STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056294	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Joaquin Nursing Center and Rehabilitation Cent	3601 San Dimas Bakersfield, CA 93301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 35649 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 96) was determined capable of self-medication administration (the ability of a person to take medication independently) when Resident 96 had eye drops at the bedside to self-administer. This failure had the potential to result in Resident 96 administering medication without the appropriate guidance on how to instill the eye drops in his eyes, possible side-effects, and drug reaction. Findings: During a concurrent observation and interview on 2/10/25 at 10 a.m. with Resident 96 in Resident 96's room, a covered container was on the overbed table and had an ophthalmic solution (artificial tears and lubricant) eye drops at the bedside. Resident 96 stated he had been using and putting eye drops in his eyes, especially after eye surgery. Resident 96 stated the nurses knew I had this eye drops for a long time. Resident 96 stated some nurses had seen him put eye drops in his eyes. During a concurrent observation and interview on 2/11/25 at 8:54 a.m. with Licensed Vocational Nurse (LVN) 1 and Resident 96 in Resident 96's room, LVN 1 stated there was a vial of eye drops inside a covered container in Resident 96's room. Resident 96 stated he had been using the eye drops for five years now since his eye surgery. During a concurrent interview and record review on 2/11/25 at 9 a.m. with LVN 2, LVN 2 stated there was no physician's order regarding the eye drops and no orders for Resident 96 to self-administer his medication. During a concurrent interview and record review on 2/12/25 at 10:39 a.m. with Minimum Data Set Coordinator (MDSC), MDSC stated, I do not see an order for self-medication administration. MDSC stated there was no IDT (Interdisciplinary Team (a group of healthcare professional in various disciplines to discuss care of the resident) documentation to determine the resident's capacity to self-administer medication. MDSC stated there was no nursing documentation in the progress notes regarding the resident's self-medication administration. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Self-Medication Administration, dated 2/2021, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that is clinically appropriate and safe for the residents to do so. 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident .3. If it is deemed safe and appropriate for a resident to self-administer medication, this is documented in the medical record and the care plan .8. Self-administered medications are stored in a safe and secure place, which is not accessible by other resident.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 41035 Based on interview and record review, the facility failed to ensure an advance directive (legal document indicating person's preference for end-of-life treatment decisions) was offered and completed for one of five sampled residents (Resident 16). This failure had the potential for Resident 16's healthcare wishes to not be honored. Findings: During a concurrent interview and record review on 2/11/25 at 2:21 p.m. with Minimum Data Set (MDS, resident assessment tool) Coordinator (MDSC), Resident 16's Medical Record (MR), [undated] was reviewed. MDSC stated she could not find Resident 16's completed AD in the MR. MDSC stated stated Resident 16's AD should be in the MR. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated 2013, the P&P indicated, 1. Prior to or upon admission of a resident to our facility, the Social Service Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.7. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41035 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Transfer or Discharge, Facility-Initiated, when the facility did not send a notice of transfer to the ombudsman (an advocate for residents of long-term care facilities) for two of two sampled residents (Resident 16 and Resident 38). This failure had the potential to result in Resident 16 and Resident 38 not having an advocate who could inform them of their admission, transfer, and discharge rights and options. Findings: During an interview on 2/11/25 at 9:28 a.m. with Resident 16, Resident 16 stated the facility sent her to the hospital on 1/26/25 and again on 2/9/25. During a concurrent interview and record review on 2/13/25 at 10:49 a.m. with Social Services Director (SSD), Resident 38's Order Summary Report (OSR), dated 11/9/24 was reviewed. SSD stated the OSR indicated Resident 38 was transferred to the hospital on 11/9/24. SSD stated she could not find documentation of the Ombudsman notification of Resident 38's transfer to the hospital on 11/9/24. SSD stated the Ombudsman should have been notified. During a concurrent interview and record review on 2/13/25 at 10:54 a.m. with SSD, Resident 16's Hospital Transfer forms, dated 1/26/25 and 2/9/25 were reviewed. SSD stated the transfer forms indicated Resident 16 was transferred to the hospital on 1/26/25 and 2/9/25. SSD stated she could not find documentation where the Ombudsman was notified of Resident 16's transfer to the hospital for both dates. SSD stated the Ombudsman should have been notified. During a review of the facility's P&P titled, Transfer or Discharge, Facility Initiated, dated 2022, the P&P indicated, 4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements),

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42148 Based on observation, interview, and record review, the facility failed to accurately assess and document urine output for one of one sampled resident (Resident 3) with a urostomy (opening in the stomach wall to allow urine to pass). This failure resulted in the physician being unaware of accurate measurements of urine output to meet the individualized needs of Resident 3. Findings: During a concurrent observation and interview on [DATE] at 3:21 p.m. with Resident 3 in Resident 3's room, Resident 3 had a urostomy on the left lower section of his abdomen without a bag attached. Resident 3 stated he self catheterizes (inserts a tube into the urostomy to collect urine) himself when needed. During a review of Resident 3's Care Plan Report (CPR), dated [DATE], the CPR indicated, Focus-Bladder: At risk for complications with urinary system . Resident may straight cath [catheter, flexible tube] via Urostomy PRN [as needed]; LN [licensed nurse] to monitor output Q [every] shift. During a review of Resident 3's Order Summary Report (OSR), dated [DATE], the OSR indicated, Output Daily Total one time a day for Intermittent Straight Catheterization. Resident may straight cath via Urostomy PRN; LN to monitor output Q shift (ASK RESIDENT # OF TIMES SELF CATHED AND # OF mL OF [urine] OUTPUT) During a concurrent interview and record review on [DATE] at 2:30 p.m. with Nurse Consultant (NC) 2, Resident 3's Medication Administration Record (MAR), dated February 2025, was reviewed. Resident 3's MAR indicated, Resident may straight cath via Urostomy PRN; LN to monitor output Q shift [indicated the following]: [DATE]- Day shift #SC (straight Catheterizations) NA (not applicable). ML (Milliliters)- NA Night shift- #SC- NA ML- NA [DATE]- Day shift- #SC zero (0) ML 0 Night shift- # SC- 0 ML 0 [DATE]- Day shift- #SC NA ML NA Night shift- #SC 0 ML 0 [DATE]- Day shift- #SC NA ML NA [DATE]- Day shift- #SC NA ML NA [DATE]- Day shift- #SC NA ML NA (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]- Day shift- #SC Y ML [DATE]- Day shift- ML NA NC 2 stated there was not consistent documentation done for number of self catheterization and MLs of urine output documented for Resident 3. During a review of Resident 3's Voiding Diary (VD), dated February 2025, the VD indicated, Total Urine Output for the month of February 2025 was 0 totals for each day (February 1st through February 12th). During a review of the facility's policy and procedure (P&P) titled, Documentation accuracy in the health record, (undated), The P&P indicated, Clinical records should accurately reflect the care given by each member of the health care team as well as the response of the person receiving services. Accurate records are vital to the individual, to the staff and to the facility administrators. For a resident, the clinical record should ensure continuity of care; for the staff, it assists in coordination of services and services as proof of work done .Clinical records are the facility personnel's mechanical memory for a resident. As a layman, an individual cannot adequately relay the details of his/her healthcare to the many different providers that he or she may contact for treatment. An accurate health record provides that thread of continuity in a complex and specialized health care delivery system. Coordination of this care in the records requires accurate information available to all member of the the health care team. Facility P/P for Urine Intake and Output was requested; none was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42148 Based on interview and record review, the facility failed to follow physician orders (PO) for six of twelve sampled residents (Resident 10, Resident 26, Resident 352, Resident 351, Resident 96, and Resident 2) when: 1. Resident 10's blood work (labs) were not drawn monthly as ordered. This failure resulted in the physician to be unaware of the medication levels and the potential for Resident to have seizures. 2. Nursing staff did not put compression stockings on Resident 26. This failure had the potential for Resident 26 to develop a Deep Vein Thrombosis (DVT- blood clot). 3. Nursing staff did not administer intravenous (IV- in the vein) medications at the ordered rate for four out of six residents (Resident 352, Resident 351, Resident 96, and Resident 2) on IV medication Findings: 1. During a review of Resident 10's, Admission Record (AR), dated 6/3/19, the AR indicated, Resident 10 has a medical diagnosis of Epilepsy (Seizure Disorder). During a review of Resident 10's, Order Summary Report (OSR), dated 6/27/24, the OSR indicated the following orders:lamoTRIgine Tablet [seizure medication] 100 MG [milligrams] Give 2 tablets by mouth two times a day for Epilepsy. levETIRAcetam Tablet [seizure medication] 1000 MG Give 2 tablet by mouth two times a day for Epilepsy. Lacosamide Tablet [seizure medication] 100 MG Give 1 tablet by mouth two times a day for Seizure Disorder. During a concurrent interview and record review on 2/13/25 at 8:21 a.m. with Nursing Consultant (NC) 2, Resident 10's, OSR, dated 8/5/24 was reviewed. The OSR indicated, Lamotrigine Level, Depakote (Seizure Medication) Level, and Levetiracetam Level Monthly every day shift every 30 days. NC 2 stated these Labs were not drawn in September, October, November, December of 2024 and was not done January 2025. NC 2 stated these labs were important to see if Resident 10 was receiving the correct dose of his seizure medications. 2. During a review of Resident 26's, AR, dated 11/18/24, the AR indicated, Resident 26 has medical diagnoses of Muscle Wasting, abnormalities of gait (the way a person moves when they walk) with mobility, and reduced mobility. During a review of Resident 26's, OSR, dated 12/30/24, the OSR indicated, compression stockings [socks used reduce swelling and increase circulation in the legs] for DVT [Deep Vein Thrombosis- blood clot] prophylaxis (prevention) every shift. During a concurrent observation and interview on 2/12/25 at 11:55 a.m. with Certified Nursing Assistant (CNA) 8 in Resident 26's room, Resident 26 was not wearing compression stockings. CNA 8 stated she has never seen Resident 26 wear compression stockings and was unable to find them in her room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and Interview on 2/12/25 at 12:01 p.m. with Licensed Vocational Nurse (LVN) 6 in Resident 26's room, LVN 6 stated Resident 26 does not wear compression stockings and was unable to find a pair in her room. During a concurrent interview and record review on 2/12/25 at 12:05 p.m. with LVN 6, Resident 26's, Medication Admission Record (MAR), dated February 2025 was reviewed. the MAR indicated, Compression stocking for DVT prophylaxis every shift had been applied and checked off as done every day in February (1st-12th). LVN 6 stated, I must have documented it was done all week by mistake, I didn't know she was supposed to wear them. During a review of the facility's policy and procedure (P&P) titled, Applying Anti-Emboli Stockings (TED Hose), dated 10/2010, the P&P indicated, The purpose of this procedure is to improve venous return to the heart, to improve arterial circulation to the feet, to minimize edema to the legs and feet, and to prevent complications associated with deep vein thrombosis and pulmonary embolism .Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that anti-emboli stockings were applied .7. The name and title of the individual who performed the procedure. 46958 3. During a concurrent observation and interview on 2/12/25 at 2:30 p.m. with RN 1 in Resident 352's room, Resident 352 had IV Antibiotic Piperacillin-Tazobactam ([NAME]/Tazo, medication to treat infection) actively infusing through an IV dial-a flow administration set (tubing connecting the IV medication to the resident's IV access site) which included a flow rate controller set to open (unmetered flow). Resident 352's IV antibiotic medication label indicated, [NAME]/Tazo to NACL[sodium chloride] as directed and immediately infuse 100 ML (3.375G) over 1 hour IV via Gravity Flow Every 8 Hours. Flow rate controller was set at 300 ml per hour. RN 1 stated IV medication was flowing at 40 drops per minute. RN 1 stated the current IV antibiotic flow rate should be at 24 drops per minute. During a concurrent observation and interview on 2/12/25 at 2:30 p.m. with RN 1 in Resident 352's room, Resident 352 had IV Antibiotic Piperacillin-Tazobactam (medication to treat infection) actively infusing through an IV dial-a flow administration set (tubing connection the IV medication to the resident's IV access site) which included a flow rate controller set to open (unmetered flow). Resident 352's IV antibiotic medication label indicated, [NAME]/Tazo to NACL[sodium chloride] as directed and immediately infuse 100 ML (3.375G) over 1 hour IV via Gravity Flow Every 8 Hours. Flow rate controller was set at 300 ml per hour. RN 1 stated IV medication was flowing at 40 drops per minute. RN 1 stated the current IV antibiotic flow rate should be at 24 drops per minute During a concurrent observation and interview on 2/13/25 at 8:50 a.m. with RN 1 in Resident 351's room, Resident 351 had IV antibiotic ceftriaxone (medication to treat infection) actively infusing through an IV dial-a flow administration set. Resident 351's IV antibiotic medication label indicated, Ceftriaxone to NACL and immediately infuse 100 ML (2 GM [grams]) over 1 hour IV via gravity flow. Flow rate controller was set on 200 ml per hour. RN 1 stated the current IV antibiotic flow rate was at 38 drops per minute, and the flow rate should be at 25 drops per minute. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/13/25 at 8:54 a.m. with RN 1 in Resident 352's room, Resident 352 had IV antibiotic Piperacillin-Tazobactam actively infusing through an IV dial-a flow administration set which included a flow rate controller set to open (unmetered flow). Resident 352's IV antibiotic medication label indicated, [NAME]/Tazo to NACL as directed and immediately infuse 100 ML (3. 375G) over 1 hour IV via Gravity Flow Every 8 Hours Flow rate controller was set on 200 ml per hour. RN 1 stated current IV antibiotic flow rate was at 38 drops per minute, and the flow rate should be at 25 drops per minute. During a concurrent observation and interview on 2/13/25 at 8:56 a.m. with RN 1 in Resident 96's room, Resident 96 had IV antibiotic Cefazolin sodium actively infusing through an IV dial-a flow administration set which included a flow rate controller set to open (unmetered flow). Resident 96's IV antibiotic medication label indicated, Cefazolin to NACL as directed and immediately infuse 100 ml (2GM) over 1 hour IV via Gravity flow three times a day. Flow rate controller was set at 200 ml per hour. RN 1 stated current IV antibiotic flow rate was at 27 drops per minute, and the flow rate should be at 25 drops per minute. During a concurrent observation and interview on 2/13/25 at 9:05 a.m. with RN 1 in Resident 2's room, Resident 2's completed IV antibiotic was connected to a dial-a flow IV administration that was set to an open flow rate. Resident 2's IV antibiotic medication label indicated, Ceftriaxone to NACL as directed and immediately infuse 100 ml (2GM) over 1 hour IV via Gravity flow. RN 1 stated IV medication was running at free flow and the flow rate should be at 25 drops per minute. RN 1 stated IV medication given too fast could affect the kidneys and cause discomfort to the resident. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, dated 4/2019, the P&P indicated, 4. Medication are administered in accordance with prescriber orders, including any required time frames. 5. Medication administration times are determined by resident need and benefit, not staff convenience, Factors that are considered include: a. enhancing optimal therapeutic effect of the medication. During a review of the facility's policy and procedure (P&P) titled, INFUSION THERAPY MEDICATION ADMINISTRATION, dated 2019, the P&P indicated, To provide for the safe and accurate administration of parenteral medications through the vein.H. Regulate flow of medication infusion as prescribed.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to ensure the discharge summary for two of two sampled residents (Resident 60 and Resident 84) were completed accurately. This failure had the potential for Resident 60 and Resident 84 to miss their follow-up care, not have details of their ongoing care, and could negatively impact Resident 60 and Resident 84's safety. Findings: 1. During a review of Resident 60's Admission Record (AR), the AR indicated, Resident 60 was admitted on [DATE] with diagnosis including Parkinsonism (group of symptoms characterized by tremor, slowed movements, rigidity, and postural instability), Muscle Wasting and Atrophy (shrinking and weakening of the muscles), Chronic Obstructive Pulmonary Disease (COPD- lung disease causing restricted airflow and breathing problems), Hepatic Encephalopathy (deterioration of brain function that occurs in people with severe liver disease), and Liver Cirrhosis (severe scarring of the liver). During a concurrent interview and record review on 2/13/25 at 11:20 a.m. with Social Services Director (SSD), SSD stated Resident 60 requested to go home on 2/10/25. SSD stated Resident 60 wanted to continue her physical therapy and occupational therapy services at home with Home Health. SSD stated she notified Resident 60's son and he agreed with the discharge plan. During a concurrent interview and record review on 2/13/25 at 11:25 a.m. with Nursing Consultant (NC) 1, Resident 60's Discharge Summary, dated 2/10/25, was reviewed. The discharge summary indicated, Follow-up with primary care physician, but the physician contact information was not listed. The name of the pharmacy was listed, but did not have the contact information about the pharmacy. The discharge summary did not include the recapitulation (summary or review) of Resident 60's stay at the facility, resident's discharge status at the time of discharge, and assessment of the resident to ensure the resident could perform the required care at home. NC 1 stated the discharge summary was incomplete. 2. During a review of Resident 84's AR, the AR indicated, Resident 84 was admitted on [DATE] with diagnosis including Fracture of left femur (break in the thigh bone), muscle wasting and atrophy, Foot Drop (inability to raise the front part of the foot due to weakness or paralysis of the muscles that lift the foot) right foot, Abnormality of gait (manner of walking) and mobility. During a concurrent interview and record review on 2/13/25 at 11:30 a.m. with NC 1, Resident 84's Discharge Summary, dated 2/10/25, was reviewed. The discharge summary indicated, Follow-up with primary care physician, but the physician contact information was not listed. The name of the pharmacy was listed but did not have the contact information about the pharmacy. The discharge summary did not include the recapitulation (summary or review) of Resident 84's stay at the facility, resident's discharge status at the time of discharge, assessment of the resident to ensure the resident could perform the required care at home, and the discharge summary was not signed by Resident 84. NC 1 stated the discharge summary was incomplete. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Discharge Summary, dated 10/2022, the P&P indicated, 1. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge. The discharge summary shall include a description of the resident's: a. current diagnosis, b. medical history (including any history of mental disorders and intellectual disabilities), c. course of illness, treatment, and/or therapy since entering the facility, d. current laboratory, radiology, consultation, and diagnosis of test results .4. The post-discharge plan is developed by the care planning/interdisciplinary team with assistance of the resident and his or her family and includes b. arrangements that have been made for follow up care and services .d. the degree of caregiver/support person availability, capacity and capability to perform required care .6. The resident/representative is involved in the post-discharge planning process.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 35649 Based on observation, interview, and record review, the facility failed to ensure foot care was provided for one of one sampled resident (Resident 84). This failure resulted in Resident 84 to not being referred to podiatry (the medical care and treatment for disorders of the feet and toenails). Findings: During a concurrent observation and interview on 2/10/25 at 11:04 a.m. with Resident 84 in Resident 84's room, Resident 84's lower extremities were uncovered. The right great toenail was thick and yellowish in color, and the 2nd, 3rd, 4th, and fifth toenails were also yellowish in color. On the right 2nd, 3rd and 4th toes were small scabs. The 2nd right toe was red. The skin behind the right great toe was thick and dry. The left great toenail was thick, long, and yellowish in color. The left 2nd, 3rd, 4th 5th toenails were also long, and yellowish in color. The skin behind the left great toe was thick and dry. On the left 2nd toe was a scab. Resident 84 stated he had not seen a podiatrist. During a concurrent observation and interview on 2/10/25 at 11:27 a.m. with Registered Nurse (RN) 1 in Resident 84's room, RN 1 state Resident 84's great toenails on the right and left feet were both long, thick, and yellowish in color. The 2nd, 3rd, 4th, and 5th toenails on both feet were also long and yellowish in color. RN 1 stated Resident 84 needed to be referred to Podiatry. RN 1 measured the toenails on both feet and the measurements indicated the following: Right big toe Length: 2 cm Width: 1 cm Thickness; 0.5 cm Right 2nd: L: 0.5 cm W:0.5 cm T: 0.3 cm Right 3rd L: 0.5 cm W: 0.5 cm Thickness: (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0.3 cm Right 4th L: 0.5 cm W: 0.6 cm Thickness: 0.2 cm Right 5th: L: 0.3 cm W: 0.5 cm Thickness: 0.2 Left Big Toe: L: 1.5 cm W: 1 cm Thickness: 0.5 cm Left 2nd: L 0.5 cm W: 0.5 cm Thickness: 0.1 cm Left 3rd: L: 1.5 cm W: 1 cm Thickness: 0.1 cm Left 4th L: 1 cm (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	W: 0.3 cm Thickness: 0.2 cm Left 5th L: 0.3 cm W: 0.2 cm Thickness: 0.1 cm. During a concurrent interview and record review on 2/12/25 at 11:46 a.m. with Minimum Data Set Coordinator (MDSC), MDSC did not find RN 1's documentation of her observation and assessment of the condition of Resident 84's feet and toenails in the progress notes. During a concurrent interview and record review on 2/12/25 at 11:50 a.m. with MDSC, MDSC was unable to find documentation that the physician was notified about the condition of Resident 84's feet and toenails. During a concurrent interview and record review on 2/12/25 at 11:55 a.m. with MDSC, MDSC was unable to find documentation of podiatry referral for Resident 84's feet and toenails. During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated 10/2022, the P&P indicated, Residents receive appropriate care and treatment in order to maintain mobility and foot health .5. Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals. During a review of the facility's P&P titled, Social Services, dated 9/2021, the P&P indicated, 4. The social worker/social services staff are responsible for .g. making referrals and obtaining needed services from outside entities.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 46958 Based on interview and record review, the facility failed to maintain competency (skills and knowledge to perform a job) for one of one Registered Nurse (RN 1) when RN 1 did not have documented competencies to calculate intravenous (IV-within the vein) medication flow rates. This failure had the potential for the residents to receive incorrect doses of medications. Findings: During a concurrent observation and interview on 2/12/25 at 2:30 p.m. with RN 1 in Resident 352's room, Resident 352 had IV Antibiotic Piperacillin-Tazobactam (medication to treat infection) actively infusing through an IV dial-a flow administration set (tubing connection the IV medication to the resident's IV access site) which included a flow rate controller set to open (unmetered flow). Resident 352's IV antibiotic medication label indicated, [NAME]/Tazo to NACL[sodium chloride] as directed and immediately infuse 100 ML (3.375G) over 1 hour IV via Gravity Flow Every 8 Hours. Flow rate controller was set at 300 ml per hour. RN 1 stated IV medication was flowing at 40 drops per minute. RN 1 stated she checked on the internet to calculate the IV flow rate. RN 1 stated she learned to calculate IV flow rate in RN school two years ago. RN 1 stated there were no competencies she received regarding how to calculate IV flow rate. RN 1 stated the current IV antibiotic flow rate should be at 24 drops per minute. During a concurrent observation and interview on 2/13/25 at 8:50 a.m. with RN 1 in Resident 351's room, Resident 351 had IV antibiotic ceftriaxone (medication to treat infection) actively infusing through an IV dial-a flow administration set. Resident 351's IV antibiotic medication label indicated, Ceftriaxone to NACL and immediately infuse 100 ML (2 GM [grams]) over 1 hour IV via gravity flow. Flow rate controller was set on 200 ml per hour. RN 1 stated the current IV antibiotic flow rate was at 38 drops per minute, and the flow rate should be at 25 drops per minute. During a concurrent observation and interview on 2/13/25 at 8:54 a.m. with RN 1 in Resident 352's room, Resident 352 had IV antibiotic Piperacillin-Tazobactam actively infusing through an IV dial-a flow administration set which included a flow rate controller set to open (unmetered flow). Resident 352's IV antibiotic medication label indicated, [NAME]/Tazo to NACL as directed and immediately infuse 100 ML (3. 375G) over 1 hour IV via Gravity Flow Every 8 Hours Flow rate controller was set on 200 ml per hour. RN 1 stated current IV antibiotic flow rate was at 38 drops per minute, and the flow rate should be at 25 drops per minute. During a concurrent observation and interview on 2/13/25 at 8:56 a.m. with RN 1 in Resident 96's room, Resident 96 had IV antibiotic Cefazolin sodium actively infusing through an IV dial-a flow administration set which included a flow rate controller set to open (unmetered flow). Resident 96's IV antibiotic medication label indicated, Cefazolin to NACL as directed and immediately infuse 100 ml (2GM) over 1 hour IV via Gravity flow three times a day. Flow rate controller was set at 200 ml per hour. RN 1 stated current IV antibiotic flow rate was at 27 drops per minute, and the flow rate should be at 25 drops per minute. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/13/25 at 9:05 a.m. with RN 1 in Resident 2's room, Resident 2's completed IV antibiotic was connected to a dial-a flow IV administration that was set to an open flow rate. Resident 2's IV antibiotic medication label indicated, Ceftriaxone to NACL as directed and immediately infuse 100 ml (2GM) over 1 hour IV via Gravity flow. RN 1 stated IV medication was running at free flow and the flow rate should be at 25 drops per minute. RN 1 stated IV medication given too fast could affect the kidneys and cause discomfort to the resident. During an interview on 2/13/25 at 11:14 a.m. with Director of Nursing (DON), DON stated competency was provided on PICC (Peripherally Inserted Central Catheter) line/Central line, insertion, complications. DON stated an intravenous flow rate of 40 drops per minute is too fast for the resident. During a review of the facility document titled,Job Description (JD): Registered Nurse (RN), dated 2/2024, the JD indicated, Qualification: Mathematical Skills -Ability to apply concepts such as fractions, percentages, ratios, and proportions to practical situations. During a review of facility document titled,R.N. Competency Skills Checklist (CSC), dated 8/2015, the CSC indicated, RN 1 was checked off for intravenous antibiotic medication administration based on previous experience. RN 1 did not have have documentation to indicate current competency for IV Medication Administration. During a review of the facility's policy and procedure (P&P) titled, INFUSION THERAPY MEDICATION ADMINISTRATION, dated 2019, the P&P indicated, To provide for the safe and accurate administration of parenteral medications through the vein.H. Regulate flow of medication infusion as prescribed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46958 Based on interview and record review, the facility failed to ensure Performance Evaluations (PE-employee feedback on job performance) for two of eight sampled employees (Certified Nursing Assistant [CNA] 1 and CNA 5) were completed. This failure had the potential for the staff to not be aware of their need for improvement in areas of patient care. Findings: During a concurrent interview and record review on 2/12/25 at 10:10 a.m. with Human Resources Payroll (HR), CNA 1's PE was reviewed. The PE indicated, CNA 1 was hired on 2/6/23. HR stated there was no PE found in CNA 1's employee file. HR stated CNA 1's annual PE had not been completed for the last two years. During a concurrent interview and record review on 2/12/25 at 10:30 a.m. with HR, CNA 5's PE was reviewed. The PE indicated, CNA 5 was hired on 3/15/23. HR stated there was no PE found in CNA 5's employee file. HR stated CNA 5's annual PE had not been completed. During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, dated February 2023, the P&P indicated, The job performance of each employee shall be reviewed and evaluated at least annually.10. The completed performance evaluation will be sent by the director or supervisor to the HR director to be placed in the employee's personnel record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45654 46958 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (5%) during the medication pass observation. The facility has a medication error rate of 9.26 % consisting of five medication errors in a sample size of 54 opportunities for error. Findings: During a concurrent observation and interview on 2/12/25 at 2:30 p.m. with RN 1 in Resident 352's room, Resident 352 had intravenous (IV, in the vein) Antibiotic Piperacillin-Tazobactam (medication to treat infection) actively infusing through an IV dial-a flow administration set (tubing connection the IV medication to the resident's IV access site) which included a flow rate controller set to open (unmetered flow). Resident 352's IV antibiotic medication label indicated, [NAME]/Tazo to NACL[sodium chloride] as directed and immediately infuse 100 ML (3.375G) over 1 hour IV via Gravity Flow Every 8 Hours. Flow rate controller was set at 300 ml per hour. RN 1 stated the current IV antibiotic flow rate should be at 24 drops per minute. During a concurrent observation and interview on 2/13/25 at 8:50 a.m. with RN 1 in Resident 351's room, Resident 351 had IV antibiotic ceftriaxone (medication to treat infection) actively infusing through an IV dial-a flow administration set. Resident 351's IV antibiotic medication label indicated, Ceftriaxone to NACL and immediately infuse 100 ML (2 GM [grams]) over 1 hour IV via gravity flow. Flow rate controller was set on 200 ml per hour. RN 1 stated the current IV antibiotic flow rate was at 38 drops per minute, and the flow rate should be at 25 drops per minute. During a concurrent observation and interview on 2/13/25 at 8:54 a.m. with RN 1 in Resident 352's room, Resident 352 had IV antibiotic Piperacillin-Tazobactam actively infusing through an IV dial-a flow administration set which included a flow rate controller set to open (unmetered flow). Resident 352's IV antibiotic medication label indicated, [NAME]/Tazo to NACL as directed and immediately infuse 100 ML (3. 375G) over 1 hour IV via Gravity Flow Every 8 Hours Flow rate controller was set on 200 ml per hour. RN 1 stated current IV antibiotic flow rate was at 38 drops per minute, and the flow rate should be at 25 drops per minute. During a concurrent observation and interview on 2/13/25 at 8:56 a.m. with RN 1 in Resident 96's room, Resident 96 had IV antibiotic Cefazolin sodium actively infusing through an IV dial-a flow administration set which included a flow rate controller set to open (unmetered flow). Resident 96's IV antibiotic medication label indicated, Cefazolin to NACL as directed and immediately infuse 100 ml (2GM) over 1 hour IV via Gravity flow three times a day. Flow rate controller was set at 200 ml per hour. RN 1 stated current IV antibiotic flow rate was at 27 drops per minute, and the flow rate should be at 25 drops per minute. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/13/25 at 9:05 a.m. with RN 1 in Resident 2's room, Resident 2's completed IV antibiotic was connected to a dial-a flow IV administration that was set to an open flow rate. Resident 2's IV antibiotic medication label indicated, Ceftriaxone to NACL as directed and immediately infuse 100 ml (2GM) over 1 hour IV via Gravity flow. RN 1 stated IV medication was running at free flow and the flow rate should be at 25 drops per minute. RN 1 stated IV medication given too fast could affect the kidneys and cause discomfort to the resident. During an interview on 2/13/25 at 11:14 a.m. with Director of Nursing (DON), DON stated an intravenous flow rate of 40 drops per minute is too fast for the resident. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, dated 4/2019, the P&P indicated, 4. Medication are administered in accordance with prescriber orders, including any required time frames. 5. Medication administration times are determined by resident need and benefit, not staff convenience, Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions. During a review of the facility's policy and procedure (P&P) titled, INFUSION THERAPY MEDICATION ADMINISTRATION, dated 2019, the P&P indicated, To provide for the safe and accurate administration of parenteral medications through the vein.H. Regulate flow of medication infusion as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46958 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled,Discarding and Destroying Medications when: 1. Two of two sampled Licensed Vocational Nurses (LVN 5 and LVN 1) did not discard medication in the pharmacy discard bin. 2. One of two sampled medication carts was left unlocked and unattended. 3. Controlled Drug Records (CDR) were not signed by two nurses. These failures had the potential for medications to go unaccounted for and potentially result in drug diversion. Findings: 1a. During a concurrent observation and interview on 2/10/25 at 9:12 a.m. with Licensed Vocational Nurse (LVN) 5 in Resident 74's room, a white round pill was seen on the floor next to Resident 74's bed. LVN 5 stated it's a pill and she (LVN 5) did not know where the medication came from. LVN 5 stated, It's [unsecure medication] high risk and a resident can pick up the medication and put it in their mouth. LVN 5 put the white pill in the trash can that was in Resident 74's room. LVN 5 stated medication should be destroyed in the blue bin in the medication room not in the trash can. 1b. During a concurrent observation and interview on 2/12/25 at 8:15 a.m. with LVN 5, in Hallway 1, at medication cart 2, LVN 5 tossed a blue colored pill into a container with no lid on top of the medication cart. LVN 5 stated she would take the medication to be destroyed later. 1c. During a concurrent observation and interview on 2/12/25 at 8:42 a.m. with LVN 1 in Hallway D, at medication cart 3, LVN 1 tossed a Vitamin C 500 mg tablet into the trash can. LVN 1 stated the medication should not go into the trash can, but should be disposed of in the pharmacy receptacle inside the medication storage room to be destroyed. 45654 2a. During a concurrent observation and interview on 2/10/25 at 9:23 a.m. with Licensed Vocational Nurse (LVN) 5, in hallway D, an unattended medication cart was unlocked in a resident's doorway. LVN 5 stated the cart was unlocked and she did not have keys. LVN 5 stated she had walked across the hall to attend to a resident and left the cart unlocked and unattended. 3. During a review of CDR, dated 1/5/25, the CDR indicated, seven capsules of dronabinol (anti-nausea medication for cancer patients) capsule 2.5 milligram (mg unit of measurement) did not have nurse signatures. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of CDR dated 1/12/25, the CDR indicated, one tablet of hydrocodone/acetaminophen (hydroco/apap, Norco) to treat moderate to severe pain) tablet 5/325 mg did not have nurse signatures. During an interview on 2/12/25 at 9:18 a.m. with LVN 1, LVN 1 stated two nurses sign the CDR and the medication was given to the Director of Nursing (DON). During an interview on 2/12/25 at 9:21 a.m. with LVN 6, LVN 6 stated nurses count the medications, sign the pill pack, and sign the CDR. The medication and CDR goes to the DON for destruction. During an interview on 2/12/25 at 9:24 a.m. with LVN 3, LVN 3 stated the licensed nurses take narcotic medication to the DON, LVN 3 signs and the DON signs the medication CDR. During a concurrent interview and record review on 2/12/25 at 9:10 a.m. with DON, Controlled Drug Record's (CDR), dated 1/2025, were reviewed. The CDR's indicated, no receiving signatures. DON stated the nurse should sign the narcotic count sheets before the medications were handed over. DON stated she had not reviewed the CDRs received. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, dated 4/2019, the P&P indicated, for unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste following the steps below: a. take the medication out of the original containers. b. mix medication, either liquid or solid with an undesirable substance . the presence of two witnesses document the disposal of the medication disposition record include the signatures of at least 2 witnesses. 8. Destruction of all controlled substances must be rendered non retrievable meaning the process of permanently alters the physical or chemical properties of the substance so the that no longer available or usable and cannot be illegally diverted. 11. h. The medication disposition record will contain the following information signature of witnesses.

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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. 35649 Based on interview and record review the facility failed to evaluate food preferences for one of one resident (Resident 90). This failure resulted in Resident 90 eating peanut butter and jelly sandwiches every meal, seven days a week, which triggered Resident 90's discontent and anger. Findings: During an interview on 2/10/25 at 10:56 a.m. with Resident 90, Resident 90 stated, Food here is terrible, it is bland. There is no seasoning, and the food is cold (temperature) when I get it. I have always asked for an alternative, but I get peanut butter and jelly sandwich every meal, seven days a week. Resident 90 stated he did not recall speaking to someone from the kitchen. During a concurrent observation and interview on 2/10/25 at 12:16 p.m. with Resident 90, in Resident 90's room, Resident 90 was served his lunch tray with peanut butter and jelly sandwich. Resident 90 refused to eat lunch. Resident 90 stated, Just leave the sandwich, I will eat it later. During a review of Resident 90's Meal Ticket for lunch was reviewed. The meal ticket indicated, Regular, NAS (No added salt), 4 fluid ounces (fl. oz.) Magic Cup, PBJ (peanut butter and jelly [sandwich]). Alerts and Dislikes blank. During an interview on 2/12/25 at 9:36 a.m. with Certified Dietary Assistant (CDM), CDM stated she was covering for the facility's dietary manager who was out on leave. CDM stated she had not visited [Resident 90] to assess his food preference. CDM stated she was aware Resident 90 had been eating peanut butter and jelly sandwiches every meal for seven days. During an interview on 2/13/25 at 10:51 a.m. with Registered Dietitian (RD), RD stated she met with Resident 90 on 2/6/25 and discussed food preferences. RD stated she updated [Resident 90]'s food preferences. RD stated Resident 90 stated he did not like the food and declined what she offered, but she was able to obtain Resident 90's food preferences. During a concurrent interview and record review on 2/13/25 at 10:55 a.m. with Assistant Director of Staff Development (ADSD), ADSD was unable to provide an updated meal ticket with food preferences dated 2/6/25. During a review of the facility's policy and procedure (P&P) titled, Menu Alternatives, [undated], the P&P indicated, An alternative meal or entree and vegetable should be provided at every meal in the event of personal food preferences or refusals. 4. If a food is disliked, an appropriate equivalent substitution must be made. Alternative meals should be available with therapeutic extensions and recipes that are of equivalent nutritional value to the meals on the menu.

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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. 35649 Based on interview and record review, the facility failed to maintain a complete and accurate medical records for one of two sampled residents (Resident 40). This failure had the potential for Resident 40's physician to be unaware of Resident 40's edema and therefore not ordering appropriate tests or order medication. Findings: During an observation on 2/10/25 at 2:50 p.m. with Resident 40 in Resident 40's room, Resident 40's lower extremities (legs) and both feet were edematous (swollen). During a concurrent observation and interview on 2/12/25 at 2:18 p.m. with Minimum Data Set Coordinator (MDSC), Resident 40's Weekly Nursing Summary (WNS-accurate reflection of the resident's status the previous week), dated 1/18/25, 1/24/25, 1/31/25, and 2/7/25, were reviewed. MDSC was unable to find nursing documentation in the WNS regarding Resident 40's lower extremities edema. MDSC stated there was no mention in the weekly nursing summary of Resident 40's edema. During a concurrent interview and record review on 2/12/25 at 2:32 p.m. with MDSC, MDSC was unable to find an IDT Note addressing Resident 40's edema to the lower extremities. MDSC stated, I do not show anything where it [Resident 40's lower leg edema] was brought to anybody's attention. During an interview on 2/13/25 at 8:53 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated weekly nursing summary refers to knowing the information about the resident on prior weeks. LVN 3 stated weekly nursing summary includes changes in resident's condition, bowel movement, pain level, amount of food eaten, and over-all assessment of the resident. LVN 3 stated the weekly nursing summary also includes a weekly narrative and any change in condition is documented in the narrative section. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, [undated], the P&P indicated, 1. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the Registered Nurse Job Description (RNJD), [undated], the RNJD indicated, Review nurses' notes to ensure they are informative and descriptive of the nursing care being provided that they reflect the resident's response to the care.

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San Joaquin Nursing Center and Rehabilitation Cent	3601 San Dimas Bakersfield, CA 93301

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 41035 Based on interview and record review, the facility failed to follow its policy & procedure (P&P) on Binding Arbitration Agreement (BAA - a way to resolve disputes between healthcare providers and residents) for two of two sampled residents (Resident 15 and Resident 33) when Admission staff did not document a verbal acknowledgement of the BAA from Resident 15's Family Representative (RP 15) and Resident 33's Family Representative (RP 33). This failure had the potential for facility staff to be unaware if family representatives fully understood the legal document they were signing. Findings: During an interview on 2/12/25 at 10:08 a.m. with RP 15, RP 15 stated she had signed the BAA for Resident 15. RP 15 stated she acknowledged the understanding of the BAA and stated she did not have any questions or concerns. During an interview on 2/12/25 at 10:22 a.m. with RP 33, RP 33 stated she had signed the BAA for Resident 33. RP 33 stated she acknowledged the understanding of the BAA and stated she did not have any issues or concerns. During a concurrent interview and record review on 2/12/25 at 10:40 a.m. with Marketing Director/Admissions (MDA). Facility's BAA P&P was reviewed. MDA stated they have not been documenting in the resident's Medical Record (MR) the verbal acknowledgement from the residents or their representative. During a concurrent interview and record review on 2/12/25 at 10:43 a.m. with MDA, Resident 15's MR and signed BAA form was reviewed. MDA stated we [Facility] did not document if the resident or RP acknowledged or understood what they were signing. During a concurrent interview and record review on 2/12/25 at 10:44 a.m. with MDA, Resident 33's MR and signed BAA form was reviewed. MDA stated we [Facility] did not document if the resident or RP acknowledged or understood what they were signing. During a review of the facility's P&P titled, Binding Arbitration Agreement, revised 2023, the P&P indicated, 5. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement, including that the resident may be giving up his or her right to have a dispute decided in a court proceeding.7. After the terms and conditions of the agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before asked to sign the document. a. A signature alone is not sufficient acknowledgement of understanding. b. The resident (or representative) must verbally acknowledge understanding, and the verbal acknowledgement documented by the staff member who explains the agreement.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35649 Based on interview and record review, the facility failed to maintain an effective Quality Assurance Performance Improvement (QAPI-takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes) Program for all 96 residents residing in the facility. This failure had the potential for residents to not receive an acceptable standards of care, and the facility to not be able to identify areas of improvement. Findings: During an interview on 2/13/25 at 9:03 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 did not know the QAPI plan. LVN 3 had no knowledge of the facility's process improvement projects. During an interview on 2/13/25 at 9:05 a.m. with LVN 4, LVN 4 did not know what QAPI meant. LVN 4 was not able to articulate the current process improvement projects being worked on in the facility. During a concurrent interview and record review on 2/13/25 at 2:21 p.m. with the Administrator, Administrator stated the facility has a QAPI Committee that meets monthly and/or quarterly and attended by the Medical Director, the leadership team, and occasionally attended by some nursing personnel. Administrator stated the facility QAPI process improvement activities focused on Falls, Rehospitalization , Call Lights, Surveyor Visits, and Complaints. Administrator was unable to identify other process improvement projects using clinical indicators apart from the Center's for Medicare and Medicaid Services (CMS) required quality measures. During a concurrent interview and record review on 2/13/25 at 3:00 p.m. with Administrator and Director of Nursing (DON), the Rehospitalization process improvement was reviewed. DON presented the rehospitalization disease processes such as Diabetes, Hypertension, Heart Disease as examples for the basis of the facility's PI project. DON was unable to provide evidence of an aggregate data in terms of the number of residents being monitored for the type of diseases that required increased hospitalization , the signs and symptoms associated with the disease process that triggered the PI project, and other clinical indicators to monitor and determine the interventions to decrease rehospitalization of residents from the facility. DON stated they monitor the signs and symptoms but did not provide specifics of how the facility identified rehospitalization as quality deficient, and what health outcomes the facility intended to achieve to sustain or decrease rehospitalization of residents. During a review of the facility's policy and procedure titled, Quality Assurance and Performance Improvement (QAPI) Plan, [undated], the P&P indicated, The facility shall develop, implement, and maintain an ongoing facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems .Objectives 7. Establish systems and practices to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program . Implementation 6. Individual departments or services shall develop quality indicators for programs and services in which they are involved, and which affect their function. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Quality Assurance and Performance Improvement (QAPI) Program, dated 2/2020, the P&P indicated, The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include a. Tracking and measuring performance . c. Identifying and prioritizing quality deficiencies. D. Systematically analyzing underlying causes of systemic quality deficiencies. e. Developing and implementing corrective action or performance improvement activities .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35649 Based on observation, interview, and record review, the facility failed to ensure nationally recognized infection prevention and control practices provided by the Centers for Disease Control and Prevention (CDC-agency responsible for preventing infectious diseases) were followed and implemented when: 1. Certified Nursing Assistant (CNA) 1 entered Resident 96's room with Enhanced Barrier Precaution (reduce transmission of multidrug-resistant organisms [MDRO]- bacteria that resist treatment with more than one antibiotic) posted outside the door, without proper Personal Protective Equipment (PPE-refers to gowns, gloves, masks, face shield, or goggles to protect the individual from injury or infection). 2. Hand hygiene was not provided for two of five sampled residents (Resident 38 and Resident 15) before their food trays were delivered. These failures had the potential for infectious diseases to be transmitted to residents. Findings: 1. During a concurrent observation and interview on 2/10/25 at 10 a.m. in Resident 96's room, it was noted Resident 96 was on EBP for a wound on the right foot. Resident 96 stated he has an infected wound on the right big toe. During a concurrent observation and interview on 2/10/25 at 10:36 a.m. with CNA 1, in Resident 96's room, CNA 1 entered Resident 96's room without proper PPE. CNA 1 did not have gloves and gown on as she assisted Resident 96 to transfer from wheelchair to bed, touching Resident 96's right foot and leg as she helped Resident 96 pivot from the wheelchair to bed. With bare hands, she moved and parked the wheelchair by the right side of Resident 96's bed. Without performing hand hygiene, CNA 1 proceeded to Resident 90, who was Resident 96's roommate, and picked up Resident 90's sandwich, which he refused to eat. CNA 1 exited the room, holding the sandwich without washing her hands. CNA 1 stated she did not wear gloves and gown. CNA 1 read the CDC EBP Guidelines posted outside the door, which indicated the following: ENHANCED BARRIER PRECAUTION EVERYONE MUST: Clean hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities: Transferring, Wound Care: any skin opening requiring a dressing. 41035 2. During a concurrent observation and interview on 2/10/25 at 12:37 p.m. with CNA 6 in Resident 38's room, CNA 6 placed the lunch tray on Resident 38's bedside table. CNA 6 was asked if he had assisted Resident 38 with hand hygiene before giving Resident 38 her lunch tray. CNA 6 stated he had not and stated he should have. During an interview on 2/10/25 at 12:41 p.m. with Resident 38, Resident 38 stated she normally does not get her hands washed before lunch. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 2/10/25 at 12:42 p.m. with CNA 7 in Resident 15's room, CNA 7 placed the lunch tray on Resident 15's bedside table. CNA 7 did not provide Resident 15 with hand hygiene. CNA 7 was asked if she had provided hand hygiene to Resident 15 before giving her lunch tray. CNA 7 stated she had not and stated she should have. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene Policy for Patients Before and after Meals, [undated], the P&P indicated, 1. Hand hygiene before meals.Nursing staff must assist resident who are unable to wash their hands by: providing hand wipes or sanitizer or assisting with handwashing at a sink if needed.