

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Windsor Vallejo Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Tuolumne Street Vallejo, CA 94589	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47197</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident needs were accommodated for four of 31 sampled residents (Resident 11, Resident 96, Resident 28, and Resident 234), when the residents did not have their call lights within reach.</p> <p>This failure had the potential to result in residents not attaining their highest practicable physical, psychosocial, and emotional well-being.</p> <p>Findings:</p> <p>1. During a review of Resident 11's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated, Resident 11 was admitted to the facility May 2012 with multiple diagnoses which included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and Macular Degeneration (a disease that causes central vision loss).</p> <p>During a review of Resident 11's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/15/24, the MDS indicated Resident 11 needed substantial assistance with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 11's Nursing Evaluation (NE), dated 11/26/24, the NE indicated Resident 11 was visually impaired.</p> <p>During a review of Resident 11's care plan, initiated 10/7/24, the care plan indicated Resident 11 was a fall risk. The care plan indicated interventions to prevent falls that included, .place call light within reach .remind resident to use call light when attempting to ambulate (walk) or transfer .</p> <p>During a concurrent observation and interview on 12/2/24 at 9:46 a.m. with Resident 11, Resident 11 was sitting in a wheelchair by the foot of her bed. Resident 11's call light was at the head of her bed. Resident 11 requested assistance and was unable to locate her call light. Resident 11 stated she was legally blind and she could not see or reach the call light on her bed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 12/3/24 at 9:10 am with Resident 11 and Certified Nursing Assistant 3 (CNA 3), Resident 11 sat in a wheelchair by the foot of her bed. Resident 11's call light was wrapped around the bed's right side rail. Resident 11 stated she could not see or reach her call light. CNA 3 confirmed that Resident 11 could not see and reach the call light.</p> <p>During a review of the facility's policy and procedure (P&amp;P), titled Quality of Life- Accommodation of Needs, dated August 2009, the P&amp;P indicated, .resident's individual needs .including the need for adaptive devices and modifications to the physical environment .shall be evaluated .in order to accommodate individual needs .adaptations may be made to the physical environment .staff shall arrange .items so that they are in easy reach of resident .</p> <p>During a review of the facility's P&amp;P titled, Call Light, Answering, dated 4/1/2019, the P&amp;P indicated, .make sure call cords are placed within the resident's reach at all times .when the residents is out of bed, call cord will be clipped to the bedspread in such a way as to be available to wheelchair bound resident .</p> <p>2. During a review of Resident 96's face sheet, the face sheet indicated, Resident 96 was admitted to the facility July 2022 with multiple diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left side.</p> <p>During a review of Resident 96's MDS dated [DATE], the MDS indicated Resident 96 needed substantial assistance with ADLs and had an impairment in upper and lower range of motion.</p> <p>During a review of Resident 96's care plan, initiated 10/8/22, the care plan indicated Resident 96 was a fall risk. The care plan indicated interventions to prevent falls that included, .be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance .</p> <p>During a concurrent observation and interview on 12/2/24 at 9:15 a.m. with Resident 96 and CNA 6, Resident 96 was lying in bed and requested assistance with her breakfast tray. Resident 96's call light was laying on the floor next to left side of her bed. Resident 96 stated she had a stroke and could not move the left side of her body. Resident 96 stated she could not reach her call light. CNA 6 confirmed Resident 96's call light was on the floor and not within Resident 96's reach.</p> <p>During a review of the facility's P&amp;P titled, Resident Rights, dated December 2021, the P&amp;P indicated, . federal and state law guarantee certain basic rights to all residents .these rights include .be treated with respect, kindness, and dignity .</p> <p>3. During a review of Resident 28's clinical record indicated Resident 28 was admitted November of 2020 and had diagnoses that included dysarthria (a speech disorder that makes it difficult to speak), tremor (an involuntary, rhythmic shaking or twitching movement), dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities, and need for assistance with personal care.</p> <p>During a review of Resident 28's care plan (CP), last revised 11/3/22, the CP indicated, The resident has an ADL Self Care Performance Deficit r/t [related to] .Dementia .tremor, weakness. A review of Resident 28's care plan intervention, dated 9/16/21, indicated, Requires x1 staff assist with most ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/5/24 at 11:27 a.m. with Assistant Director of Staff Development (ADSD), ADSD stated the expectation was for call lights to be within residents' reach. ADSD further stated there was a risk for falls and resident needs not being met if call lights are not within reach.</p> <p>During a review of the facility's P&amp;P titled, CALL LIGHT, ANSWERING, dated 4/1/2019, the P&amp;P indicated, . make sure call cords are placed within the resident's reach at all times .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>47197</p> <p>Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS - an assessment tool used to guide care) assessment for one out of 31 sampled residents (Resident 254), when Resident 254's admission MDS oxygen (O2) therapy assessment was inaccurate.</p> <p>This failure resulted in inaccurate health status data for Resident 254 and the potential for Resident 254 to not achieve his highest practicable well-being.</p> <p>Findings:</p> <p>During a review of Resident 254's clinical record, Resident 254 was admitted November of 2024 and had diagnoses that included pneumonitis (a general inflammation of the lungs that makes it difficult to breathe), need for assistance with personal care, hemiplegia (complete loss of the ability to move one side of the body), hemiparesis (partial weakness of one side of the body), and congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body).</p> <p>During a review of Resident 254's MDS Cognitive Patterns, dated 11/29/24, Resident 254 had moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 254's MDS Special Treatments, Procedures, and Programs, dated 11/29/24 indicated Resident 254 did not have O2 therapy on admission and while he was a resident in the facility.</p> <p>During a review of Resident 254's Nurses Progress Note, dated 11/22/24, indicated, Received resident in bed awake .On oxygen (O2) support at 2 LPM (lpm- unit of measurement for oxygen administration) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) .</p> <p>During an observation on 12/2/24 at 11:07 a.m. at Resident 254's room, Resident 254 was observed to be using O2 delivered using a nasal cannula with O2 concentrator (machine) set at 2 liters per minute.</p> <p>During a concurrent interview and record review on 12/4/24 at 4:16 p.m. with the MDS Coordinator (MDSC), Resident 254's clinical records were reviewed. The MDSC confirmed that Resident 254's admission MDS O2 therapy assessment inaccurate and reflected Resident 254's O2 therapy use on admission and while he was a resident in the facility. The MDSC stated, .I made a mistake. I'll change it. The MDSC further stated she would expect MDS assessments to be accurate.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the Director of Nursing (DON), the DON stated that she expected that MDS assessments were done timely and should accurately reflect the resident's status and condition.</p> <p>During a review of the facility's policies and procedures (P&amp;P) titled, Resident Assessments, revised 10/2023, indicated, Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observation/interviews.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47197</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure three of 31 sampled residents (Resident 11, Resident 254, and Resident 280) received respiratory care consistent with professional standards of practice, physician orders, and care plans, when:</p> <ol style="list-style-type: none"> <li>1. Resident 11 did not receive oxygen as ordered and as care planned;</li> <li>2. Resident 280's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not in place; and</li> <li>3. Resident 254 had no physician's order for oxygen therapy and nasal cannula was not in place.</li> </ol> <p>These failures caused Resident 11 to experience shortness of breath and had the potential to result in respiratory distress for Resident 11, Resident 254, and Resident 280.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 11's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated, Resident 11 was admitted to the facility May 2012 with multiple diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - a chronic lung disease causing difficulty breathing).</li> </ol> <p>During a review of Resident 11's care plan, initiated 5/19/23, the care plan indicated Resident 11 had difficulty breathing .interventions included, .give oxygen therapy as ordered .monitor .difficulty breathing .</p> <p>During a review of Resident 11's physician orders, dated 10/24/24, the physician orders indicated, .oxygen at 2L/min (liters per minute -measurement of how much oxygen should be given) via nasal cannula .titrate (measure and adjust) oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) .every shift .</p> <p>During a concurrent observation and interview on 12/2/24 at 9:46 a.m. with Resident 11 and Certified Nursing Assistant 3 (CNA 3), Resident 11 was sitting in a wheelchair by the foot of her bed. Resident 11 was not wearing a nasal cannula or receiving oxygen. Resident 11 stated that she did not receive oxygen for the past 30 minutes and she was short of breath. CNA 3 confirmed Resident 11 was not receiving oxygen and should have been receiving oxygen 2L/min. CNA 3 further stated the last time she saw Resident 11 receiving oxygen was before breakfast.</p> <p>During an interview on 12/5/24 at 11:27 a.m. with Assistant Director of Staff Development (ADSD), ADSD stated the expectation was for oxygen orders to be followed. ADSD further stated there was a risk for shortness of breath, confusion and loss of consciousness when oxygen orders were not followed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's undated policy and procedure (P&amp;P), titled Oxygen Administration, the P&amp;P indicated, .review the physician's orders .for oxygen administration .review the resident's care plan .oxygen therapy is administered .nasal cannula .</p> <p>2. During a review of an Admission Record indicated Resident 280 was admitted to the facility in late 2024 with multiple diagnosis of acute respiratory failure with hypoxia and cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain) affecting right side. A review of MDS, dated [DATE], indicated Resident 280 had severe cognitive impairment. Further review of the MDS indicated that Resident 280 was on oxygen therapy and on hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility).</p> <p>During an observation on 12/2/24 at 9:30 a.m., Resident 280 was lying in bed with eyes closed. The nasal cannula was found under resident's chin.</p> <p>During a concurrent observation and interview on 12/2/24 at 10:29 a.m., Resident 280 was lying in bed without the nasal cannula in nostril. The oxygen tubing was found under resident's chin. Infection Preventionist (IP) confirmed that the nasal cannula was not in Resident 280's nostril. IP confirmed resident should be on oxygen. IP further stated that the risks of not having the oxygen correctly placed would lead to low oxygen levels and shortness of breath.</p> <p>During a review of Resident 280's Order Summary Report, dated 11/29/24, the Order Summary Report indicated that Resident 280 was on Oxygen at 2 liters/min via nasal cannula .Continuously every shift for SOB (shortness of breath) related to pneumonia (an infection/inflammation in the lungs).</p> <p>During a review of Resident 280's Care Plan, dated 12/2/24, indicated no documented evidence that an oxygen therapy care plan was initiated upon admission.</p> <p>During an interview on 12/4/24 at 8:05 a.m., with Director of Nursing (DON), the DON stated that the risks of not having oxygen on was that the resident could have low levels of oxygen.</p> <p>During a review of the facility's P&amp;P titled, Medication Administration revised October 2017, the P&amp;P indicated, Medications are administered in accordance with prescriber orders.</p> <p>3. A review of Resident 254's clinical record indicated Resident 254 was admitted November of 2024 and had diagnoses that included pneumonitis (a general inflammation of the lungs that makes it difficult to breathe), need for assistance with personal care, hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body), and congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body).</p> <p>A review of Resident 254's MDS Cognitive Patterns, dated 11/29/24, indicated Resident 254 had a moderately impaired cognition (mental process of acquiring knowledge and understanding).</p> <p>During a concurrent observation and interview on 12/2/24 at 11:07 a.m. with Resident 254, at Resident 254's room, Resident 254 was observed to be using oxygen delivered using a nasal cannula with oxygen concentrator (machine) set at 2 liters per minute. Both prongs of the nasal cannula were observed on the left cheek of Resident 254 and were not inserted into his nose. Resident 254 stated he could not reposition and insert the prongs of the nasal cannula into his nose.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47197</p> <p>Based on observation, interview, and record review the facility failed to ensure safe and effective pharmaceutical services for a census of 155 residents when:</p> <ol style="list-style-type: none"> <li>1. Resident 71 and Resident 255's controlled drug (drug with potential for abuse) use and removal signed out from Controlled Drug Record (CDR- a paper log of controlled drug removal for administration to resident) was not documented in their Medication Administration Record (MAR-a legal document that list administered drugs) and Resident 53's controlled drug use documented in the MAR was not accurately signed out in Resident 53's CDR,</li> <li>2. Resident 11 received 15 doses of insulin (a medication used to treat high blood glucose level) past the discard date and Resident 71 received 16 doses of expired medication,</li> <li>3. Hazardous medications (drugs that can cause harm to the body when handled unsafely) were stored in the medication carts with no hazardous drug and warning label on how to be handled by nursing staff and,</li> <li>4. Resident 8's medication was not administered for two days.</li> </ol> <p>These failed practices may contribute to unsafe medication use and handling, and risk of controlled drug diversion.</p> <p>Findings:</p> <p>1a. During a review of Resident 71's clinical record indicated Resident 71 was admitted February of 2020 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body), contracture (shortening and hardening) of muscle in multiple sites, and low back pain. A review of Resident 71's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 9/8/24, indicated Resident 71 had an intact cognition (mental process of acquiring knowledge and understanding).</p> <p>During a review of Resident 71's physician's order, dated 6/6/22, indicated, oxyCODONE-Acetaminophen [a medication for pain which contains a combination of Oxycodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] 5-325 MG [milligrams- unit of measurement] Give 1 tablet by mouth every 12 hours as needed for breakthrough pain .</p> <p>During a random audit of Resident 71's MAR and the CDR for oxycodone/APAP, for the month of November 2024, indicated nursing staff did not document oxycodone/APAP administration on the MAR when signed out from CDR on 11/26/24 at 3 p.m.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1b. During a review of Resident 255's clinical record indicated Resident 71 was admitted November of 2024 and had diagnoses that included rhabdomyolysis (a serious medical condition that occurs when muscle tissue breaks down causing muscle pain, stiffness, or aching), and need for assistance with personal care. A review of Resident 255's MDS Cognitive Patterns, dated 11/10/24, indicated Resident 255 had an intact cognition.</p> <p>During review of Resident 255's physician's order, dated 11/3/24, indicated, Norco [a medication for pain which contains a combination of Hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever that increases the effects of hydrocodone] Oral Tablet 5-325 MG .Give 1 tablet by mouth every 6 hours as needed for moderate-severe pain related to RHABDOMYOLYSIS.</p> <p>During a random audit of Resident 255's MAR and the CDR for Hydrocodone/APAP, for the month of November 2024, indicated nursing staff did not document Hydrocodone/APAP administration on the MAR when signed out from CDR on 11/20/24 at 9:02 a.m., and 11/24/24 at 1:56 p.m.</p> <p>1c. During a review of Resident 53's clinical record indicated Resident 53 was admitted October of 2024 and had diagnoses that included chronic pain syndrome (condition that involves persistent pain that lasts for weeks to years), and need for assistance with personal care. A review of Resident 53's MDS Cognitive Patterns, dated 10/25/24, indicated Resident 255 had intact cognition.</p> <p>During a review of Resident 53's physician's order, dated 10/18/24, indicated, Methadone .[a controlled pain medication] Oral Tablet 10 MG .Give 1 tablet by mouth two times a day related to CHRONIC PAIN SYNDROME.</p> <p>During a random audit of Resident 53's MAR and the CDR for methadone, for the month of December 2024, indicated the methadone 10 mg administration documented in the MAR of Resident 12 on 12/1/24 at 8 p.m. and 12/2/24 at 8 a.m. was not accurately signed out in Resident 12's CDR.</p> <p>During a concurrent interview and record review on 12/4/24 at 3:49 p.m. with the Director of Staff Development (DSD), Resident 71 and Resident 255's CDR and MAR for November 2024 and Resident 53's CDR and MAR for December 2024 were reviewed. The DSD confirmed the finding of Resident 71's oxycodone/APAP being signed out of the CDR but was not documented on the MAR on 11/26/24 at 3 p.m. The DSD also confirmed the finding of Resident 255's Hydrocodone/APAP being signed out of the CDR but was not documented on the MAR on 11/20/24 at 9:02 a.m., and 11/24/24 at 1:56 p.m. The DSD further confirmed the finding of Resident 53's methadone 10 mg administration being documented in the MAR but was not accurately signed out in the CDR on 12/1/24 at 8 p.m. and 12/2/24 at 8 a.m. The DSD stated she would expect that staff were signing both CDR and MAR accurately as part of controlled drug accountability.</p> <p>During a phone interview on 12/5/24 at 9:21 a.m. with the Consultant Pharmacist (CP), the CP stated facility staff should be signing both CDR and MAR accurately for proper controlled drug handling and tracking.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the Director of Nursing (DON), the DON stated, .The process should be, take it out [of the medication container], sign it in the record [CDR], give [administer] it [to the resident], and then sign the MAR. The DON further stated the controlled drug count will be off if staff will not be signing both CDR and MAR and there would be risk for controlled drug diversion (illegal distribution and/or abuse of prescription drugs).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policies and procedures (P&amp;P) titled, Controlled Substances, revised 11/2022, indicated, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records . 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.</p> <p>During a review of the facility's P&amp;P titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, dated 10/2017, indicated, c. Documentation 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given .In no case should the individual who administered the medication report off-duty without first recording the administration of any medication.</p> <p>2a.During a review of Resident 11's clinical record indicated Resident 11 was admitted October of 2024 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), and dementia (memory loss that interferes with daily functions).</p> <p>During a review of Resident 11's physician's order, dated 11/10/24, indicated, Humulin R [a man-made insulin that is used to control high blood sugar] Injection Solution 100 UNIT/ML [Unit/milliliters- unit of measurement] . Inject as per Sliding scale .subcutaneously [beneath the skin] before meals and at bedtime related to .DIABETES MELLITUS .</p> <p>During a concurrent medication cart inspection and interview on 12/2/24 at 3:45 p.m. with Licensed Nurse (LN) 1 of 100 Hallway medication cart, an opened bottle of Humulin R for Resident 11 was found stored in the medication cart labeled, . (DISCARD ON 28TH DAY AFTER OPENING) .DATE OPENED 10-29-24 . ONCE BOTTLE IS OPENED, DISCARD UNUSED MEDICATION AFTER 11-26-24 . No other bottle of Humulin R for Resident 16 was found in 100 Hallway medication cart. LN 1 confirmed the observation. LN 1 agreed that this would mean Resident 11 would have received Humulin R passed the discard date from 11/27/24 to 12/2/24. LN 1 stated the insulin passed the discard date should be thrown out.</p> <p>During a review of Resident 11's MAR for November 2024 and December 2024 indicated Resident 11 received Humulin R as follows:</p> <p>11/27/24 at 11:30 a.m.- 2 units</p> <p>11/27/24 at 5:30 p.m.- 8 units</p> <p>11/28/24 at 11:30 a.m.- 2 units</p> <p>11/28/24 at 5:30 p.m.- 6 units</p> <p>11/29/24 at 7:30 a.m.- 2 units</p> <p>11/29/24 at 11:30 a.m.- 2 units</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/29/24 at 5:30 p.m.- 2 units</p> <p>11/29/24 at 9 p.m.- 2 units</p> <p>11/30/24 at 7:30 a.m.- 2 units</p> <p>11/30/24 at 5:30 p.m.- 8 units</p> <p>11/30/24 at 9 p.m.- 4 units</p> <p>12/1/24 at 11:30 a.m.- 2 units</p> <p>12/1/24 at 5:30 p.m.- 4 units</p> <p>12/1/24 at 9 p.m.- 4 units</p> <p>12/2/24 at 11:30 a.m.- 4 units</p> <p>2b. During a review of Resident 71's clinical record indicated Resident 71 was admitted February of 2020 and had diagnoses that included major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and insomnia (difficult to fall or stay asleep). A review of Resident 71's MDS Cognitive Patterns, dated 9/8/24, indicated Resident 71 had an intact cognition.</p> <p>During a review of Resident 71's physician's order, dated 11/10/24, indicated, busPIRone . [a medication used to treat feeling of fear, dread, and uneasiness] Oral Tablet 5 MG .Give 1 tablet by mouth three times a day for general anxiety [a feeling of fear, dread, and uneasiness of the unknown] .</p> <p>During a concurrent medication cart inspection and interview on 12/3/24 at 12:29 p.m. with LN 3 of 300 Hallway medication cart, a bubble pack (a form of packaging where an individual pushes individually sealed tablets through the foil to remove the medication) of buspirone for Resident 71 was found stored in the medication cart labeled, .Exp [expiration date] 11/27/24 . No other bubble pack of buspirone for Resident 71 was found in 300 Hallway medication cart. LN 3 confirmed the observation. LN 3 agreed that this would mean Resident 71 would have received the expired buspirone from 11/28/24 to 12/3/24. LN 3 stated administering expired medications could negatively affect the resident's health.</p> <p>During a review of Resident 71's MAR for November 2024 and December 2024 indicated Resident 71 received buspirone three times daily from 11/28/24 to 12/2/24 and the morning dose on 12/3/24 which made it a total of 16 doses.</p> <p>During an interview on 12/5/24 at 8:50 a.m. with the DSD, the DSD stated when a staff finds an expired or passed the discard date medication, the staff should have checked the facility's automatic medication dispensing system or should have called the pharmacy to order that medication. The DSD also stated it is not allowed to take or share medication from another resident. The DSD further stated she would expect the expired/passed discard date medications to be discarded and residents should not receive expired medication.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 12/5/24 at 9:21 a.m. with the CP, the CP stated facility staff should not be administering expired/passed the discard date medications to residents because the medication efficacy (effectiveness) is affected, and the medication might not work as well.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the DON, the DON stated, .It's [administering expired or passed the discard date medication] not good. We [facility staff] have to look [for the expiration date/ discard date] before administering [the] medication.</p> <p>During a review of the facility's P&amp;P titled, STORAGE OF MEDICATIONS, revised 4/2008, indicated, M. Outdated .medications .are immediately removed from stock, disposed of according to procedure for medication disposal, and reordered from the pharmacy if a current order exists.</p> <p>3. During a concurrent medication cart inspection and interview on 12/3/24 at 12:02 p.m. with LN 2 of 700 Hallway medication cart, a bottle of liquid medication called Valproic Acid (a medication used to treat mood disorder or uncontrolled brain activity) in a dark colored bottle was found in the bottom drawer. The Valproic bottle did not have a hazardous drug warning label for safe handling. A small, printed label on the bottle indicated, .IF YOU BECOME PREGNANT DO NOT TAKE THIS DRUG . LN 2 confirmed the observation. LN 2 stated she was not aware that the medication was hazardous and agreed that it needs a label on how to safely handle the medication.</p> <p>During a concurrent medication cart inspection and interview on 12/3/24 at 12:29 p.m. with LN 3 of 300 Hallway medication cart, a bottle of liquid medication called Valproic Acid in a dark colored bottle was found in the bottom drawer. The Valproic Acid bottle did not have a hazardous drug warning label for safe handling. A small, printed label on the bottle indicated, .IF YOU BECOME PREGNANT DO NOT TAKE THIS DRUG . LN 3 confirmed the observation. LN 3 stated the bottle should have a visible hazardous drug label and safe handling instructions so staff would be aware how to handle the drug properly.</p> <p>During a phone interview on 12/5/24 at 9:21 a.m. with the CP, the CP stated that Valproic Acid bottle should have a clear and visible hazardous drug label on it for the safety of the nurses handling the medication.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the DON, the DON stated that Valproic Acid is a potent medication and a visible hazardous drug label on it would make sure that the nurse handling the medication would be alerted on how to handle the medication safely and properly.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of The Centers for Disease Control and Prevention's (CDC- the national public health agency of the United States) National Institute for Occupational Safety and Health (NIOSH- a federal agency sets standard of safety in health care) online document titled, Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated 4/2023, indicated Many .drugs intended for individual use can be hazardous to healthcare workers with potential occupational exposure to those who handle, prepare, dispense, administer, or dispose of these drugs. Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes . PPE (or Personal Protective Equipment, items like glove or mask) provides worker protection to reduce exposure to hazardous drugs .Efforts should be made to reduce all worker exposures to hazardous drugs. Occupational exposure to hazardous drugs merits serious consideration, as workers may be exposed daily to multiple hazardous drugs over many years. NIOSH suggests careful precautions and safeguards to protect workers, fetuses, and breastfed infants. Further review of the document indicated to use double glove for handling oral liquid form of the hazardous medications as directed.</p> <p>(<a href="https://www.cdc.gov/niosh/docket/review/docket233c/pdfs/2023-130.pdf">https://www.cdc.gov/niosh/docket/review/docket233c/pdfs/2023-130.pdf</a>)</p> <p>A review of CDC's NIOSH online document titled, NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016, dated 9/2016, indicated Valproic Acid was included in their list of hazardous drugs that could cause severe reproductive effects.</p> <p>(<a href="https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf">https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf</a>)</p> <p>4. During a review of Resident 8's Admission Record, indicated resident was admitted to the facility in late 2019 with diagnosis of malignant neoplasm of right female breast (breast cancer).</p> <p>During a review of Resident 8's physician order, dated 10/3/24, indicated, Letrazole oral tablet (medication for breast cancer) MALIGNANT NEOPLASM .RIGHT FEMALE BREAST.] .</p> <p>During a review of Resident 8's MAR, dated 12/2/24 and 12/3/24, indicated Letrazole was not administered.</p> <p>During a review of Resident 8's Progress Notes, dated 11/5/24 to 12/5/24 found no documented evidence on pharmacy follow up and doctor notification of missed doses.</p> <p>During an interview on 12/2/24 at 11:50 a.m., with Resident 8, Resident 8 stated that she missed her morning dose of Letrazole because the medication was unavailable in the medication cart. Resident 8 stated It hurts me and disturbs me that my medication was missed.</p> <p>During a concurrent observation and interview on 12/3/24 at 12:42 p.m., Letrazole medication card was not in the medication cart. LN 2 stated she called pharmacy yesterday and medication still was not delivered. LN 2 confirmed that the medication was for cancer and the resident could be at increased risk for infection if not given. LN 2 acknowledged that Resident 8 did not receive medication for two days.</p> <p>During an interview on 12/4/20 at 8:30 a.m. with the DON, the DON confirmed that LN 2 did not notify the doctor when Resident 8 missed her medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, dated 10/2017, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.</p> <p>During a review of the facility's P&amp;P titled, Medication Orders, the P&amp;P indicated, The prescriber is contacted for direction when medication will not be available.</p> <p>49933</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>47197</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in accordance with the facility's policies and procedures (P&amp;P), and accepted professional principles for a census of 155 when:</p> <ol style="list-style-type: none"> <li>1. A total of 5 loose pills were found in 100 hallway medication cart, 700 hallway medication cart, and 400-Odd Hallway med cart;</li> <li>2a. Two opened insulin medication (a medication used to treat high blood glucose level) passed the discard date were found stored in 100 hallway medication cart;</li> <li>2b. An expired bubble pack (a form of packaging where an individual pushes individually sealed tablets through the foil to remove the medication) of buspirone (a medication used to treat feeling of fear, dread, and uneasiness) was found stored in 300 hallway medication cart;</li> <li>3. An unused insulin medication was found stored in 100 hallway medication cart; and,</li> <li>4. Five eye medications, an insulin, and three semaglutide medications (a medication used to treat high blood sugar and for long term weight management) were found stored in 300 hallway medication cart without an opened date label.</li> </ol> <p>These failures resulted in Resident 11 receiving insulin medication past the discard date and Resident 71 receiving expired buspirone medication, had the potential for diversion of the loose medications, and for residents to receive medication that was expired or with unsafe or reduced potency.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent medication cart inspection and interview on 12/2/24 at 3:45 p.m. with Licensed Nurse (LN) 1 of 100 Hallway medication cart, two loose pills were found inside the medication cart. LN 1 confirmed the observation and stated he was not sure what medications were the loose pills.</li> </ol> <p>During a concurrent medication cart inspection and interview on 12/3/24 at 12:02 p.m. with LN 2 of 700 Hallway medication cart, one loose pill was found inside the medication cart. LN 2 confirmed the observation and stated there should not be a loose pill in the medication cart.</p> <p>During a concurrent medication cart inspection and interview on 12/4/24 at 11:38 a.m. with LN 4 of 400-odd Hallway medication cart, two loose pills were found inside the medication cart. LN 4 confirmed the observation.</p> <p>During a phone interview on 12/5/24 at 9:21 a.m. with the Consultant Pharmacist (CP), the CP stated it would not be ideal to have loose pills in medication carts because of the risk that the loose pills would fall on the floor and resident might pick it up and take it.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/5/24 at 9:33 a.m. with the Director of Nursing (DON), the DON stated there should be no loose tablets in medication carts because staff would not know which resident would get the medication.</p> <p>During a review of the facility's P&amp;P titled, STORAGE OF MEDICATIONS, revised 4/2008, indicated, Medications and biologicals are stored safely, securely, and properly .A. The provider pharmacy dispenses medications in containers that meet legal requirements .Medications are kept in these containers .</p> <p>2a. During a concurrent medication cart inspection and interview on 12/2/24 at 3:45 p.m. with LN 1 of 100 Hallway medication cart, two opened insulin medications prescribed for specific residents which were passed the discard date were found stored in 100 hallway medication cart. One had a discard date of 11/29/24 and the other one had a discard date of 11/26/24. LN 1 confirmed the observation and stated the insulins passed the discard dates should be thrown out.</p> <p>2b. During a concurrent medication cart inspection and interview on 12/3/24 at 12:29 p.m. with LN 3 of 300 Hallway medication cart, a bubble pack of buspirone prescribed for a specific resident was found stored in the medication cart. The medication was labeled, .Exp [expiration date] 11/27/24 . LN 3 confirmed the observation and stated expired medications should not be stored in medication carts because it could be given to the resident.</p> <p>During a phone interview on 12/5/24 at 9:21 a.m. with the CP, the CP stated staff should always check the discard or expiration date because of the risk of administering unsafe medications to residents.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the DON, the DON stated medications that are past the discard date or expiration date should not be stored in the medication carts and should be discarded.</p> <p>During a review of the facility's P&amp;P titled, STORAGE OF MEDICATIONS, revised 4/2008, indicated, M. Outdated .medications .are immediately removed from stock, disposed of according to procedure for medication disposal, and reordered from the pharmacy if a current order exists.</p> <p>3. During a concurrent medication cart inspection and interview on 12/2/24 at 3:45 p.m. with LN 1 of 100 Hallway medication cart, an unused insulin medication was found stored in 100 hallway medication cart with a label that indicated, Refrigerate until used .Once in use, store at room temperature. LN 1 confirmed the observation and stated the unused insulin should be refrigerated because it could affect the efficacy (ability to produce a desired or intended result) of the medication.</p> <p>During a phone interview on 12/5/24 at 9:21 a.m. with the CP, the CP stated unused insulins should be stored in the refrigerator so the medication is stored per requirements (last longer refrigerated).</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the DON, the DON stated staff should follow the storage label of the insulin medication.</p> <p>During a review of the facility's P&amp;P titled, STORAGE OF MEDICATIONS, revised 4/2008, indicated, K. Medications requiring refrigeration .are kept in a refrigerator .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a concurrent medication cart inspection and interview on 12/3/24 at 12:29 p.m. with LN 3 of 300 Hallway medication cart, five eye medications, an insulin, and three semaglutide medications prescribed to specific residents were found stored in the medication cart without an opened date label. The label of the eye medications and insulin indicated, .DISCARD UNUSED PORTION AFTER 28 DAYS . The opened date and discard date label of the semaglutide medications were left blank. LN 3 confirmed the observation and stated staff should label the medications with its opened date so staff would know when to discard the medications.</p> <p>During a phone interview on 12/5/24 at 9:21 a.m. with the CP, the CP stated there should have been an opened date label of the medications so staff would know when to discard the medication, which was usually after 28 days of opening the medication.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the DON, the DON stated staff should always label eye medications, insulins, and semaglutide with its open date because the medications need to be discarded after 28 days.</p> <p>During a review of the facility's P&amp;P titled, STORAGE OF MEDICATIONS, revised 4/2008, indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>39489</p> <p>Based on observation, interview, and record review, the facility failed to ensure 11 of 31 sampled residents' (Resident 1, Resident 8, Resident 50, Resident 57, Resident 77, Resident 91, Resident 96, Resident 97, Resident 238, Resident 239, and Resident 240's) meal tray ticket (guidance to staff on what to serve for a meal to a resident) was accurate and followed.</p> <p>This failure had the potential to negatively impact all 11 residents' nutritional status, and not provided meals consistent with their preferences.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated, Resident 1 was admitted in the facility on 12/1/23 with diagnosis that included Hypertensive Heart and Chronic Kidney Disease (damage kidney) with Heart Failure.</p> <p>During a review of Resident 8's Admission Record, the Admission Record indicated, Resident 8 was admitted in the facility on 10/3/24 with diagnosis that included Severe Sepsis with Septic Shock (life-threatening condition that occurs when a severe infection causes organ damage).</p> <p>During a review of Resident 50's Admission Record, the Admission Record indicated, Resident 50 was admitted in the facility on 9/25/19 with diagnosis that included Acute Posthemorrhagic Anemia (acute blood loss).</p> <p>During a review of Resident 57's Admission Record, the Admission Record indicated, Resident 57 was admitted in the facility on 7/23/24 with diagnosis that included Severe Sepsis with Septic Shock.</p> <p>During a review of Resident 77's Admission Record, the Admission Record indicated, Resident 77 was admitted in the facility on 2/24/22 with diagnosis that included Pulmonary Hypertension (serious medical condition where the blood pressure in the arteries of the lungs becomes abnormally high).</p> <p>During a review of Resident 91's Admission Record, the Admission Record indicated, Resident 91 was admitted in the facility on 10/13/24 with diagnosis that included Hypertensive Heart and Chronic Kidney Disease.</p> <p>During a review of Resident 96's Admission Record, the Admission Record indicated, Resident 96 was admitted in the facility on 7/24/22 with diagnosis that included Congestive Heart Failure (chronic condition, the heart can't pump enough blood to meet the body's needs).</p> <p>During a review of Resident 97's Admission Record, the Admission Record indicated, Resident 97 was admitted in the facility on 7/26/24 with diagnosis that included Anemia (blood disorder).</p> <p>During a review of Resident 238's Admission Record, the Admission Record indicated, Resident 238 was admitted in the facility on 7/26/24 with diagnosis that included Hypertensive Heart and Chronic Kidney Disease.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Windsor Vallejo Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2200 Tuolumne Street Vallejo, CA 94589	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 239's Admission Record, the Admission Record indicated, Resident 239 was admitted in the facility on 7/26/24 with diagnosis that included Atherosclerotic Heart Disease of Native Coronary Artery (plaque buildup in the arteries (blood vessels)).</p> <p>During a review of Resident 240's Admission Record, the Admission Record indicated, Resident 240 was admitted in the facility on 11/9/24 with diagnosis that included Spinal Stenosis, Lumbar Region (narrowing of the spinal canal in the lower back)</p> <p>During a concurrent tray line (a traditional food service in which trays are assembled on an assembly line for delivery) observation, record review and interview in the kitchen with Dietary Manager Assistant (DMA) on 12/3/24 at 12:50 pm., observed the residents' meal tray tickets did not match what was on the residents' meal plates for Resident 1, Resident 8, Resident 50, Resident 57, Resident 77, Resident 91, Resident 96, Resident 97, Resident 238, Resident 239, and Resident 240. The DMA confirmed they served pork loin for lunch today, and all 11 residents mentioned they disliked pork. The DMA further stated, they have not updated the facility's system yet to reflect the meal on their plates and the meal tray tickets. The DMA acknowledged the food written in the meal ticket and the food on the residents' meal plates should match.</p> <p>During a review of Resident 1's meal tray ticket, dated 12/3/24, indicated, Resident 1 .Dislikes: Pork, Tomato .</p> <p>During a review of Resident 8's meal tray ticket, dated 12/3/24, indicated, Resident 8 .Dislikes: Pork .</p> <p>During a review of Resident 50's meal tray ticket, dated 12/3/24, indicated, Resident 50 .Dislikes: Fish, Pork .</p> <p>During a review of Resident 57's meal tray ticket, dated 12/3/24, indicated, Resident 57 .Dislikes: Pork, Pineapple .</p> <p>During a review of Resident 77's meal tray ticket, dated 12/3/24, indicated, Resident 77 Dislikes: Pork, Fish .</p> <p>During a review of Resident 91's meal tray ticket, dated 12/3/24, indicated, Resident 91 Dislikes: Beef, Milk, Egg Pork .</p> <p>During a review of Resident 96's meal tray ticket, dated 12/3/24, indicated, Resident 96 Dislikes: Ham, Fish, Pork .</p> <p>During a review of Resident 97's meal tray ticket, dated 12/3/24, indicated, Resident 97 Dislikes: Pork</p> <p>During a review of Resident 238's meal tray ticket, dated 12/3/24, indicated, Resident 238 Dislikes: Beef, Pork</p> <p>During a review of Resident 239's meal tray ticket, dated 12/3/24, indicated, Resident 239 Dislikes: Pork, Beef .</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39489</p> <p>Based on observation, interview and record review, the facility failed to provide palatable, attractive, and appetizing food at preferred temperatures for eight of 31 sampled residents (Resident 1, Resident 8, Resident 15, Resident 39, Resident 60, Resident 83, Resident 121, and Resident 130), when, residents stated the food was cold, bad, and late.</p> <p>These failures resulted in residents' dissatisfaction with their meals and had the potential for decreased food intake leading to unplanned weight loss, nutritional deficiencies, and delayed healing from illness or injury.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted late 2023 with diagnoses which included hypertensive heart (high blood pressure that affects the heart) and chronic kidney disease (damaged kidney).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/26/24, the MDS indicated Resident 1 had intact cognition (mental process of acquiring knowledge and understanding).</p> <p>During an interview on 12/3/24 at 2:47 p.m. with Resident 1, Resident 1 stated the food was cold, especially breakfast. Resident 1 stated the facility did not want to buy a cart warmer to keep food warm. Resident 1 stated that meals were cold because the kitchen served the food late to the residents.</p> <p>2. During a review of Resident 8's Admission Record, the Admission Record indicated, Resident 8 was admitted to the facility in late 2019 with diagnosis of malignant neoplasm of right female breast (breast cancer).</p> <p>During a review of the MDS, dated [DATE], the MDS indicated Resident 8 had intact cognition.</p> <p>During an interview on 12/2/24 at 11:50 a.m., with Resident 8, Resident 8 stated meals were served cold, especially breakfast.</p> <p>During an observation on 12/3/24 at 9:00 a.m., Resident 8's breakfast had not been delivered by the kitchen.</p> <p>3. During a review of Resident 15's Admission Record, the Admission Record indicated, Resident 15 was admitted to the facility on [DATE] with diagnoses which included diabetes (low blood sugar level) and dehydration.</p> <p>During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 8's cognition level was moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/2/24 at 10:05 a.m., with Resident 15, Resident 15 stated the food was bad and he never ate the food served by the facility. Resident 15 further stated his family brought him food every day.</p> <p>4. During a review of Resident 39's Admission Record, the Admission Record indicated, Resident 39 was admitted to the facility on [DATE] with diagnoses which included diabetes and chronic kidney disease.</p> <p>During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 8 had intact cognition.</p> <p>During an interview on 12/2/24 at 9:45 a.m., with Resident 39, Resident 39 stated, Food is lousy prepared and super cold. Resident 39 wished the facility had a better way to keep the food warm.</p> <p>5. During a review of Resident 60's Admission Record, the Admission Record indicated, Resident 60 was admitted to the facility on [DATE] with diagnoses which included diabetes and end stage renal disease (terminal illness of the kidney).</p> <p>During a concurrent observation and interview on 12/2/24 at 2:40 p.m., with Resident 60 and Licensed Nurse 3 (LN 3), LN 3 delivered Resident 60's lunch meal tray and placed it on his bedside table. When asked, Resident 60 accurately identified self, current location, confirmed and stated, They just served his lunch. Resident 60 stated breakfast was normally cold, and he did not have a choice but to eat it.</p> <p>6. During a review of Resident 83's Admission Record, the Admission Record indicated, Resident 83 was admitted to the facility on [DATE] with diagnosis such as chronic kidney disease and pressure ulcer (skin breakdown).</p> <p>During a review of Resident 83's MDS, dated [DATE], the MDS indicated Resident 83's cognition level was moderately impaired.</p> <p>During an interview on 12/2/24 at 9:35 a.m., with Resident 83, Resident 83 stated, Food tastes like crap, it's cold all the time, all the time.</p> <p>7. During a review of Resident 121's Admission Record, the Admission Record indicated, Resident 121 was admitted to the facility on [DATE] with diagnosis such as end stage renal disease and benign prostatic hyperplasia (enlarged prostate).</p> <p>During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121's cognition level was moderately impaired.</p> <p>During an interview on 12/2/24 at 9:50 a.m., with Resident 121, Resident 121 stated, the food tasted like garbage.</p> <p>During an interview with LN 5 on 12/2/24 at 11 a.m., LN 5 indicated [Hall's name/unit] was the last hall to receive food, and stated, The [breakfast]meal cart came today at 10 a.m. Most residents' complained meals were always late. LN 5 stated she wished the kitchen will make some changes and deliver meals on time because some residents complained about late meals.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Certified Nursing Assistant 5 (CNA 5) on 12/2/24 at 11:05 a.m., CNA 5 stated breakfast was delivered at 10 a.m. today, the breakfast meal cart was announced overhead and ready to be picked up from the kitchen, Yes, I picked up the cart from the kitchen. CNA 5 further stated the meal carts were late most of the time, and some residents complained they were hungry while waiting for their breakfast.</p> <p>During a test tray service on 12/2/24 at 2:50 p.m., in the [Hall/unit] hall with RD and Regional RD performed temperature checks on the test tray. Meat/loin 92.4 F; beans 92.4 F; coleslaw 84.7 F; puree pork 84.7 F; cream soup 121.6 F; puree cobbler 83.3 F; coffee 113.0 F; cold milk 56.4 F; cold juice 58.1 F. RD wrote down the same temperature reading as the surveyor's reading and confirmed the hot food temperatures were cold and not at the recommended temperatures.</p> <p>8. A review of Resident 130's Admission Record, the Admission Record indicated, Resident 130 was admitted November of 2024 and had diagnoses which included diabetes mellitus, need for assistance with personal care, and muscle weakness.</p> <p>During a review of Resident 130's MDS dated [DATE], the MDS indicated, Resident 130 had an intact cognition.</p> <p>During a concurrent observation and interview on 12/3/24 at 9:47 a.m. with LN 5, in front of Resident 130's room, LN 5 was observed getting Resident 130's breakfast meal inside the meal delivery cart, and stated, It's [inside of the meal delivery cart] cold. LN 5 confirmed the inside ambient temperature of the meal delivery cart was cold. and stated, It's supposed to be warm to keep the food warm. LN 5 was then delivered the breakfast meal to Resident 130.</p> <p>During a concurrent observation and interview on 12/3/24 at 9:55 a.m. with Resident 130 at Resident 130's room, Resident 130 was observed being served his breakfast meal which included a serving of cereal, a sausage patty, a pancake, and a glass of milk. Resident 130 then took a bite of the pancake and stated the food was cold. Resident 130 further stated he wanted his food to be warm and he did not want to eat his breakfast meal because it was no longer warm.</p> <p>During an interview on 12/4/24 at 11 a.m., with the Registered Dietician (RD), the RD confirmed the meals were serve very late on Monday [12/2/24] and Tuesday [12/3/24]. The RD further stated my expectations for breakfast's first cart should be out of the kitchen at 7:15 a.m., and first cart for lunch should be out at 12 noon. The RD acknowledged some residents complained the food was cold and tasted like garbage.</p> <p>During an interview on 12/4/24 at 3:45 p.m. with the Director of Nursing (DON), the DON stated she expected the kitchen staff to follow the facility's meal service times as scheduled for breakfast, lunch, and dinner.</p> <p>During an interview on 12/5/24 at 9:08 a.m. with the RD, the RD stated, It's [cold food] not palatable [pleasant to eat] .It's also a danger hazard if it's been out for too long . The RD further stated that she would expect all warm food to be warm when served.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the DON, the DON stated warm meals should be served warm.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled Food Receiving and Storage, undated, the P&amp;P indicated, 1. Critical Control Point means a specific point, procedure, or step in food preparation and serving process at which control can be exercised to reduce, eliminate, or preven [sic] the possibility of food safety hazard. Some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating of foods .</p> <p>During a review of the facility's P&amp;P titled, Meal Service Times, undated, the P&amp;P indicated, . Breakfast 7:30 am - 8:30 am</p> <p>During a review of the facility's P&amp;P titled, Meal Service Times, undated, the P&amp;P indicated, . Lunch 12:00 pm - 1:00 pm .</p> <p>47197</p> <p>49933</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>47197</p> <p>Based on observation, interview, and record review, the facility failed to provide food that accommodates resident's needs and preferences for two out of 31 sampled residents (Resident 130 and Resident 240) when:</p> <ol style="list-style-type: none"> <li>1. Resident 130 was not served coffee during the 12/3/24 breakfast meal; and,</li> <li>2. Facility did not accommodate Resident 240's preference of decaffeinated (decaf) coffee.</li> </ol> <p>These failures had the potential to negatively affect Resident 130 and Resident 240's meal intake.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 130's clinical record indicated Resident 130 was admitted November of 2024 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood), need for assistance with personal care, and muscle weakness.</li> </ol> <p>During a review of Resident 130's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 11/11/24, indicated Resident 130 had an intact cognition (mental process of acquiring knowledge and understanding).</p> <p>During a concurrent observation, interview, and meal ticket review on 12/3/24 at 9:55 a.m. with Resident 130, at Resident 130's room, Resident 130 was observed being served his breakfast meal which did not include coffee. Resident 130 confirmed the observation and stated he always wanted coffee with his breakfast meal, but staff did not always give him coffee. Resident 130's meal ticket was checked and indicated, .BREAKFAST Tue [Tuesday] -12/3/2024 .COFFEE .8-FL OZ [Fluid ounce- unit of measurement] . Likes .Beverage Pref [Preference]: .Coffee .</p> <p>During a concurrent observation, interview, and meal ticket review on 12/3/24 at 10 a.m. with Licensed Nurse 5 (LN 5), at Resident 130's room, LN 5 confirmed that Resident 130 was not served coffee. LN 5 also confirmed that coffee was listed in Resident 130's breakfast meal ticket for 12/3/24.</p> <p>During an interview on 12/3/24 at 10:40 a.m. with Resident 130, at Resident 130's room, Resident 130 stated he never received his coffee for breakfast. Resident 130 further stated he felt frustrated and tired of always asking staff for coffee since the staff already knows that he always wants to have coffee with his breakfast meal.</p> <p>During an interview on 12/5/24 at 9:08 a.m. with the Registered Dietician (RD), the RD stated that coffee should be given by the Certified Nurse's Assistants (CNAs). The RD further stated that she would expect that coffee will be given to the resident if it is in the meal ticket.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the Director of Nursing (DON), the DON stated, .If it's [coffee] in the [meal] ticket, it should be served .</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a review of Resident 240's clinical record indicated Resident 240 was admitted November of 2024 and had diagnoses that included diabetes mellitus, need for assistance with personal care, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion).</p> <p>During a review of Resident 240's MDS Cognitive Patterns, dated 11/16/24, indicated Resident 240 had a moderately impaired cognition.</p> <p>During an interview on 12/2/24 at 1:02 p.m. with Resident 240, at Resident 240's room, Resident 240 stated she liked decaf coffee and had told facility staff about it, but the facility did not serve decaf.</p> <p>During a concurrent observation and interview on 12/4/24 at 8:49 a.m. with CNA 1, at nurses' station 2, the coffee cart was observed to have two dispensers, one for regular coffee and one for warm water. CNA 1 confirmed the observation and stated if a resident did not like the regular coffee, they would give tea to the resident. CNA 1 further stated they would go ask for decaf in the kitchen.</p> <p>During an interview on 12/4/24 at 8:55 a.m. with the RD, at the kitchen, the RD stated currently they did not serve decaf in the facility. The RD also stated she was aware about a newly admitted resident who preferred decaf coffee. The RD further stated she told the Dietary Manager Assistant (DMA) about a newly admitted resident's preference of decaf coffee but was not sure if they had ordered it.</p> <p>During an interview on 12/4/24 at 8:58 a.m. with the DMA, at the kitchen, the DMA stated he was not aware about a resident wanting decaf coffee and that they only serve regular coffee in the facility. The DMA also stated he did not order decaf coffee because decaf cost more than regular coffee. The DMA further stated that he would expect that if a resident preferred decaf coffee, then it should be provided to the resident.</p> <p>During an interview on 12/5/24 at 9:08 a.m. with the RD, the RD stated she was aware about Resident 240's preference of decaf coffee. The RD further stated that food and beverage preferences of residents should be catered.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the DON, the DON stated, . [Facility staff should] Honor [resident's] food preferences.</p> <p>A review of the facility's policies and procedures titled, Resident Food Preferences, revised 7/2017, indicated, 2. The Dietary Department will provide residents with meals consistent with their preferences, as indicated on their tray card. a. If a preferred item is not available, a suitable substitute should be provided.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39489</p> <p>Based on observation, interview and record review the facility failed to store, and distribute food in accordance with professional standards for food service safety for a census of 155 residents when:</p> <ol style="list-style-type: none"> <li>1. Several staff did not wear hair nets and did not perform hand hygiene upon entering the kitchen: <ol style="list-style-type: none"> <li>a. Maintenance Director (MDir);</li> <li>b. Registered Dietician (RD);</li> <li>c. [name of company] food delivery driver; and</li> <li>e. Dietary Manager Assistant (DMA)</li> </ol> </li> <li>2. Assorted expired food products were found in the walk-in freezer and dry storage room: <ol style="list-style-type: none"> <li>a. Opened container of mayonnaise with net contents of 3.78 lbs., unlabeled with open and use by date;</li> <li>b. Expired cilantro in a plastic bag dated [DATE];</li> <li>c. Expired corn meal in bag with a net weight of 25 lbs. with use by date [DATE];</li> <li>d. Expired [brand name] Iced Tea in a box with a net weight of 6 lbs. with use by date [DATE]; and</li> <li>e. Expired 2 plastic containers of raisins with use by date [DATE].</li> </ol> </li> </ol> <p>These failures had potential to cause food-borne illness in a highly susceptible residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. a. During a concurrent observation and interview with the MDir on [DATE] at 8:15 a.m., MDir came from outside/parking lot, entered the kitchen through the back door #3, and walked straight out of main door. He did not wear a hair net and did not perform hand hygiene. When asked, he stated, I was just passing by. MDir acknowledged he should have washed his hands and worn a hair net when he entered the kitchen to comply with their policy and procedure and infection control purposes.</li> <li>b. During a concurrent observation and interview with the RD on [DATE] at 8:20 a.m., the RD entered the kitchen from the main door, went straight to the tray line area and spoke with the dietary staff, and did not wash her hands. The RD confirmed she should have washed her hands to promote infection prevention.</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Windsor Vallejo Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2200 Tuolumne Street Vallejo, CA 94589	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. During a concurrent observation and interview with the RD and DMA on [DATE] at 8:45 a.m., a food delivery driver of [name of company], with mustache and long beard past his chin, came inside the kitchen through door #3 and brought in a [NAME] stacked with boxes of food supplies. He did not wash his hands and did not wear hair and facial hair nest. DMA confirmed, the delivery driver should have worn hair and facial hair nets to comply with the facility's policy and procedure for sanitary practices.</p> <p>d. During a concurrent observation and interview with the DMA on [DATE] at 9:26 a.m., in the kitchen, the DMA did not wear a facial hair net. He stated, he should have worn a facial hair net to prevent hair from contacting the food. The DMA also clarified there were 3 entry/exit door in the kitchen. Door #1/main door, door #2, staff used to bring dirty carts/trays, and door #3 for deliveries.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated [DATE], the P&amp;P indicated, .Hand Washing/Hand Hygiene 1. Employees must wash their hands .c. whenever entering or re-entering the kitchen .1. Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food .</p> <p>2. a/b During a concurrent observation and interview with the RD and DMA on [DATE] at 8:30 a.m., in the walk-in freezer, found an opened container of mayonnaise, unlabeled of open and use by date. Also found, an expired bag of cilantro dated [DATE]. DMA stated, the mayonnaise should have been labeled so the staff were aware when to throw it, and the cilantro should have been disposed of on its expiration date as it may cause foodborne illness to the residents.</p> <p>c/d/e. During a concurrent observation and interview with the RD and DMA on [DATE] at 8:50 a.m., in the Dry Storage Room, found expired corn meal in a bag; expired [brand name] Iced Tea in a box; and expired 2 plastic containers of raisins. DMA acknowledged and stated, these food items were expired and should have been discarded. The DMA stated he regularly checked the stocks for expiration date and cannot explain how he missed those expiration dates.</p> <p>During a review of the facility's P&amp;P titled, Food Receiving and Storage, undated, the P&amp;P indicated, . Food shall be received and stored in a manner that complies with safe food handling practices .All foods stored in the refrigerator or freezer are covered, labeled, and dated .</p> <p>On [DATE] at 11 a.m., Surveyor requested the facility's policy and procedure regarding expired food products but according to the RD, the facility did not have a policy and procedure for expired food products.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47197</p> <p>49933</p> <p>Based on observation, interview and record review, the facility failed to ensure infection prevention measures were implemented for a census of 155 when:</p> <ol style="list-style-type: none"> <li>1. Personal Protective Equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) was not worn by housekeeping staff when cleaning a room with Enhanced Barrier Precautions (EBP) (infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that requires gown and glove use);</li> <li>2. Staff was observed putting dirty linen into the clean linen storage closet;</li> <li>3. Resident 1, 36, and 58 urinals were observed stored on the floor with no date or resident label;</li> <li>4. Residents' non-pharmaceutical (not medication related) personal belongings were found stored in the medication carts next to pharmaceutical products; and,</li> <li>5. A shared glucometer (a device which measures blood sugar using blood from the fingertip) was not sanitized properly after use of two residents (Resident 104 and Resident 15).</li> </ol> <p>These failures had the potential to cause the spread of infection among a vulnerable resident population.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 12/3/24 at 10:30 a.m., Resident room [ROOM NUMBER] was designated as Enhanced Barrier precautions with a yellow sign posted at its door. Resident PPE bins were located hanging outside the room door. Housekeeper 1 (HK 1) was observed inside room mopping the floor and cleaning surfaces. HK 1 came out of the room and passed by two other staff members putting on PPE before entering room [ROOM NUMBER]. HK 1 looked at them and stated I did not know it was that kind of room.</li> </ol> <p>During an interview on 12/4/24 at 10:23 a.m., with HK 1, HK 1 confirmed that he bypassed the sign and should have worn PPE while cleaning the room.</p> <p>During an interview on 12/4/24 at 3:57 p.m., with the Infection Preventionist (IP), the IP stated that the expectation of housekeeping staff is to wear PPE while cleaning resident rooms that have Enhanced Barrier Precautions.</p> <p>During a review of a facility sign titled, STOP, Enhanced Barrier Precautions, indicated, Providers and staff must . Wear gloves and a gown .cleaning the environment.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Enhanced Barrier Precautions, undated, the P&amp;P indicated, It is the policy of this facility to implement enhanced standard/barrier precautions for the prevention of transmission of multidrug-resistant organisms .Wear gowns and gloves while performing the following tasks .involving contact with environmental surfaces likely contaminated by the resident.</p> <p>2.During an observation on 12/3/24 at 10:34 a.m., with Certified Nursing Assistant 1 (CNA 1) observed walking down the hallway carrying new linens. The new linens were touching CNA 1's uniform. CNA 1 observed going back into the linen closet and placing all the linens back unto the shelf. Afterwards, CNA1 went to ask housekeeping staff for a plastic bag. CNA1 then used the plastic bag to put the linens she previously returned into the bag.</p> <p>During an interview on 12/4/24 at 10:26 a.m., with CNA 1, CNA 1 confirmed that all new linen should be placed in a plastic bag while walking down the hallway. CNA1 stated she forgot to get a plastic bag before handling new linen out of the closet. CNA 1 confirmed that she put dirty linen in the clean linen closet.</p> <p>During an interview on 12/4/24 at 4:00 p.m., with the IP, the IP stated that CNA 1 should have discarded the linen because it made contact with staff clothing. The IP further stated the CNA should not have put the dirty linen back into the closet due to risk of cross contamination. The IP further stated the dirty linens could carry microorganisms back to the residents.</p> <p>3.During a review of Resident 36's Admission Record indicated Resident 36 was admitted late 2024 with diagnosis of end stage renal disease (ESRD -irreversible kidney failure) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed.)</p> <p>During an observation on 12/2/24 at 9:03 a.m., resident 36 was lying in bed asleep. One urinal observed to be hanging at the foot of the bed with dark yellow liquid. The urinal was out of reach from the resident. The urinal also contained no date or label.</p> <p>During a review of Resident 1's Admission Record indicated Resident 1 was admitted late 2023 with diagnosis of hypertensive heart (high blood pressure that affects the heart) and chronic kidney disease.</p> <p>During an observation on 12/2/24 at 10:20 a.m., Resident 1 was lying in bed asleep. Two urinals were found on the floor with no date or labels. One urinal contained dark yellow liquid and the second was empty.</p> <p>During an observation on 12/2/24 at 3:19 p.m., Resident 1 was not in the room. Two empty urinals were found on the floor with no date or labels.</p> <p>During a review of Resident 58's Admission Record indicated Resident 58 was admitted early 2021 with diagnosis of type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/4/24 at 10:24 a.m., Resident 58 was not in the room. One urinal containing dark yellow liquid was found on the floor. The urinal could be seen from outside the resident door and also be seen from the hallway.</p> <p>During a concurrent interview and review of date stamped pictures taken of urinals on 12/4/24 at 4:15 p.m., with IP, the IP stated if a urinal was not labeled with a resident identifier and the date it was initially used, there would be a risk for residents to use each other's urinal. The IP further stated that staff would not know who the urinal was for. The IP further stated that urinals stored on the floor was a risk for infection control if urine was spilled.</p> <p>During a review of the facility's P&amp;P titled, Cleaning and Disinfecting of Resident-Care Items and Equipment, revised September 2022, indicated, Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., .urinals).</p> <p>4. During a concurrent medication cart inspection and interview on 12/3/24 at 12:29 p.m. with LN 3 of 300 Hallway medication cart, a wireless earphone in a bedazzled charging case and a set of personal keys were found stored next to oral and eye medications. LN 3 confirmed the observation. LN 3 stated she does not know who owns those personal items in the cart. LN 3 further stated personal items should not be stored in medication carts for infection control.</p> <p>During a concurrent medication cart inspection and interview on 12/4/24 at 11:38 a.m. with LN 4 of 400-odd Hallway medication cart, a cell phone labelled with a resident's room number and name, a music player connected to a black earphone, a pink wallet, and cash were found stored next to the controlled medications (medications with high potential for abuse or addiction). LN 4 confirmed the observation. LN 4 stated those were personal items of the residents.</p> <p>During an interview on 12/5/24 at 8:54 a.m. with the IP, the IP stated that medication carts should be kept clean and personal items should not be stored in it for infection control.</p> <p>During a phone interview on 12/5/24 at 9:21 a.m. with the Consultant Pharmacist (CP), the CP stated it was not best practice to store personal items inside medication carts.</p> <p>During an interview on 12/5/24 at 9:33 a.m. with the Director of Nursing (DON), the DON stated that staff should not store any personal items inside the medication carts because there would be a risk the personal items might contaminate the medications.</p> <p>During a review of the facility's P&amp;P titled, STORAGE OF MEDICATIONS, revised 4/2008, indicated, Medications and biologicals are stored safely, securely, and properly .N. Medication storage areas are kept clean and free from clutter .</p> <p>5. During a medication administration observation on 12/4/24 at 11:50 a.m., LN 5 took a shared glucometer and supplies in Resident 104's room to measure Resident 104's blood sugar level. LN 5 used a lancet (a sharp piercing device) to pierce Resident 104's finger to get blood and then applied the blood to the test strip that was attached to the glucometer. After reading the result, LN 5 went out of Resident 104's room, discarded the used lancet and test strip, and wiped the shared glucometer using one wipe of [Brand name] GERMICIDAL DISPOSABLE WIPES (the wipe with chemicals the facility is using to disinfect surfaces), quickly (less than 10 seconds), which dried-up immediately, to clean the glucometer's outer surface, then placed it inside the medication cart next to other supplies.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a subsequent medication administration observation on 12/4/24 at 12 noon, LN 5 again took a shared glucometer and supplies in Resident 15's room to measure the blood sugar of Resident 15. LN 5 pierced Resident 15's finger using a new lancet to get blood and then applied the blood to the new test strip that was attached to the glucometer. After reading the result, LN 5 went out of Resident 15's room, discarded the used lancet and test strip, and again wiped the shared glucometer using one wipe of [Brand name] GERMICIDAL DISPOSABLE WIPES, quickly (less than 15 seconds), which dried-up immediately, to clean the glucometer's outer surface, then placed it back inside the medication cart next to other supplies.</p> <p>During an interview on 12/4/24 at 12:15 p.m. with LN 5, LN 5 confirmed the two subsequent observations of her cleaning the shared glucometer quickly (less than 10-15 seconds) in between use of two residents. LN 5 stated the shared glucometer needed to be cleaned for two (2) minutes to sanitize it properly and prevent cross contamination.</p> <p>During an interview on 12/5/24 at 8:54 a.m. with the IP, the IP stated that the facility's shared glucometer should be disinfected properly after each resident's use. The IP further stated the shared glucometer should remain visibly wet for 2 minutes when using the [Brand name] GERMICIDAL DISPOSABLE WIPES to disinfect it properly.</p> <p>During an interview on 12/5/24 at 9:44 a.m. with the DON, the DON stated staff should clean the shared glucometer thoroughly. The DON further stated that there would be a risk of spreading infection to the residents if the shared glucometer was not sanitized properly.</p> <p>During a review of the facility's P&amp;P titled, Glucometer Cleaning, undated, indicated, .3. ALL glucometers that will be shared by multiple patients will be thoroughly wiped with disinfectant and allowed air dry after every use and between every patient .</p> <p>During a review of the label of [Brand name] GERMICIDAL DISPOSABLE WIPES, undated, indicated, . DISINFECTS IN 2 MINUTES .TO DISINFECT AND DEODORIZE HARD, NONPOROUS SURFACES: If present, use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry.</p> <p>During a review of the facility's P&amp;P titled, Policies and Procedures- Infection Prevention and Control, undated, the P&amp;P indicated, the facility .maintain a safe, sanitary .environment .to help prevent and manage transmission of diseases and infections.</p>		