he should have discarded the medication and should not have left it in the medication cart. During a concurrent observation and interview on 7/25/24 at 10:03 p.m., with LVN 3 in the hall, medication cart three had two sodium (supplemental medication to treat low salt level) pills in a clear plastic bag. LVN 3 stated, it was a sodium pill. LVN 3 stated the sodium pills should not be stored with the other medications. LVN 3 stated the sodium pills should be destroyed as soon as possible. During a concurrent observation and interview on 7/25/24 at 10:57 a.m., with LVN 5 in the nurses' station, medication cart four had a cup with medications and applesauce. LVN 5 stated she did not know who it belonged to or what medication the cup contained. During an interview on 7/26/24 at 9:14 a.m., with the PC, the PC stated, over the counter medications that was not given should be destroyed and placed in the medication destruction container. During an interview on 7/26/24 at 3:49 p.m., with the DON, the DON stated medications that were not given needed to be discard after medication pass. During a review of the facility's policy and procedure titled, IE5: Medication Destruction dated 2019, the P&P indicated, .C. Non-controlled medication destruction occurs only in the presences of (two) individuals . Medications dropped on the floor or spit out by resident shall be placed in medication waste containers . 5. During a concurrent observation and interview on 7/25/24 at 10:51 a.m., with LVN 5 in the nurses' station, one insulin pen did not contain the resident name or open date. LVN 5 stated, there should have been a name on the pen. LVN 5 stated, it was important to label the insulin pen with the resident's name. LVN 5 stated, labeling the pen with the resident's name ensured it was given to the correct resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/26/24 at 9:14 a.m., with the PC, the PC stated, insulin pen should always have the name of the resident and the date it was opened. The PC stated insulin pens were sent in a bag. The PC stated, insulin pen could fall out of the bags and mixed with other insulin pens. The PC stated insulin pens without names can be given to the wrong residents. During an interview on 7/26/24 at 3:49 p.m., with the DON, the DON stated insulin pens should be labeled with the resident's name. The DON stated it was important to have a label with the resident's name on the insulin pen to ensure it was administered to the correct resident. During a review of the facility's policy and procedure (P&P) titled, Administering Medications dated revised 12/2012, the P&P indicated, .14. Insulin pens will be clearly labeled with the resident's name or other identifying information . 41608 6. During an observation on 7/22/24 at 12:35 p.m. between bathroom one and two, a treatment cart (a cart use to store medical or treatment supplies) was observed unattended with the key in the lock and other keys on a keychain dangling from the lock. During a concurrent observation and interview on 7/22/24 at 12:37 p.m. with Licensed Vocational Nurse (LVN) 6, in front of the treatment cart, LVN 6 removed the keys from the lock of the unattended treatment cart. LVN 6 stated, the keys should not be left in the lock when the treatment cart was unattended. LVN 6 stated, residents could get into the treatment cart and harm themselves. During an interview on 7/25/24 at 10:29 a.m. with Wound Nurse (WN), the WN stated, keys should never be left in the lock of the wound cart when unattended. During an interview on 7/25/24 at 10:30 a.m. with LVN 1, LVN 1 stated, keys should never be left in the lock of the medication carts or treatment carts, a resident could get into the medication cart and take another resident's medication or get something sharp from inside the treatment cart and cause harm to themselves or other residents. During an interview on 7/26/24 at 3:00 p.m. with Director of Nurses (DON), the DON stated the wound cart should be locked when unattended to keep residents and visitors from getting into medications and wound supplies. During a review of the facility's policy and procedure (P&P) titled, ID1: Storage of Medications dated 2019, indicated .Medications and biologicals are stored safely, securely .medication supply is assessable only to license nursing personnel . Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 48424 Based on observation, interview and record review, the facility failed to accommodate resident meal preferences and provide an appropriate alternative for one of 18 sampled residents (Resident 35) when Resident 35 received a sandwich on white bread instead of wheat bread. This failure resulted in Resident 35 refusing to eat lunch and missing out on the nutritional value of the meal and had the potential to cause Resident 35 to experience weight loss as a result of not eating. Findings: During an observation on 7/22/2024 at 12:28 P.M. in Resident 35's room, Resident 35 received a sandwich on white bread instead of wheat bread. Resident 35's meal tray ticket indicated wheat bread under preferences. Resident 35's meal ticket indicated his sandwich should have been on wheat bread. During an interview on 7/22/2024 at 12:28 P.M. with Resident 35, Resident 35 stated he did not like white bread, and he would not eat his lunch. Resident 35 stated he had told staff about his preference, and wheat bread was listed on his meal ticket under preferences. During a concurrent observation and interview on 7/22/2024 at 12:34 P.M. with the Dietary Manager (DM), Resident 35 was served white bread instead of wheat bread. The DM stated Resident 35 should have been served wheat bread. The DM stated the kitchen ran out of wheat bread the previous night and was aware there was none left for the following day. The DM stated resident preferences print out on the meal ticket and should have been followed. During an interview on 7/25/24 at 3:12 P.M. with Dietary Aid (DA)1, DA 1 stated meal tickets list residents likes and dislikes under preferences. If a preference was for wheat bread, kitchen staff would have given the resident their preference. DA 1 stated if the preference was not available the DM would discuss an alternative with the resident. DA 1 stated it was the dietary aids, certified nursing assistants (CNA) and licensed vocational nurses (LVN) duty to check meal tickets match resident meal orders, as well as to notify the DM. DA 1 stated it was important to follow meal preferences so residents will eat their meals; if residents did not like their meals they will not eat. During an interview on 7/25/24 at 3:24 P.M. with the DM, the DM stated a kitchen staff member should have identified wheat bread was out of stock the night before and notified the DM so alternatives could be discussed with Resident 35. The DM stated it was important to follow meal tickets as residents may not eat if their preferences were not followed. DM stated they should have discussed alternatives with residents if preferences were not available. During an interview on 7/25/2024 at 4:18 P.M. with CNA 1, CNA 1 stated LVN's checked every meal tray for accuracy. CNA 1 stated the CNA's role was to help set up meal trays and report to the LVN if a resident did not receive food that was their preference. CNA 1 stated meal ticket preferences should have been followed. CNA 1 stated if a resident did not receive their preference, they would not have eaten their meal. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/24 at 11:04 A.M. with LVN 1, LVN 1 stated at mealtime the tray contents should have been compared to the meal ticket and reviewed with the resident, this should have been done for every meal delivery. LVN 1 stated this was done to ensure the correct diet and preferences were given to each resident. LVN 1 stated if food items were inaccurate, staff should have sent the food back to the kitchen and ensure the resident got the correct order. LVN 1 stated it was important to follow preferences so the resident would eat their meals. During an interview on 7/26/23 at 3:33 p.m. with the Director of Nursing (DON), the DON stated Resident 35's meal ticket should have been followed. The DON stated nurses were responsible for checking the meal trays for accuracy and they should have checked Resident 34's meal tray more carefully. The DON stated if Resident34's meal preferences were not followed, he would not eat and it could have led to Resident 35 experiencing weight loss. During a review of the facility's policy and procedure (P&P) titled, Menus, dated 10/21, the P&P indicated, . menu items and available snacks reflect .preferences of the residents . During a review of the facility's P&P titled, Resident Food Preferences, dated 7/2017, the P&P indicated, . Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41608 Based on observation, interview, and record review, the facility failed to ensure food was stored and/or prepared in accordance with professional standards for food services safety for 91 of 96 residents when: 1. A plastic container of dry bran cereal was uncovered in the dry food storage. 2. An uncovered Styrofoam cup with brown liquid was left on top of an ice chest in the dry food storage. 3. No air gap (an unobstructed vertical space between the water outlet and the flood level of a fixture), under the sink where food was being prepared. 4. The food thermometer (a tool to measure temperature), was not calibrated (verifying the capability and performance of an item of measuring and test equipment by comparison to traceable measurement standards), prior to use during lunch service. 5. The thermometer was not sanitized prior to being placed in a metal container of freshly cooked broccoli during lunch service. 6. The temperature of the soup was not measured prior to serving to residents. 7. The cook touched multiple surfaces with gloves on and then continued to serve food during lunch service without changing gloves. 8. The cook did not follow the recipe during tray line and used the same size scoop for small, regular, and large portions. 9. A Dietary Aid (DA) 2, walked through the kitchen without a hair net while food was being served. These failures placed all residents that receives meals are at risk for food borne illness. Findings: 1. During a concurrent observation and interview on 07/22/24 at 7:41 a.m. in the dry storage area with the Certified Dietary Manager (CDM), a plastic container of dry bran cereal was uncovered in the dry food storage. The CDM stated, the lid should have been replaced on the bin to prevent insects and other contaminants from getting into the food. During an interview on 7/22/24 at 7:42 a.m. with the Registered Dietitian (RD), the RD stated there should be no uncovered food in the dry food storage area, uncovered food could get flies, debris, or other contaminants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's Policy and Procedure (P&P) titled, Food Receiving and Storage dated 11/2022, indicated, .Food services maintain clean .food storage area at all times .all foods are covered . 2. During a concurrent observation and interview on 7/22/24 at 7:46 a.m. in the dry food storage area, with the CDM and the RD, a white Styrofoam cup half full of brown liquid was sitting uncovered on top of an ice chest sitting on the floor next to the shelves in the dry storage area. The CDM stated, staff personal drinks were not to be in the food pantry area. The RD stated personal drinks were not to be stored in pantry area, the drinks could spill onto the food being stored and contaminate it. During a review of the facility's P&P titled, Food Receiving and Storage dated 11/2022, indicated, .Food services maintain clean .food storage area at all times .all foods are covered . 3. During a concurrent observation and interview on 7/22/24 at 8:24 a.m. in the facility's kitchen, with the CDM and the RD, the food preparation sink was observed to not have an air gap. The CDM stated, she was not familiar with the food preparation sink needing an airgap, the CDM stated Maintenance would be the department responsible for the airgap. The RD stated, she needed to review the air gap regulations. During an interview on 7/25/24 at 5:10 p.m. with the Administrator (ADM), the Administrator stated the facility does not have an air gap under the food preparation sink. The facility does not have an air gap policy. During a review of the Food Code U.S Food and Drug Administration, dated 2022, indicated, . 5-202.13 Backflow Prevention, Air Gap. During periods of extraordinary demand, drinking water systems may develop negative pressure (when water flows in the opposite direction) in portions of the system. If a connection exists between the system and a source of contaminated (dirty) water during times of negative pressure, contaminated water may be drawn into and foul (to make dirty) the entire system. Standing water in sinks . and other equipment may become contaminated with cleaning chemicals or food residue . 4. During an observation on 7/23/24 at 11:54 a.m. of the facility's lunch tray line service, the [NAME] (CK), did not calibrate the new food thermometer prior to taking the temperature of the food. During an interview on 7/23/24 at 1:15 p.m. with the CK, the CK stated she did not follow the facilities expectations during the lunch meal service. CK stated she should have calibrated the food thermometer to verify the temperatures were accurate. During an interview on 7/23/24 at 2:27 p.m. with CDM, the CDM stated, the cook should have calibrated the thermometer prior to taking the temperature of the food during the tray line service to prevent food born illness from food being served at incorrect temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 7/23/24 at 2:50 p.m. with the RD, the facility's P&P, titled, Food Preparation and Service dated 11/2022, was reviewed. The P&P indicated, .Adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of food borne illness .food preparation staff are to adhere to proper hygiene and sanitary practices .food thermometers . are clean, sanitized, and calibrated .foods held in steam tables are monitored throughout the meal service . the RD stated, the CK should have should have calibrated the food thermometer . During a review of facility P&P titled, Thermometer and Calibration dated 2018, indicated, .Food thermometer are to be used properly and calibrated to ensure accurate temperature reading .food thermometer are to be calibrated each week .when a thermometer is new .it is recommended to put thermometer calibration on a cook's duties/sanitation list that must be initialed upon completion . During a review of Job description: [NAME] (JD), [undated], the JD indicated, .Maintain kitchen and cooking area in a safe, orderly, clean, and sanitary manner .follow .portion control guidelines .record food temperatures for the meals . During a review of JD Dietary Supervisor. [undated], the JD indicated, .Supervises all dietary functions and personnel .inspects Dietary Department .ensures continued compliances with all federal, state, and local regulations . During a review of JD Registered Dietitian. [undated], the JD indicated, .Monitor food services operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulations . 5. During an observation on 7/23/24 at 11:55 a.m. of the facility's lunch tray line service, the CK did not sanitize the thermometer prior to placing it into a container of broccoli. During an interview on 7/23/24 at 1:15 p.m. with the CK, the CK stated she should have sanitized the food thermometer before she placed it into the broccoli to prevent contamination of the broccoli. During an interview on 7/23/24 at 2:27 p.m. with the CDM, the CDM stated, the CK should have sanitized the food thermometer prior to placing it into the container of broccoli to prevent cross contamination. During a concurrent interview and record review on 7/23/24 at 2:50 p.m. with the RD, the facility's policy and procedure (P&P), titled, Food Preparation and Service dated 11/2022, was reviewed. The P&P indicated, . Adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of food borne illness .food preparation staff are to adhere to proper hygiene and sanitary practices .food thermometers . are clean, sanitized, and calibrated .foods held in steam tables are monitored throughout the meal service . the RD stated, the cook should have sanitized the thermometer During a review of facility P&P titled, Thermometer and Calibration dated 2018, indicated, .Food thermometers are to be used properly and calibrated to ensure accurate temperature reading .thermometers are to be cleaned and sanitized after use . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Job description: [NAME] (JD), [undated], the JD indicated, .Maintain kitchen and cooking area in a safe, orderly, clean, and sanitary manner .follow .portion control guidelines .Record food temperatures for the meals . During a review of JD Dietary Supervisor [undated], the JD indicated, .supervises all dietary functions and personnel .Inspects Dietary Department .ensures continued compliances with all federal, state, and local regulations . During a review of JD Registered Dietitian. [undated], the JD indicated, .Monitor food services operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulations . 6. During an observation on 7/23/24 at 11:56 a.m. of the facility's lunch tray line service, The CK did not take the temperature of the soup prior to serving to residents. During an interview on 7/23/24 at 1:16 p.m. with the CK, the CK stated she should have taken the temperature of the soup prior to serving to the residents. Serving food not cooked to the proper temperature could lead to food born illness. During an interview on 7/23/24 at 2:26 p.m. with the CDM, the CDM stated, the cook should have taken the temperature of the soup prior to serving to Residents. prevent food born illness from food being served at incorrect temperatures. During a concurrent interview and record review on 7/23/24 at 2:50 p.m. with the RD, the facility's P&P, titled, Food Preparation and Service dated 11/2022, was reviewed. The P&P indicated .Adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of food borne illness .food preparation staff are to adhere to proper hygiene and sanitary practices .food thermometers . are clean, sanitized, and calibrated .foods held in steam tables are monitored throughout the meal service . the RD stated, the CK should have taken the temperature of the soup . During a review of Job description: [NAME] (JD), [undated], the JD indicated, .Maintain kitchen and cooking area in a safe, orderly, clean, and sanitary manner .follow .portion control guidelines .Record food temperatures for the meals . During a review of JD Dietary Supervisor. [undated], the JD indicated, .Supervises all dietary functions and personnel .inspects Dietary Department .ensures continued compliances with all federal, state, and local regulations . During a review of JD Registered Dietitian [undated], the JD indicated, .Monitor food services operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulations . 7. During an observation on 7/23/24 at 11:55 a.m. of the facility's lunch tray line service, the cook stopped serving food to open a drawer, retrieved a ladle and continued serving food while without changing gloves. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute	4840 E.Tulare Avenue Fresno, CA 93727

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/23/24 at 1:17 p.m. with the CK, the CK stated, she should have changed her gloves prior to serving food during the lunch tray line, not changing gloves could have resulted in cross contamination. During an interview on 7/23/24 at 2:27 p.m. with the CDM, the CDM stated, the CK should have changed her gloves prior to serving food during tray line to prevent cross contamination which could lead to food borne illness. During a concurrent interview and record review on 7/23/24 at 2:50 p.m. with the RD, the facility's policy and procedure (P&P), title Food Preparation and Service dated 11/2022, was reviewed. The P&P indicated, . Adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of food borne illness .food preparation staff are to adhere to proper hygiene and sanitary practices .food thermometers . are clean, sanitized, and calibrated .foods held in steam tables are monitored throughout the meal service . the RD stated, the CK should have changed her gloves before returning to the tray line to serve food . During a review of JD [NAME] [undated], the JD indicated, .Maintain kitchen and cooking area in a safe, orderly, clean, and sanitary manner .follow .portion control guidelines .Record food temperatures for the meals . During a review of JD Dietary Supervisor [undated], the JD indicated, .supervises all dietary functions and personnel .inspects Dietary Department .ensures continued compliances with all federal, state, and local regulations . During a review of JD Registered Dietitian. [undated], the JD indicated, .Monitor food services operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulations . 8. During an observation on 7/23/24 at 11:56 a.m. of the facility's lunch tray line service, the CK used the medium scoop for small, medium, and large portions. During an interview on 7/23/24 at 1:17 p.m. with the CK, the CK stated, she did not follow the menu when she used the same size scoop for small, medium, and large portions. During an interview on 7/23/24 at 2:27 p.m. with the CDM, the CDM stated, the CK should have followed the menu and used the correct scoop for the small, medium, and large portions. CDM stated not following the menu could cause weight loss, weight gain, and or improper nutrition to the residents. During an interview on 7/23/24 at 2:50 p.m. with the RD, the RD stated, the CK should have used the scoop size listed on the menu . During a review of the Food Code U.S Food and Drug Administration S 483.60 42 CFR Ch., dated 1-1-19, indicated, .Menus must .be prepared in advance . be followed . be reviewed by the facility's dietitian . During a review of Job description: [NAME] (JD), [undated], the JD indicated, .Maintain kitchen and cooking area in a safe, orderly, clean, and sanitary manner .follow .portion control guidelines .Record food temperatures for the meals . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of JD Dietary Supervisor. [undated], the JD indicated, .Supervises all dietary functions and personnel .inspects Dietary Department .ensures continued compliances with all federal, state, and local regulations . During a review of JD Registered Dietitian. [undated], the JD indicated, .monitor food services operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulations . 9. During a concurrent observation and interview on 7/23/24 at 12:30 p.m. of the facility's lunch tray line service, with DA 2, DA 2 walked through the kitchen without having a hair net, DA 2 stated, she knew she was not to be in the kitchen without a hair net. DA 2 stated her hair could have gotten in the food and contaminated it. During a concurrent interview and record review on 7/23/24 at 2:50 p.m. with the RD, the facility's P&P, titled, Food Preparation and Service dated 11/2022, was reviewed. The P&P indicated, .Adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of food borne illness .food preparation staff are to adhere to proper hygiene and sanitary practices .food thermometers . are clean, sanitized, and calibrated .foods held in steam tables are monitored throughout the meal service .Gloves are worn when handling food directly .changed between tasks .hair restraints (hair net, hat, beard restraint, etc.) so, hair does not contact the food . The RD stated, the DA 2 should have had a hair net so that hair did not contaminate the food. During a review of DA 2's Verification of Job Competency Demonstration-Diet Aides (JC) dated 3/18/24, the JC indicated DA 2 was competent on the use of hair coverings. During a review of JD Dietary Supervisor. [undated], the JD indicated, .supervises all dietary functions and personnel .inspects Dietary Department .ensures continued compliances with all federal, state, and local regulations . During a review of JD Registered Dietitian. [undated], the JD indicated, .Monitor food services operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulat

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 41608 Based on observation, interview and record review, the facility failed to follow their policy and procedure Food-Related Garbage and Refuse Disposal for one of three outside trash bins, when one of the trash bins was uncovered, and a large amount of plastic and debris was noted on the ground behind the trash bin. This failure had the potential to attracts animals, insects and pests which could lead to infestations, unsanitary conditions, and the spread of disease. Findings: During an observation on 7/22/24 at 2:24 p.m. behind the facility in the trash bin storage area, a trash bin was observed with the lid open and large amounts of thin clear plastic and other debris was noted behind the trash bins along the fence. During an interview on 7/23/24 at 2:30 p.m. with the Certified Dietary Manager (CDM), the CDM stated, the trash bins should be closed at all times and there should not be trash on the ground or around the trash bins. The CDM stated, the open trash bin and trash on the ground around the trash bins could attract rats and bugs. During an interview on 7/23/24 at 2:45 p.m. with the Registered Dietitian (RD), the RD stated, the trash bins should always be closed, and there should never be trash on the ground to prevent an infestation of pests. During an interview on 7/24/24 at 2:22 p.m. with the Environmental Director (ED), the ED stated, the lid of the trash should not have been open and there should never be trash on the ground around the trash bins. The ED stated trash around the trash bin can attract animals and insects which could cause infestation. During an interview on 7/26/24 at 3:40 p.m. with the Administrator (ADM), the ADM stated there should be no garbage or debris on the ground around the trash bins and the trash bins should be always covered to discourage insects and animals from getting into the trash and bringing infection. During a review of the facilities policy and procedure titled, Food Related Garbage and Refuse Disposal dated 10/2017, indicated, .Food Related Garbage and Refuse Disposal indicated . 1. All food waste shall be kept in containers .garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests . outside dumpsters will be kept closed ad free of surrounding litter .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on observation, interview, and record review the facility failed to maintain complete and accurately documented records for one of 18 sampled residents (Resident 47) when, Resident 47's hearing aids were not documented on her inventory sheet. This failure resulted in Resident 47 not wearing her hearing aids and staff being unaware of where they were located causing Resident 47 to think they went missing. Findings: During a review of Resident 47's Admission Record (AR- a document which provides resident contact details, a brief medical history level of functioning, preferences, and wishes), dated 12/20/23, the AR indicated, Resident 4's admitting diagnoses included: encephalopathy (term for any brain disease that alters brain function), muscle weakness, chronic obstructive pulmonary disease(a common lung disease causing restricted airflow and breathing problems), and epilepsy (condition which causes recurrent involuntary movements of the muscles). During a review of Resident 47's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive (Mental) abilities), dated 6/21/24, the MDS indicated a BIMS (brief interview for mental status- assessment used to determine the cognitive ability of a resident) score of 10 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 47 had moderate cognitive impairment. During a concurrent observation and interview on 7/2/24 at 8:25 a.m. with Resident 47, in Resident 47's room, Resident 47 was using a walker and had no hearing aids in place. Resident 47 stated she was hard of hearing. Resident 47 stated her hearing aids went missing and she had difficulty hearing without them. During a concurrent observation and interview on 7/24/24 at 8:42 a.m. with Certified Nursing Assistant (CNA) 6 outside of Resident 47's room, Resident 47 was seen in her room without her hearing aids . CNA 6 stated Resident 47 was hard of hearing, and she needed hearing aids to properly hear. CNA 6 stated staff members had to raise their voices when speaking with Resident 47 if she did not have hearing aids on. CNA 6 stated she had seen Resident 47's hearing aids in the past and they should have been inventoried so staff were aware she had them. CNA 6 stated CNAs were responsible for documenting inventory upon admission. CNA 6 stated staff should inventory anytime they see new resident' belongings. CNA 6 stated Resident 47's hearing aids should have been documented upon admission. During a concurrent observation and interview on 7/24/24 at 8:50 a.m. with CNA 6 in Resident 47's room. Resident 47's hearing aids were found in the drawer next to her bed. CNA 6 stated CNAs should have documented Resident 47's hearing aids upon admission and they should have accurately been reflected in her inventory sheet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/24/24 at 2:00 p.m. with the social services director (SSD), Resident 47's inventory sheet, dated 12/20/23 was reviewed. The inventory sheet indicated Resident 47's hearing aids were not inventoried. The SSD stated hearing aids were considered high value items and staff should have documented them on the inventory sheet. The SSD stated all resident belongings needed to be documented on the inventory sheet. The SSD stated it was important to include hearing aids on the inventory sheet, so staff were aware of all the belongings Resident 47 had. During an interview on 7/25/24 at 4:35 p.m. with CNA 1, CNA 1 stated CNAs were responsible for filling out inventory sheets upon admission. CNA 1 stated all residents' belongings needed to be included on the inventory sheet. CNA 1 stated if residents received new items during any time of their stay, those new items should also be documented on the inventory sheet. CNA 1 stated it was important to inventory all resident belongings, so residents had all their items with them during their stay and when they get discharged . During an interview on 7/25/24 at 4:35 p.m. with Licensed vocational Nurse (LVN) 1, LVN 1 stated CNAs were supposed to ensure the inventory sheet for Resident 47 was completed upon admission. LVN 1 stated all inventory items residents came in with or acquired during their stay needed to be inventoried. LVN 1 stated it was important to inventory resident belongings, so residents have all their possessions during stay and upon discharge. During a concurrent interview and record review on 7/26/24 at 2:49 p.m. with the minimum data set coordinator (MDSC), Resident 47's MDS, dated [DATE] was reviewed. The MDS indicated no hearing aids were documented for Resident 47. The MDSC stated the MDS is documented at bedside and through a review of resident records. The MDSC stated if she did not see Resident 47's hearing aids at bedside or if they were not documented in her record the hearing aids would be missed during her documentation. The MDSC stated Resident 47's hearing aids should have been included in her MDS in order to accurately reflect the care provided. During an interview on 7/26/24 at 3:33 p.m. with director of nursing (DON), the DON stated Resident 47's hearing aids should have been inventoried. The DON stated it was important to have a completed inventory sheet that included the hearing aids so Resident 47's items did not go missing. During a review of the facility's job descriptions titled Certified Nursing Assistant, dated 2/19, indicated, . Inventory and mark the resident's personal possessions as instructed . During a review of the facility's policy and procedure (P&P) titled, Hearing Impaired Resident, Care of, dated 2001, the P&P indicated, .staff will assist residents with care and maintaining hearing devices .5. When interacting with the hearing impaired or deaf resident, staff will implement the following: a. Evaluate the resident's preferred method of communication . During a review of the facility's policy and procedure (P&P) titled, Personal Property, dated 8/22, the P&P indicated, . 10. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41119 Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program when: 1. Licensed nurses did not maintain one of one medication rooms in a sanitary manner in accordance with the standards referenced by the Centers for Disease Control and Prevention (CDC) and facility policy. This failure resulted in the potential harm of cross contamination. 2. Powder was observed on the surface areas around four of four pill crushers and Licensed Vocational Nurses (LVN's) did not use appropriate cleaning disinfectant as per manufacturer guidelines. This failure resulted in the potential harm of cross contamination. 3. A certified nursing assistant (CNA) did not perform hand hygiene after handling a bag with feces. This failure had the potential to cross contaminate (the process in which harmful germs transfer from one surface to another) other surfaces and get residents sick. 4. LVN 5 did not remove her gloves or perform hand hygiene (a general term referring to any action of hand cleansing) after obtaining a fingerstick (a method that involves the use of a lancet (needle) to draw a few drops of blood from a fingertip) and giving insulin (medication to control blood sugar) to Resident 57. This failure had the potential for cross contamination. Findings: 1. During a concurrent observation and interview on 7/24/24 at 11:15 a.m. with LVN 1, in the medication room, two spoons, dust, hair and two cockroaches were observed on the ground. Surveyor washed hands at the sink in the medication room and no trash bin was located to discard the paper towel. LVN 1 validated the dirty medication room and stated the medication room should be clean. LVN 1 stated there was no trash bin to discard the paper towel. During a concurrent interview and records review on 7/26/24 at 3:48 p.m. with the Director of Nursing (DON), the facility policy titled Storage of Medications dated 11/2020 was reviewed. The policy indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . The DON stated the medication room should be clean and that it was housekeeping and nurses responsibility to keep the medication room clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Centers for Disease Control and Prevention, titled Environmental Cleaning Procedures, dated 3/2024, retrieved from https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html, the Environmental Cleaning Procedures indicated .Departments or areas where medication is prepared (e.g., pharmacy or in clinical areas) often service vulnerable patients in high-risk and critical care areas, in addition to other patient populations. The staff who work in the medication preparation area might be responsible for cleaning and disinfecting it, instead of the environmental cleaning staff. Table 13. Recommended Frequency and Process for Medication Preparation Areas. Frequency: Before and after every use. Countertops and portable carts used to prepare or transport medications. At least once every 24-hours: All high -touch surfaces (e.g., light switches, countertops, handwashing skinks, cupboard doors) and floors. Scheduled basis (e.g., weekly, monthly): low-touch surfaces, such as the tops of shelves, walls, vents . 2. During a concurrent observation and interview on 7/25/24 at 10:41 a.m. with LVN 3, in the facility hallway, the pill crusher on medication cart number three was coated in white and orange colored powder-like debris. LVN 3 stated the pill crusher should be clean and free of debris to prevent potential medication mixture. LVN 3 stated he would use bleach disinfectant wipes to clean the pill crusher. During a concurrent observation and interview on 7/25/24 at 10:45 a.m. with LVN 5, in the facility hallway, the pill crusher on medication cart number four and number one was coated in white and orange colored powder-like debris. LVN 5 stated the pill crusher should be clean and free of debris to prevent potential medication mixture. LVN 5 stated she would use bleach disinfectant wipes to clean the pill crusher. During a concurrent observation and interview on 7/25/24 at 11:09 a.m. with LVN 4, in the facility hallway, the pill crusher on medication cart number two was coated in white and orange colored powder-like debris. LVN 4 stated the pill crusher should be clean and free of debris to prevent potential medication mixture. LVN 4 stated she would use bleach disinfectant wipes to clean the pill crusher and did not clean the ledge of pill crusher. During a concurrent interview and records review on 7/26/24 at 3:48 p.m. with the DON, the Instruction for Using (IFU) [Brand Name] pill crusher titled Cleaning and Maintenance Instructions undated was reviewed. The IFU indicated, .Made entirely of non-rusting materials. When dirty it may be cleaned with soap and water and a damp cloth. Do not use bleach . The DON stated the pill crusher should be clean and bleach should not be used to clean the pill crusher. 48424 3. During an observation on 7/23/24 at 10:39 a.m. CNA 2 did not perform hand hygiene after transporting a bag of feces down the hall and disposing of it. During an interview on 7/23/24 at 12:38 p.m. with the Infection Preventionist (IP), the IP stated hand hygiene should have been done anytime staff members interacted with a resident or handled bodily fluids. The IP stated hand hygiene was important in order to not spread infections or contaminate surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 4:22 p.m. with CNA 1, CNA 1 stated hand hygiene was supposed to be done before and after handling feces. CNA 1 stated it was important to perform hand hygiene to prevent cross contamination. During an interview on 7/26/24 at 3:33 p.m. with the DON, the DON stated hand hygiene should have been performed by staff before handling resident waste and after they disposed of it. The DON stated it was important to perform hand hygiene in order to prevent infections from spreading. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated 10/23, indicated, .This facility considers hand hygiene the primary means to prevent the spread if healthcare-associated infections . Administrative Practices to Promote Hand Hygiene . 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and infections . 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol-based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility . Indications for Hand Hygiene 1. Hand Hygiene is indicated: . c. after contact with blood, body fluids, or contaminated surfaces . 49949 4. During an observation on 7/24/25 at 11:48 a.m. in Unit 4 with (LVN) 5, LVN 5 checked Resident 57's fingerstick. LVN 5 returned to the medication cart (movable piece of equipment used in healthcare facilities to store, transport, and dispense mediation) with her gloves on LVN 5 opened the medication cart with her gloves and obtained Resident 57 's insulin medication (used to lower blood sugar). LVN 5 did not take off her gloves and did not perform hand hygiene. During an observation on 7/24/25 at 11:50 a.m., in Unit 4 with LVN 5, LVN 5 administered insulin to Resident 57 and returned to the medication cart. LVN 5 removed her gloves and no hand hygiene was performed. During an interview on 7/24/25 at 11:55 a.m. in Unit 4 with LVN 5, LVN 5 stated, It was important to take gloves off and perform hand hygiene to prevent infection and cross contamination. During an interview on 7/26/24 at 3:49 p.m., with the DON, the DON stated, all staff should perform hand hygiene before and after resident care. The DON stated all staff should perform hand hygiene after removing gloves. The DON stated, LVN 5 should have removed her gloves and performed hand hygiene before touching the medication cart. The DON stated hand hygiene was important to prevent the spread of infections and cross contamination. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 2001, the P&P indicated, .The facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections .Indications for hand hygiene .C. after contact with blood, body fluids or contaminated surfaces .G. immediately after glove removal .