STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summerfield Health Care Center	1280 Summerfield Rd Santa Rosa, CA 95405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure the nursing care plans to manage pain for two of four sampled residents (Resident 11 and Resident 109) were comprehensive (Covering completely or broadly), resident-centered, and contained specific pharmacological (Relating to medications) and non-pharmacological (Not involving medications) interventions to prevent pain, based on the residents' pain assessments. These findings had the potential to result in ineffective pain management interventions to control the residents' pain, which could have caused them suffering and distress. Findings: Record review indicated Resident 11 was admitted to the facility on [DATE] with medical diagnoses including Diabetes Mellitus (A chronic disease characterized by high levels of blood sugar) with Diabetic Neuropathy (A type of nerve damage that can occur to people with diabetes and causes pain and numbness to the legs and feet), according to the facility Face Sheet (Facility demographic). During an interview with Resident 11 on 3/12/24 at 8:55 a.m., he stated he was frequently in severe pain, due to his neuropathy. Record review of a facility assessment titled, Pain Management Review, dated 2/11/24 at 11:56 a.m., indicated that at the time of the assessment, Resident 11's pain was 5/10 (Pain scale where 10 is the worst pain experienced in a person's lifetime, and 0 is no pain), and he was currently taking Acetaminophen (An analgesic drug used to relieve mild or chronic pain) and Oxycodone (A narcotic analgesic to treat moderate to severe pain) to relieve his pain. This assessment also indicated Resident 11 experienced pain daily or several times a day, and his pain affected his sleep, emotions, and interactions with people. This assessment also described the pain characteristics, and indicated the following non-pharmacological interventions made the pain better: cold packs, hot packs, rest and repositioning. Record review of Resident 11's nursing care plan to manage pain, initiated on 2/11/24, contained standard nursing interventions such as, Anticipate need for pain relief and respond immediately .Follow pain scale to medicate as ordered .Monitor/document for probable cause of each episode. There were no specific pharmacological, or non-pharmacological interventions to prevent pain for Resident 11 and none of the responses in the assessment titled, Pain Management Review, dated 2/11/24 at 11:56 a.m., were incorporated into this nursing plan of care to manage pain. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review indicated Resident 109 was initially admitted to the facility on [DATE] with medical diagnoses including Presence of Left Artificial Shoulder Joint (Removal and replacement of the shoulder joint with artificial components, through surgery) according to the facility Face Sheet. During an interview and observation on 3/11/24 at 11:19 a.m., Resident 109 was observed with a sling on her left arm. Resident 109 stated she had fallen at home and broken her left arm, and was constantly in pain, although she did not like to take strong medication for pain. Resident 109 stated she had undergone about five surgeries to repair her left arm. Record review of a facility assessment titled, Pain Management Review, dated 2/14/24 at 6:56 p.m., indicated Resident 109 was taking Tylenol (Brand name for Acetaminophen) and Oxycodone for pain relief. This document also indicated Resident 109 experienced pain daily or several times a day, and the pain affected her emotions, and therapy or activities of choice. Pain characteristics were documented in this assessment, along with non-pharmacological interventions that made Resident 109's pain better such as warm packs, breathing and relaxation, and repositioning. Record review of Resident 109's nursing plan of care to manage pain, initiated on 1/02/24, contained the same standard nursing interventions as the nursing care plan for Resident 11 (above) such as, Anticipate need for pain relief and respond immediately .Follow pain scale to medicate as ordered .Monitor/document for probable cause of each episode. There were no specific pharmacological, or non-pharmacological interventions to prevent or manage Resident 109's pain, and none of the responses in the assessment titled, Pain Management Review, dated 2/14/24 at 6:56 a.m., were incorporated into this nursing plan of care. During a concurrent interview and record review on 3/14/24 at 3:13 p.m., LVN K reviewed the pain care plans for Resident 11 and Resident 109. LVN K indicated she did not feel the care plans were comprehensive, and she could see the need for the care plans to be more patient specific. During a concurrent interview and record review on 3/14/24 at 3:31 p.m., Registered Nurse L reviewed the pain care plans for Resident 11 and Resident 109. Registered Nurse L agreed the care plans were too generalized. Record review of the facility policy titled, Care Planning, last revised in June of 2021, indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41283 Based on observation, interviews, and record reviews, the facility did not provide the necessary respiratory care consistent with resident's care plan for oxygen therapy and current physician's orders for one of two sampled residents, Resident 41, when he was observed receiving oxygen therapy via nasal cannula (A nasal cannula is a device that gives you additional oxygen (supplemental oxygen or oxygen therapy) through your nose) at 3.5 LPM (liters per minute). This failure had the potential to result in respiratory acidosis (A condition that occurs when your lungs can't remove all of the carbon dioxide produced by your body. This causes the blood and other body fluids to become too acidic) and may affect the health and well-being of Resident 41. Findings: A review of Resident 41's Admission Record, dated 3/14/24, indicated his medical diagnoses included COPD (Chronic Obstructive Pulmonary Disease) and Chronic Respiratory Failure with Hypoxia (Hypoxia is low levels of oxygen in your body tissues, causing confusion, bluish skin, and changes in breathing and heart rate). A review of Resident 41's Order Summary Report, dated 3/14/24, indicated Resident 41 had an active order for oxygen therapy since 2/2/24, which stated, PRN (Pro Re Nata=As Needed) O2 (Oxygen) titrated (Drug titration is the process of adjusting the dose of a medication for the maximum benefit without adverse effect) up to 2 LPM via NC (nasal cannula) for O2 saturation < (less than) 90% or SOB (shortness of breath) as needed. During a concurrent observation and interview on 3/14/24, at 8:35 a.m., with Licensed Vocational Nurse J (LVN J) inside Resident 41's room, she stated Resident 41 was on 3.5 LPM O2 for COPD and CHF (Congestive Heart Failure). LVN J stated that Resident 41's current O2 order was 3.5 LPM continuous. The O2 concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) observed with LVN J indicated that resident 41 was currently on 3.5 LPM of oxygen delivery. Licensed Nurse J stated that when she needed to check the oxygen order, she would look into resident's (Resident 41's) physician's orders. LVN J stated it (order) would also be reflected in the MAR (Medication Administration Record). A review of Resident 41's MAR, for March 2024, indicated on page 28 of 31, PRN O2 titrated up to 2 LPM via NC for O2 saturation <90% or SOB. During an interview on 3/14/24, at 9:19 a.m., with the Director of Nursing (DON), she stated that she and Resident 41's physician expected the licensed nurses to verify the physician's order for oxygen therapy. A review of Resident 41's Care Plan, indicated, Has PRN Oxygen Therapy r/t (related to) ARF (Acute Respiratory Failure) with Hypoxia and COPD. One of the interventions indicated, Give medications as ordered by physician, monitor/document side effects and effectiveness. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an article from Respiratory Therapy (RT), dated November 15. 2022, under, Risks in Providing Oxygen Therapy to COPD Patients, the article indicated, .If too much supplemental oxygen is given to the patients who are relying on blood O2 to trigger breathing, the need to breath is reduced resulting in high levels of CO2 (Carbon Dioxide). A review of a facility policy and procedure (P&P) titled, Oxygen Administration, dated October 2010, indicated the purpose of the P&P, The purpose of this procedure is to provide guidelines for safe oxygen administration. Under Preparation, the P&P indicated: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41283 Based on observation, interviews, and record reviews, the facility failed to provide pain management that met professional standards of practice, and pain management that was based on the comprehensive care plan of one of three sampled residents, Resident 151, when the facility did not have a physician's order indicated to address severe pain. This failure had the potential to result in ineffective pain management that could affect his well-being, his ability to perform activities of daily living, or his ability to participate in therapeutic physical exercises. Findings: A review of Resident 151's History and Physical, dated 3/2/24, indicated under chief complaint, . Patient states he's been taking a lot of aspirin at home for his chronic low back pain. He said he has 4 (four) compression fractures (A compression fracture is a type of fracture or break in your vertebrae. The vertebrae are the bones in your back that are stacked on top of each other to make your spine) .They also found kidney stones and a possible UTI (Urinary Tract Infection). A review of Resident 151's Order Summary Report, dated 3/14/24, indicated, Resident (Resident 151) has the capacity to make health care decisions. This report indicated Resident 151 had an order for Hydrocodone-Acetaminophen (combination of opioid and analgesic pain reliever) Oral Tablet 5-325 MG (milligrams). Give 1 tablet by mouth every 4 hours as needed for MODERATE PAIN 4-6. This report indicated that Resident 151 did not have a physician's order for severe pain. During an initial interview on 3/11/24, at 11:45 a.m., with Resident 151, inside his room, he stated he had been at this facility for about a week. He stated staff here should be watched over. Resident 151 stated he had issues about his meds (medications). He stated he had pain on his abdomen and back. During a concurrent observation and interview on 3/14/24, at 9:49 a.m., with Resident 151 in his room, he was asked if he was in pain, he stated that his pain was about a 7 or 8. (Pain score 1-10 Numeric Rating Scale: 0= No pain, 1-3, Mild Pain, 4-6=Moderate Pain, 7-9, Severe pain, 10=Worst pain imaginable). Resident 151 was not in distress at this time, no facial grimacing noted. Resident 151 stated he usually gets one white pill for his pain, but this does not relieve his pain. He stated he had pain because of his compression fractures and kidney stones (Kidney stones are hard, pebble-like pieces of material that form in one or both of your kidneys when high levels of certain minerals are in your urine .A small kidney stone may pass through your urinary tract on its own, causing little or no pain. A larger kidney stone may get stuck along the way. A kidney stone that gets stuck can block your flow of urine, causing severe pain or bleeding). A review of Resident 151's MAR, (Medication Administration Record) for March 2024, indicated the dates and times when Hydrocodone-Acetaminophen 5-325 MG was administered to Resident 151, and what his pain levels were when the medication was administered. The MAR indicated that the Hydrocodone-Acetaminophen 5-325 MG was to be administered for MODERATE PAIN (4-6 pain level) but was administered on multiple occasions (32 times) where Resident 151's pain level was severe (7-9). The MAR indicated that this PRN (as needed) pain medication was administered to Resident 151 forty-four (44) times from 3/3/24 to 3/14/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/24, at 2:35, with Licensed Vocational Nurse K (LVN K), she stated on 3/5/24, at 4:35 p.m., she went to Resident 151's room and assessed his pain level, quality of pain, and location of pain. LVN K stated Resident 151's pain level was 9, severe pain. When LVN K was asked if it was appropriate to administer the Hydrocodone-Acetaminophen 5-325 MG that was indicated for moderate pain, she stated, No. LVN K stated she should have called the doctor, gave an update, and requested an order for a stronger pain medication, but stated, she did not do that. During a concurrent record review and interview on 3/14/24, at 3:04 p.m., with Registered Nurse L (RN L), she stated it was her initials that indicated she administered the Hydrocodone-Acetaminophen 5-325 MG tablet to Resident 151 on 3/2/24, at 4:08, 3/3/24, at 4:30 p.m., and 3/4/24, at 7:42 p.m. for severe pain. When RN L was asked if it was appropriate to administer the Hydrocodone-Acetaminophen 5/325 MG for moderate pain if Resident 151's pain level was severe, RN L stated, No. RN L stated she should have called the doctor and asked for a stronger pain medication. During a concurrent record review and interview on 3/15/24, at 8:30 a.m., with the Director of Nursing (DON) she was shown the MAR of Resident 151 regarding the administration of his Hydrocodone/Acetaminophen 5/325 MG. She was shown that on multiple occasions that Resident 151 was assessed to have severe pain and the nurses administered the pain medication which was indicated for moderate pain. The DON stated she would further investigate if there was communication between the nurses and the doctor. The DON stated that there should be communication between the nurse and the doctor. A review of Resident 151's Care Plan, for acute (sudden or severe in onset)/ chronic (pain that lasts for more than 3 months, or in many cases, beyond normal healing time) pain, included an intervention that indicated, Follow pain scale to medicate as ordered. A review of the facility policy and procedure (P&P) titled, Recognition and Management of Pain, dated 1/2020, indicated, It is the policy of this facility to ensure that pain management is provided to residents who require such service, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Under monitoring, the P&P indicated, Consult physician if pain is not relieved by current orders. A review of a facility policy and procedure (P&P) titled, Administration Procedures For All Medications, dated June 2021, under policy, it indicated, To administer medications in a safe and effective manner, under procedures, it indicated, Check MAR for order.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 26917 Based on interviews and a review of facility documents, it was determined that the pharmacy consultant did not identify instances where patients received Polycarbophil in conjunction with other oral medications, contrary to the manufacturer's guidelines. These guidelines stipulate that Polycarbophil should be taken at least two hours before or after other medications. These errors occurred in three of three patients who received Polycarbophil alongside other medications. Findings: A review conducted on 3/12/24, using Lexicomp Online, a nationally recognized drug information resource, indicated that Polycarbophil should be taken at least 2 hours before or after other medications. This is because laxatives can interfere with your body ' s ability to absorb other medicines. Some laxatives can bind to medications taken concurrently, potentially diminishing their effectiveness. During an observation on 3/12/24 at 7:10 AM Licensed Vocational Nurse (LVN) A administered a series of prescribed medications to Resident 28. It was noted that LVN A was responsible for administering all these medications to Resident 28. Among the medications, the largest pill, Polycarbophil (fiber laxative) 650 mg, was 2-3 times larger than the others. Resident 28 swallowed the polycarbophil along with the other medications. A review on 3/12/24 of the electronic clinical record for Resident 28 revealed that Resident 28 had been prescribed Polycarbophil. The Medication Administration Record (MAR) indicated that the Polycarbophil was scheduled to be administered at 8 AM, coinciding with the administration of other medications. However, according to the manufacturer's guidelines, Polycarbophil should not be administered simultaneously with other medications. During an observation on 3/12/24 at 7:30 AM Registered Nurse B administered multiple medications to Resident 153, including Polycarbophil 625 mg, with only a few sips, which was approximately 50 cc, of water. Resident 153 also took a total of 8 other prescribed pills with Polycarbophil. A review on 3/12/24 of the electronic clinical record for Resident 153 revealed that the Resident 153 had been prescribed Polycarbophil. The Medication Administration Record (MAR) indicated that the Polycarbophil was scheduled to be administered at 8 AM, coinciding with the administration of other medications. During an observation on 3/12/24 at 7:57 AM LVN C administered multiple medications to Resident 106, including Polycarbophil 625 mg. Resident 106 only consumed a few sips of water, approximately 100cc, with the Polycarbophil, which is less than the recommended amount. Additionally, Resident 106 took 12 other pills simultaneously with the Polycarbophil. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review on 3/12/24 of the electronic clinical record for Resident 106 revealed that Resident 106 had been prescribed Polycarbophil for at least the past three months. The Medication Administration Record (MAR) indicated that the Polycarbophil was scheduled to be administered at 8 AM, coinciding with the administration of other medications. A review on 3/13/24 of the Pharmacy Consultant reports, completed by Pharmacy Consultant E, for January and February 2024 revealed no documented irregularities related to the administration of Polycarbophil and the required spacing between it and other medications. The Pharmacy Consultant report is a monthly summary that identifies any medication-related irregularities, which are then reported to the facility for further action. However, in this case, the reports did not mention any issues regarding the administration of Polycarbophil. During an interview on 3/13/24 at 1:12 PM, the Pharmacy Consultant E reported that she was unaware of the fact that Polycarbophil was being administered concurrently with other medications, despite the manufacturer's guideline stipulating a minimum two-hour interval between the administration of Polycarbophil and other medications. When questioned further, the Pharmacy Consultant E acknowledged that she was not informed about the required separation time for Polycarbophil administration. 48660

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 26917 Based on observations, interviews, and a review of records, it was found that the facility failed to maintain a medication error rate of less than 5%. During the medication pass, six medication errors were observed out of twenty-eight opportunities for three of three residents, resulting in an error rate of 21%. Findings: Polycarbophil is a bulk-forming laxative that increases the amount of water in your stools to help make them softer and easier to pass. It works by increasing the bulk of your stool, which increases pressure and prompts the muscles in your intestines to move stool. During an observation on 3/12/24 at 7:10 AM Licensed Vocational Nurse (LVN) A administered a series of prescribed medications to Resident 28. It was noted that LVN A was responsible for administering all these medications to Resident 28. Among the medications, the largest pill, Polycarbophil (fiber laxative) 650 mg, was 2-3 times larger than the others. After swallowing the Polycarbophil along with the other medications, Resident 28 took three quick sips of water through a straw. The cup used for water had measurement lines, which indicated that the resident consumed approximately 30 milliliters of water. A review conducted on 3/12/24, using Lexicomp Online, a nationally recognized drug information resource, revealed that Polycarbophil should be administered with sufficient fluids. Specifically, each dose should be taken with 8 ounces of water, equivalent to approximately 236.6 milliliters. It helps to relieve constipation and prevent dehydration and if not taken with enough fluids, Polycarbophil may swell and block your throat, leading to choking. During an observation conducted on 3/12/24, at 7:10 AM, Resident 28 was administered Polycarbophil along with a total of 12 other prescribed pills. Resident 28 ingested all the medications in a span of a few minutes. A review conducted on 3/12/24, using Lexicomp Online, a nationally recognized drug information resource, indicated that Polycarbophil should be taken at least 2 hours before or after other medications. This is because laxatives can interfere with your body ' s ability to absorb other medicines. Some laxatives can bind to medications taken concurrently, potentially diminishing their effectiveness. During an interview on 3/12/24 at 11:30 AM with LVN A, she stated that she was not aware that the fiber laxative needed to be taken with 8 ounces of water and that other medications should be separated by at least two hours. She said that this information was indicated on the medication label. A review on 3/12/24 of Lexicomp Online, a nationally recognized drug information resource, indicated for Potassium Chloride oral dosage forms should be taken with meals and a full glass of water and or other liquid to minimize the risk of GI irritation. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview on 3/12/24 at 7:10 AM, Resident 28 reported not having any food and only took three sips of water while taking the Potassium Chloride. During an interview on 3/12/24 at 11:30 AM, LVN A stated that she was not aware that potassium chloride should be taken with food. She acknowledged that Resident 28 did not have food at the time of the medication administration. During an observation on 3/12/24 at 7:30 AM Registered Nurse (RN) B administered multiple medications to Resident 153, including Polycarbophil (Fiber Laxative) 625 mg with only a few sips, which was approximately 50 cc, of water. Resident 153 took a total of 8 other prescribed pills with the polycarbophil. During an interview on 3/12/24, at 11:15 AM, Registered Nurse B acknowledged that Resident 153 received his polycarbophil with only 50-60ml of water (a few sips), instead of the recommended 8 ounces. RN B also admitted to administering other prescribed pills with the polycarbophil, despite the requirement to separate it. RN B stated that she was not aware of the proper administration guidelines for polycarbophil, including the required amount of water and the need for separation from other medications. A review of the manufacturer's information indicated that metformin should be given with food to decrease the risk of stomach upset. Metformin is a medication used to control high blood sugar in people with type 2 diabetes. It works by reducing the amount of sugar your body absorbs from food and the amount of sugar your liver makes. This helps to lower the overall amount of sugar in your blood. It was recommended to take metformin with food to help reduce the chance of an upset stomach. During an observation on 3/12/24, at 7:30 AM, Registered Nurse B administered metformin to Resident 153 without any food, despite the requirement for the medication to be taken with food. There was no food at the resident's tray table, and Resident 153 confirmed that he had not been given any food prior to receiving the medication. During an observation on 3/12/24 at 7:57 AM LVN C administered multiple medications to Resident 106, including Polycarbophil (Fiber Laxative) 625 mg. Resident 106 only consumed a few sips of water, approximately 100cc, with the Polycarbophil, which is less than the recommended amount. Additionally, Resident 106 took 12 other pills simultaneously with the Polycarbophil. During an interview on 3/12/24 at 11:05 AM LVN C was not aware that Polycarbophil should be taken with a full 8-ounce glass of water, nor did she know that it should be administered separately from other medications. This lack of knowledge was the reason she had contributed to the medication administration errors. During an observation on 3/12/24, at 7:57am, LVN C administered over-the-counter fish oil to Resident 106 instead of the prescribed Lovaza. Lovaza is a prescription medication, while fish oil supplements are typically available over the counter (OTC) without a prescription. This distinction is important because it highlights the differences in regulatory oversight and intended use between the two products. This error was made because LVN C mistakenly believed that the two medications were interchangeable. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/24 at 11:35 AM LVN C stated that she believed that Lovaza and over-the-counter fish oil supplements were interchangeable, which led to her administering the incorrect medication. She indicated that her confusion was due to a lack of knowledge about the differences between the two medications. 48660

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	056364	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summerfield Health Care Center	1280 Summerfield Rd Santa Rosa, CA 95405

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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. 26917 Based on interviews and a review of facility records, it was discovered that the facility did not maintain proper temperature controls for medication storage during the months of December 2023 through February 2024. The medication refrigerator temperatures were found to be outside the acceptable range during this period, which is a critical requirement for ensuring the safety and efficacy of stored drugs. It was found that when the medication refrigerator was out of range, no direct actions were taken to address the temperature deviations. This lack of action further compromised the safety and effectiveness of the stored medications. Findings: A review on 3/13/24 of the facility's policy and procedures titled Medication Refrigerator, last revised in January 2022, was designed to ensure that medications requiring refrigeration are stored at the correct temperatures to maintain their efficacy. The policy stipulates that such medications should be kept in a refrigerator where the temperature is consistently held between 36 F and 46 F. In the event that the temperature is recorded outside of the appropriate range, the staff is instructed to immediately inform the Director of Nursing. This prompt notification is crucial to address any potential issues with medication storage and to maintain the facility's high standards of patient care. A review on 3/12/24 of the medication refrigerator temperature logs from December 2023 through February 2024 revealed daily temperature recordings inside the refrigerator. The logs indicated multiple instances where the temperature fell outside the acceptable range of 36 F to 46 F. Maintaining medications within this temperature range is crucial for preserving their efficacy and stability, as fluctuations can potentially compromise the quality and safety of the medications. The temperature log showed several temperature excursions during the specified timeframe: *December 2023; 15 days out of range temperatures between 32 degrees F and 34 degrees F. There were 7 days at 36 degrees F. *January 2024; 4 days out of range temperatures between 34 degrees F and 35 degrees F. There were 25 days at 36 degrees F. *February 2024; 11 days out of range temperatures between 30 degrees F and 34 degrees F. There were 10 days at 36 degrees F. The above indicated that, on average, the medication refrigerator temperatures were either too low or at the lower end of the acceptable range for the majority of each month, which would indicate an adjustment to the refrigerator temperature setting to make it slightly warmer, targeting the midpoint of the acceptable temperature range. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/24 at 1:40 PM the Director of Nursing (DON) stated that she did not possess any documented evidence indicating her awareness of the temperature excursions that occurred in the medication refrigerator from December 2023 through February 2024. The DON acknowledged the existence of multiple temperature deviations during this period but was unable to provide documentation demonstrating that appropriate actions were taken to address these issues. During an interview on 3/12/24 at 3:16 PM Pharmacy Consultant D stated that he had provided multiple in-services to educate staff on the importance of maintaining proper temperature controls for medication refrigerators. He emphasized that when temperatures deviated from the acceptable range, staff were required to document the temperature excursions and any corrective actions taken to ensure the safety and effectiveness of stored medications. During an interview on 3/13/24 at 11:00 AM the Infection Preventionist stated that the Director of Nursing would inform her when to check the medication refrigerator. During these checks, if the refrigerator temperature was within the acceptable range, she would not take any further action. She also stated that she had not taken any action from December 2023 through February 2024. The Infection Preventionist also mentioned that she does not look at the data recorded on the medication temperature logs. During the interview she reviewed the temperatures logs from December 2023 to February 2024, the Infection Preventionist acknowledged that the medication refrigerator was consistently too cold and frequently out of range. She agreed that adjustments should have been made to the refrigerator to ensure that medications were stored at the appropriate temperature. She said she was not aware of any adjustments made to the medication refrigerator during those three months. The Infection Preventionist acknowledged that medications were stored at freezing temperatures. Freezing and thawing cycling can diminish the efficacy of vaccines and medications through various mechanisms. Firstly, proteins may denature, losing their structural integrity and rendering them inactive or less effective. Lipid-based components, like liposomes, may experience instability when frozen and thawed, compromising effectiveness. Additionally, adjuvants, substances added to vaccines to enhance the immune response, can degrade during freeze-thaw cycles, impacting potency. Changes in pH due to freezing and thawing can also affect the stability and efficacy of active ingredients. Furthermore, ice crystal formation during freezing can damage components, further reducing potency upon thawing. These factors collectively highlight the importance of maintaining proper storage conditions to preserve the effectiveness of vaccines and medications. 48660

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure the food preferences of one of four sampled residents (Resident 107) was honored when he was not served the alternate meal he had ordered for lunch. This finding caused Resident 107 frustration, and had the potential to result in malnutrition, weight loss, and feelings of helplessness for Resident 107. Findings: Record review indicated Resident 107 was admitted to the facility on [DATE] with medical diagnoses including Iron Deficiency Anemia (A condition in which blood lacks adequate healthy red blood cells, due to insufficient iron in the body) according to the facility Face Sheet (Facility demographic). During an interview with the Dietary Manager (DM) on 3/11/24 at 9:40 a.m., she started trayline service (A system of food preparation, used in nursing homes, in which trays move along an assembly line) in the kitchen started at 11:45 a.m. for lunch. During a concurrent dining observation and interview on 3/11/24 at 12:36 p.m., Resident 107 was observed in bed, with his lunch tray on top of his bedside table placed in front of him. Resident 107 had received the regular meal of the day which consisted of tarragon chicken, vegetables, and a salad. Resident 107 was observed visibly upset (Based on facial expressions). Resident 107 stated he had ordered food from the alternate meal menu, which involved soup and a tuna wrap, but was served the regular meal of the day instead. Resident 107 stated this was not the first time it happened, and stated being, At my wit's end (An expression to show worry, confusion or annoyance). During an interview with the DM and Assistant Administrator (AA) on 03/11/24 at 12:44 p.m., they both confirmed Resident 107 had ordered a meal from the alternate menu earlier that day, and they were preparing it. That interview was conducted after Resident 107 had received the incorrect lunch meal. During a concurrent interview and record review with the DM on 03/11/24 at 2:45 p.m., the DM stated residents were provided with alternate meal menu forms to fill out if they wanted something different to the regular meal of the day. Sitting on top of one of the kitchen counters was a form titled, Meal Change Request Form, which indicated that for lunch on 3/11/24, Resident 107 had requested, the soup of the day and a tuna roll up (one piece-not two). The form also stated, patient wants orange juice with BF (Breakfast) and milk at every meal. The DM was unable to recall what time the kitchen received this form from Resident 107. The DM stated during trayline service, this form got missed by the cooks. The DM was asked to provide this form to the Surveyor in printed form, but it was not provided. During an interview on 3/12/24 at 3:18 p.m., Witness G stated Resident 107 had told him on several occasions that he had received the wrong meals. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/24 at 1:26 p.m., Cook H stated alternate meal menu forms had to be received by the kitchen prior to trayline service, as during trayline it was already too late to prepare a different meal for a resident. Cook H was unable to remember what time they received the form titled, Meal Change Request Form for Resident 107 on 3/11/24. During an interview on 3/15/24 at 2:08 p.m., Occupational Therapist I stated she helped Resident 107 fill out the Meal Change Request Form, and delivered it to Cook H sometime in between 9:52 a.m. and 10:45 a.m., on 3/11/24 (Minimum one hour before trayline services started). Record review of the facility policy titled, FOOD SUBSTITUTIONS FOR RESIDENTS WHO REFUSE THE MEAL, dated 2023, indicated, Residents will be provided a suitable nourishing alternate meal, after the planned, served meal has been refused. Resident 107 refused the planned meal of the day at the time he filled out the form titled, Meal Change Request Form, with assistance from Occupational Therapist I on 3/11/24 sometime between 9:52 a.m. and 10:45 a.m. (One hour before trayline service) and was still served the meal of the day instead of his meal request written on this form.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39621 Based on observation, interview and record review, the facility failed to ensure resident food was stored safely, and staff were knowledgeable of sanitizing practices when: 1. A Kitchen Aid (Dietary Aid F) was not able to describe the three-compartment method for washing and sanitizing dishes during emergencies, and was unable to find the facility policy/procedure that explained the indications for this process, and; 2. The temperature in the dry storage room and emergency food storage room, where the facility stored food and drinks for residents, was not checked regularly, and the temperatures were not being recorded to verify that food was being stored at safe temperatures. These findings had the potential to result in food borne illnesses and infections to the residents of the facility and did not support safe practices during emergency situations. Findings: 1. During a concurrent interview and observation on 3/12/24 at 10:20 a.m., Dietary Aid F, who was observed washing dishes, was asked about the process for disinfecting dishes without the use of electricity. This interview was conducted in Spanish, Dietary Aid F's primary language. Dietary Aid F explained the three-compartment process but was unable to verbalize how much sanitizing solution was required, and to what level the tray with the sanitizing solution should be filled out. Dietary Aid F was asked if there were any documents in the facility that could provide her with this information. Dietary Aid F checked the policy binder but was unable to find or understand the information in the kitchen policy manual. When asked if English was difficult for her, Dietary Aid F confirmed she was unable to understand English, and the policies were written in English. Dietary Manager (DM) was present during this interview with Dietary Aid F. Record review of an undated facility document titled, STEPS FOR 3 COMPARTMENT WASHING, indicated, WASH items in SINK BAY 1 (1st Compartment) in a solution of 2 oz (Ounces) detergent and hot water . RINSE items thoroughly in SINK BAY 2 (2nd Compartment) in clean, clear water with a temp of at least 110 degrees Fahrenheit .SANITIZE by adding 0.5 oz diluted quat sanitizer per 1 gallon of water to SINK BAY 3 (3rd Compartment). Check with test strip dipped in sanitizer solution 5-10 seconds. Must read 200 PPM (Parts per million). 2. During an observation on 3/11/24 at 9:35 a.m., during the kitchen's initial tour, no thermometer or recording log were observed in the dry storage of the facility to check and record the temperature of this room, which was inside the kitchen, separated by a wall to the kitchen area where food was cooked and prepared for the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During a concurrent interview and observation on 3/12/24 at 10:30 p.m., the emergency water and food supply for residents was checked with the DM and Administrative Assistant (AA). The emergency food and water were stored in a small room that was inside the main building of the facility but had the only exit door towards the outside of the building. A thermometer was found inside this small storage room, but there was no log available to check if anybody had recorded the temperature. The DM stated she did check the temperature occasionally in this room when rotating food items, but not daily. When asked for evidence the temperature of this room was being checked, the DM was unable to provide it. The DM was asked to provide the policy on storing emergency food and water. During a concurrent interview and record review on 3/12/24 at 3:37 p.m., the policy titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, was provided by the DM and reviewed with the DM and AA. The policy indicated, The storeroom should be well-lighted, well-ventilated, cool, dry, and clean at all times. Thermometers should be placed in all storage areas and checked frequently. Recommended temperature is 50 F (Degrees Fahrenheit)-85 F- if dry storage goes over 85 F take corrective action. The AA stated that although this policy required food to be stored within a specific temperature range, there was no requirement to document the temperatures. The Surveyor asked AA and DM how it could be verified they were taking the temperatures of the emergency food storage room if it was not recorded. They were unable to provide an answer to this question. During an interview on 3/15/24 at 11:24 a.m., the DM stated there was no log to record the temperature of the dry storage of the facility or emergency food storage. She also stated there was no requirement to check the temperature in the kitchen of the facility (Dry storage area was inside the kitchen of the facility) in their policies. The DM stated the policy titled, STORAGE OF FOOD AND SUPPLIES, applied to both, the dry storage of the facility, and the emergency food storage. During an interview on 3/15/24 at 11:58 a.m., the Maintenance Director stated he did check the temperature every other day in the residents' rooms to ensure it was adequate, but he did not check the temperature of the kitchen. Record review of an article titled, Proper Storage Temperatures for USDA (United States Department of Agriculture Foods) published by the California Department of Education (An agency within the Government of California that oversees public education) on 3/16/23 indicated, Store dry foods at 50 F for maximum shelf life. However, 70 F is adequate for dry storage of most products. Place a thermometer on the wall in the dry storage area. Check the temperature of the storeroom daily.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Dispose of garbage and refuse properly. 39621 Based on observation, interview and record review, the facility failed to ensure two of four trash cans in the kitchen were completely covered when not in use. These trash cans had large circular holes measuring approximately 12 inches in diameter that had been cut out in their lids, which made it convenient for the staff to discard garbage without removing the lid, but kept the trash exposed and open to air at all times. This finding had the potential to result in development and growth of pests such as insects and rodents, foul odors in the kitchen and the spread of pathogenic microorganisms (bacteria or viruses capable of producing disease), which could have caused infections and diseases to the residents of the facility. Findings: During an observation on 03/11/24 at 11:55 a.m., one of the kitchen trash cans was observed overflowing with garbage. This trash can had a circular hole that had been cutout in the middle of the lid, measuring approximately 12 inches in diameter, that allowed staff to discard trash even when the lid was closed. During this observation, the overflowing garbage was already above the level of the lid, therefore it was open and exposed to air. A Kitchen Aid discarded soiled gloves in this trash can, but because of the situation with the overflowing garbage, the gloves were easily retrievable, exposed, and sitting on top of other garbage. This trash can was not in continuous use as there were lapses of five to ten minutes when nobody disposed of garbage. There was a second trash can observed right next to the dishwashing area that had the same hole in the middle of the lid. During a second observation on 3/13/24 at 11:40 a.m., the two large trash cans observed on 3/11/24 with the holes in the middle of the lids were again observed in the kitchen, with the lids in place but the holes allowing access to the trash, even when not being used. The trash cans were not in continuous use, as there were time lapses of five to ten minutes when nobody was observed disposing of garbage inside these trash cans. During an interview on 3/14/24 at 1:26 p.m., Cook H stated he began his employment with the facility one year prior, and the trash cans with the holes on the lids were already in use in the kitchen since he was hired. Cook H stated it was easy to discard trash through the hole without having to open the lid every time. Record review of the facility policy titled, MISCELLANEOUS AREAS, dated 2023, indicated, All food waster must be placed in sealed leak-proof, non-absorbent, tightly closed containers .Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the FDA Food Code 2022 (The U.S. Food and Drug Administration's (FDA) Food Code is a model code that represents the FDA's best advice for a uniform system of provisions that address the safety and protection of food offered at retail and in food service), under the section titled, Receptacles, and Covering Receptacles, indicated, receptacles and waste handling units for REFUSE (Food waste, scraps, or garbage), recyclables, and returnables and for use with materials containing FOOD residue shall be durable, cleanable, insect- and rodent-resistant, leakproof, and nonabsorbent . Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility failed to ensure clinical documentation for one of four sampled residents (Resident 11) was complete and accurate, when a physician's order to recheck Resident 11's glucose (BG-Blood sugar) level was not documented in the medical record as completed. As a result, there was no way to verify that this physician order was carried out as written, which could have resulted in serious diabetic (Referring to Diabetes Mellitus-A chronic disease characterized by high levels of blood sugar) complications for Resident 11. This finding also had the potential to result in in clinical documentation that did not reflect the resident's condition and the care and services provided across all disciplines to ensure information was available to facilitate communication among the interdisciplinary team. Findings: Record review indicated Resident 11 was admitted to the facility on [DATE] with medical diagnoses including Diabetes Mellitus with Diabetic Neuropathy (A type of nerve damage that can occur to people with diabetes and causes pain and numbness to the legs and feet) according to the facility Face Sheet (Facility demographic). Record review of a physician order for Resident 11 dated 2/15/24 indicated, HumaLOG Solution (A fast-acting insulin used to control high blood sugar in adults and children with diabetes)100 UNIT/ML (Milliliter) Inject as per sliding scale .FOR BLOOD GLUCOSE OVER 350 SWITCH OVER TO Q3H (Every three hours) GLUCOSE CHECKS UNTIL UNDER 250 (Until BG is under 250 milligrams per deciliter [mg/dl]). Record review of Resident 11's Medication Administration Record (MAR) for March 2024, indicated that Resident 11's BG level was recorded as 384 (mg/dl) on 3/03/24 at 11:30 a.m. The staff member who recorded this BG level was LVN J. Record review of Resident 11's entire medical record, did not indicate his BG levels were rechecked in 3 hours from 11:30 a.m., on 3/03/24, as indicated in the physician's order dated 2/15/24. During an interview with the Director of Nursing (DON) on 3/15/24 at 8:49 a.m., she stated that after documenting Resident 11's BG level as 384 (mg/dl), LVN J rechecked Resident 11's BG at 1:30 p.m., based on information saved in the glucometer (A device for measuring the concentration of glucose in the blood) used and an interview the DON had with LVN J, therefore, according to the DON, LVN J followed the physician's order to recheck Resident 11's BG levels after testing 384 mg/dl at 11:30 a.m., on 3/03/24. The DON was asked to bring the glucometer, and facilitate a phone interview with LVN J, who was not working on 3/15/24. The DON asked for the Surveyor's phone number so LVN J could call her, but LVN J never called. The DON was asked if it was a requirement for Licensed Nurses to document BG level checks in the residents' medical records. The DON stated it was best practice but did not confirm it was a requirement. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with the DON on 03/15/24 at 9:35 a.m., the DON brought a glucometer that had saved data of a BG reading dated 3/03/24 at 1:30 p.m. that was recorded as 125 mg/dl, however, the glucometer did not indicate this BG reading belonged to Resident 11, as the glucometer did not indicate the identity of the residents whose BG levels were checked with it. The DON was asked how she knew this reading belonged to Resident 11, and she stated it was based on the interview she had with LVN J and the fact that this BG reading was taken at 1:30 p.m., on 3/03/24. Record review of the physician's order for Resident 11 (above) indicated to recheck the blood glucose level every three hours after a blood glucose level greater than 350 (mg/dl), therefore, the correct time to have rechecked Resident 11's blood glucose level would have been at 2:30 p.m., and not 1:30 p.m., on 3/03/24, which created serious problems with the credibility of this BG level as belonging to Resident 11, and indicated the physician's order to recheck the BG levels in 3 hours was not followed. During an interview on 3/15/24 at 10:29 a.m., the Director of Staff Development (DSD) was asked if it was a requirement for Licensed Nurses to document blood glucose rechecks for residents. The DSD stated it was best practice to document, but it was not required. The DSD was asked if it not required, how they verified Licensed Nurses were following physician orders for BG rechecks. The DSD was unable to answer. The DSD stated she did not personally provide instructions to Licensed Nurses on clinical documentation requirements. Record review of the facility policy titled, Charting and Documentation, last revised in July of 2017, indicated, all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medial record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident's medical record: c. Treatments or services performed; e. Events, incidents or accidents involving the resident . Documentation in the medical record will be objective, complete, and accurate.