STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056370	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home	22427 Montgomery Street Hayward, CA 94541

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45091 Based on interview and record review the facility failed to schedule a registered nurse (RN) for eight consecutive hours a day, seven days a week, for 86 days in 2024. This failure had the potential to place residents at risk to receive insufficient care. Findings: During an interview on 10/23/24 at 1:32 p.m. with Minimum Data Set Coordinator (MDSC), MDSC stated there were multiple days when the facility did not have a RN on duty for eight hours a day. During an interview on 10/23/24 at 1:50 p.m. with Director of Staffing Development (DSD), DSD stated it was important to have an RN on duty for emergency assessments, initial resident assessments, IV medications (intravenous medications - a method of administering fluids or substances into a vein using a needle or tube) and for medication destruction. During a concurrent interview and record review on 10/24/24 at 10:31 a.m. with Administrator (ADM), PBJ (Payroll-Based Journal) Staffing Data Report [NAME] Report 1705D FY (Fiscal Year) Quarter 2 2024 (a method staffing data from nursing facilities), dated 10/15/24 and PBJ Staffing Data Report [NAME] Report 1705D FY Quarter 3 2024, dated 10/15/24 were reviewed. ADM stated they were aware there were multiple days with no RN on duty for 8 hours a day. ADM stated they were not able to refute any of the days an RN was not on duty for 8 hours a day listed in the reports. ADM stated they should have had an RN on duty for eight hours a day. During a review of the PBJ Staffing Data Report [NAME] Report 1705D FY Quarter 2 2024, dated 10/15/24, the report indicated there were no RN hours on 2/03/24, 2/04/24, 2/07/24, 2/10/24, 2/17/24 - 2/19/24, 2/24/24 - 2/28/24, 3/02/24 - 3/04/24, 3/09/24, 3/15/24 - 3/17/24, 3/23/24, 3/24/24, 3/31/24. During a review of the PBJ Staffing Data Report [NAME] Report 1705D FY Quarter 3 2024, dated 10/15/24, the report indicated there were no RN hours on 4/01/24 - 4/04/24, 4/07/24 - 4/17/24, 4/19/24, 4/20/24, 4/22/24 - 4/30/24, 5/01/24 - 5/03/24, 5/06/24 - 5/09/24, 5/12/24 - 5/17/24, 5/20/24 - 5/23/24, 5/25/24, 5/27/24, 5/29/24, 6/01/24, 6/03/24, 6/05/24, 6/07/24, 6/08/24, 6/10/24, 6/11/24, 6/14/24, 6/16/24, 6/17/24, 6/19/24 - 6/21/24, 6/23/24, 6/25/24, 6/27/24, 6/28/24, 6/30/24. (continued on next page)

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

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, revised August 2022, the P&P indicated, A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 45091 Based on interview and record review the facility failed to ensure four out of four Certified Nursing Assistants (CNAs) and one out of one Certified Nursing Assistant Lead (CNAL) had the appropriate competencies to care for residents when the facility did not complete Annual Performance Evaluations for CNAs 1, 2, 3 and 4 and CNAL. This failure had the potential for resident care to be provided in an unsafe and incompetent manner. Findings: During an interview on 10/23/24 at 2:10 p.m. with CNA 1, CNA 1 stated they did not have an Annual Performance Evaluation in the last year. During a concurrent interview and record review on 10/23/24 at 2:18 p.m. with Director of Staffing Development (DSD), CNAs 1, 2, 3, 4 and CNAL's personnel folders were reviewed. DSD stated CNA 1's personnel folder indicated their last Annual Performance Evaluation was 4/22/23. DSD stated CNA 2's personnel folder indicated their last Annual Performance Evaluation was 10/12/23. DSD stated CNA 3's personnel folder indicated their last Annual Performance Evaluation was 6/28/23. DSD stated CNA 4's personnel folder indicated their last Annual Performance Evaluation was 11/15/22. DSD stated CNAL's personnel folder indicated their last Annual Performance Evaluation was 4/11/23. DSD stated CNAs 1, 2, 3, 4 and CNAL's Annual Performance Evaluations were past due. DSD stated their Annual Performance Evaluations should have been done annually and were important to make sure they could have performed their required CNA skills and tasks. During a concurrent interview and record review on 10/23/24 at 3:50 p.m. with CNA 2, CNA 2's Annual Performance Evaluation, dated 10/12/23, was reviewed. CNA 2 confirmed their last Annual Performance Evaluation was 10/12/23. During a concurrent interview and record review on 10/23/24 at 3:55 p.m. with CNAL, CNAL's Annual Performance Evaluation, dated 4/11/23, was reviewed. CNAL confirmed their last Annual Performance Evaluation was 4/11/23. During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, undated, the P&P indicated, The job performance of each employee shall be reviewed and evaluated at least annually.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42766 Based on observation, interview, and record review, the facility failed to ensure medications were appropriately acquired, received, and dispensed when: 1. One oral (administered by mouth) emergency medication kit (E-Kit) was not replaced within 72 hours after opening. 2. One injectable (medications that are administered into the body using needle and syringe) E-Kit had 15 expired medications. These failures had the potential to result in delayed treatments during emergency situations and placed residents at risks for receiving expired medications. Findings: During a concurrent observation and interview on 10/22/24 at 3:40 p.m. during an inspection of the E-kit, in the medication room, with Licensed Vocational Nurse (LVN) 2, there were two E-kits in the medication room. The first E-kit containing oral medications was noted to have been opened and sealed with red plastic ties, and a medication was last used on 10/9/24. According to LVN 2, the red plastic ties indicated the E-kit had been opened and used. LVN 2 stated they notified pharmacy on 10/9/24, but Pharmacy still had not replaced it. She stated the oral meds E-kit will expire next month 11/24. The second E-kit labeled Injectable E-kit containing injectables had several expired meds. The expiration date on the E-Kit indicated 4/24. The following expired medications were noted inside the E-kit: Atropine 1 mg/ml (expired: 4/24) Benztropine Amp (expired: 4/24) Chlorpromazine Amp (expired: 7/24) Digoxin 0.5mg/2ml (expired: 8/24) Diphenhydramine Vial (expired: 4/24) Epinephrine Amp (expired: 7/24) Furosemide 20mg/2ml (expired: 8/24) Haloperidon 5mg/ml Vial (expired: 8/24) Heparin 5 ml Vial (expired: 7/24) Hydralazine 20mg/ml (expired: 9/24) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ipratropium BR Inhalation 0.02% (expired: 9/24) Naloxone 0.4 mg/ml (expired: 5/24) Prochlorperazine 10mg/2ml (expired: 5/24) Sodium chloride 30ml 0.9% (expired: 9/1/24) Water for Injection 30 ml (expired: 9/1/24) LVN 2 stated they rarely use the injectable E-kit. LVN 2 acknowledged it had expired and was not supposed to be in the medication room. She stated she was not sure if anyone had called pharmacy to replace it. During another interview on 10/22/24 at around 4:28 pm, LVN 2 stated it is not good practice to keep expired medications (meds) in the medication room. During a telephone interview on 10/23/24 at 4:27 p.m. with the Pharmacy Consultant (PC), the PC acknowledged expired meds should not be in the medication room. PC stated she did an inspection of the medication room in August and must have missed the expired E-Kit. PC stated the injectables were IM (intramuscular injection - a procedure that involves injecting a substance into the muscle). Regarding the E-kit for oral meds that was opened, the PC stated it takes 72 hours or three days to replace E-kits after facility notifies pharmacy. PC acknowledged they should have replaced the E-kit. During an interview on 10/24/24 at around 3:25 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated the opened E-kit should be replaced within the same day, within 24 hours, should always be replenished. MDSC stated for the expired E-kit with injectables, even though they rarely use it, they should not have expired meds, and they do not want to give expired meds. During a review of the facility's policy and procedures (P&P) titled, Pharmacy Services, undated, the P&P indicated, The provider pharmacy .provide services that comply with ., but not limited to the following .provide and maintain the facility's emergency medication supply . During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy Provider: Emergency Pharmacy Service and Emergency Kits, dated 2007, the P&P indicated, the faxed log sheet .will notify the pharmacy to replace the kit or item. Drugs used from the kit shall be replaced within 72 hours and the supply resealed by the pharmacist .The consultant pharmacist or provider pharmacy designee checks the emergency kits monthly for expiration dating of the contents. The date of expiration is noted on the outside of the kit .

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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. 42766 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. During the medication pass, two medication errors were observed out of 33 opportunities for two of four residents ((Resident 16, Resident 24) resulting in an error rate of 6.06 percent. 1. Mirabegron (medication for overactive bladder) extended release 25 mg 1 tablet oral (by mouth) was crushed and administered to Resident 16. 2. Timolol maleate eye drops were not properly administered to Resident 24. These deficient practices resulted in medication not given in accordance with the manufacturer's specifications and per the standard professional practice, which may result in residents not receiving the full therapeutic effects of the medications. Findings: 1. During a medication pass observation (a process through which medication is administered to the resident) on 10/22/24 at 10:02 a.m., Licensed Vocational Nurse (LVN) 1 crushed mirabegron ER (extended release- medication that allows the body to feel the effects of the specific medication over a longer time period) tablet in a plastic pill crusher with Resident 16's other medications, mixed the medications in applesauce in a medicine cup and administered it to Resident 16 with half a cup (4 ounces) of thickened water in her room. A review of Resident16's Physician Order, dated 10/1/24 - 10/31/24, indicated mirabegron tablet extended release 24 hr; 25mg; 1 tab oral once a day; Start date 9/15/20. During an interview on 10/23/24 at 9:02 a.m. with LVN 1, LVN 1 confirmed he crushed the mirabegron medication, but he was not supposed to crush the medication because it is an extended-release tablet, as it needed to go slowly in the body to be effective. During a review of the facility's policy and procedure (P&P) titled, Crushing Medications, dated April 2018, the P&P indicated, Medications shall be crushed only when it is appropriate and safe to do so . The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long acting .medications. During a review of the manufacturer's information provided by the facility, titled, Highlights Prescribing Information for mirabegron dated 4/2021, the manufacturer's information indicated, .mirabegron: Adult patients: Swallow mirabegron whole with water. Do not chew, divide, or crush . 2. During a medication pass on 10/23/24 at 9 a.m. in Resident 24's room with LVN 1, LVN 1 administered Timolol maleate eye drop to Resident 24: one drop into the right eye, and one drop into the left eye. LVN 1 did not ask Resident 1 to gently close eyes for the drops to be evenly distributed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 24's Physician Order, dated 10/1/24 - 10/31/24 indicated, Timolol maleate gel forming solution; 0.5 %; 1 drop in both eyes; ophthalmic (eye) for glaucoma (a disease that does not have a cure and causes irreversible blindness) twice a day. During an interview on 10/23/24 at 9:43 a.m. with LVN 1, LVN 1 confirmed he did not ask Resident 24 to close her eyes for about one minute after instilling the drops. He stated it was important so there can be proper distribution. During a review of the facility's P&P titled, Instillation of eye drops, dated January 2014, the P&P indicated, . Instruct the resident to slowly close his/her eyelid to allow for even distribution of the drops. Instruct the resident not to blink or squeeze the eyelids shut, which forces the medicine out of the eye .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45091 Based on interview and record review the facility failed to employ a full time Dietary Manager (DM) while they had a part time Registered Dietician (RD). This failure had the potential to result in inadequate resident kitchen oversight and placed 32 residents who received food from the kitchen, at risk to receive inadequate nutrition. Findings: During an interview on 10/21/24 at 2:09 p.m. with DM, DM stated they worked part time. DM stated they normally worked about 30 hours a week. During an interview on 10/22/24 at 10:38 a.m. with RD, RD stated they worked part time. RD stated they usually worked once a month for six to eight hours on site and consult remotely as needed. During an interview on 10/24/24 at 2:02 p.m. with RD, RD stated it was important to have a DM to make sure kitchen staff were following sanitation rules and regulations and to make sure they are following residents' diets and choices. During an interview on 10/24/24 at 12:07 p.m. with Administrator (ADM), ADM stated DM worked about 30 hrs. a week. During an interview on 10/25/24 at 11:20 a.m. with ADM, ADM stated they did not have documentation of the RD's work schedule. ADM stated they did not have a policy and procedure (P&P) for a full time DM requirement. ADM stated they are looking for a full time DM. During an interview on 10/25/24 at 11:52 a.m. with DM, DM stated the DM's role included: kitchen staff scheduling, staff training, infection control, safety compliance and overall kitchen management. DM stated they should have a full time DM. During a review of the California Code, Health and Safety Code (HSC) 1265.4, the code indicated A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor . to supervise dietetic service operations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45091 Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared under sanitary conditions when: 1. The freezer had three food items not labeled with date. 2. The freezer had two food items unsealed and open to air. 3. Staff did not wear a beard restraint while preparing resident food. 4. Resident refrigerator had three unlabeled and undated food items. 5. Six dry foods were stored less than 6 inches above the ground. 6. One expired canned food was available for resident use. 7. The refrigerator had one box of rotten bell peppers. These failures had the potential to put 32 residents at risk for cross contamination and food borne illnesses. Findings: During a concurrent observation and interview on [DATE], at 9:29 a.m. with [NAME] (CK) 1, the walk-in freezer was observed. The freezer had one box of Danish pastries opened to air and not sealed, one closed package of waffles that was not labeled with date, one opened package of waffles that was not labeled with date, and one package of pot roast was opened to air, unsealed, and not labeled with date. CK 1 stated the Danish pastries, two packages of waffles and pot roast were not good for the residents and stated they needed to be thrown in the trash. CK 1 also stated, food should be labeled with date, so they know how old it is and to prevent food born illness. During a concurrent observation and interview on [DATE], at 9:56 a.m., in the kitchen, resident meal preparation was observed. CK 1 was observed with an uncovered mustache and goatee. CK 1 stated they were preparing marinara sauce for lunch. CK 1 stated their facial hair should have been covered. During a concurrent observation and interview on [DATE], at 10:25 a.m. with Infection Preventionist (IP), the resident refrigerator was observed. The refrigerator was observed with an unsealed jar that contained an unknown brown and beige substance that was not labeled with resident name or date and an opened package of cheese that was not labeled with resident name or date. IP stated food that was not labeled with resident name and date was a potential for food born illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE], at 2:09 p.m. with Dietary Manager (DM), the kitchen dry storage was observed. The following food items were stored less than six inches from the floor: one opened box of cream of wheat, one box of all-purpose cookie mix, one bulk container of rice, one bulk container of brown rice, one bulk container of chicken soup base and one can of cranberry sauce with a use by date [DATE]. DM stated unlabeled, undated, and expired food were a risk for food borne illness. DM stated food should be stored at least 6 inches from the ground to prevent pests, contamination and food borne illness. DM stated frozen food should be labeled with date. During an interview on [DATE], at 10:38 a.m. with Registered Dietician (RD), RD stated opened food stored in the freezer should have been labeled with open date to prevent food borne illness. RD stated food in the freezer should have been closed to prevent freezer burn. RD stated staff with a mustache or goatee should have worn a beard restraint while in the kitchen because there was a risk for hair to fall in resident food. RD stated it was important to keep food stored above six inches from the floor to prevent pests from getting to it, contamination, and for infection control. RD stated expired food should have been thrown away to prevent food borne illness. RD stated resident food should have been labeled with resident name and date opened to prevent food borne illness. During a concurrent observation and interview on [DATE], at 4:12 p.m. with Minimum Data Set Coordinator (MDSC), the resident refrigerator was observed. The refrigerator had one unsealed plastic container with a white unknown food item that was not labeled with resident name or date. MDSC stated food that was not labeled with resident name or date was a risk for infection. During a concurrent observation and interview on [DATE], at 12:21 p.m. with CK 1, the walk-in refrigerator was observed with a box of rotten bell peppers. CK 1 stated the bell peppers were rotten and had mold. CK 1 stated they were not safe to serve to residents and stated they should have been thrown away. During an interview on [DATE], at 2:29 p.m. with DM, DM stated staff were supposed to check the refrigerator every day and rotten food should have been thrown out. DM stated it was a risk for food borne illness. During a review of the facility's policy and procedure (P&P) titled, Food receiving and Storage, undated, the P&P indicated, all food stored in the refrigerator or freezer are covered, labeled and dated. The P&P indicated, Food in designated dry storage areas are kept at least six (6) inches off the floor . The P&P indicated, When food is delivered to the facility it is inspected for safe transport and quality before being accepted. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, dated 2023, the P&P indicated, Food brought in from outside sources . It must be placed in a tightly sealed container with the resident's name and date on it. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, dated 2023, the P&P indicated, Personal hygiene . Beards and/ or mustaches should be covered during meal preparation and service. During a review of the facility's policy and procedure (P&P) titled, Refrigerators and Freezers, revised [DATE], the P&P indicated, Supervisors will be responsible for ensuring food items in pantry, refrigerators and freezers are not expired or past perish dates.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42766 Based on observation, interview, and record review, the facility failed to follow infection control practices for three (Resident 2, Resident 4, and Resident 16) of 34 sampled residents when licensed staff did not sanitize the reusable medication tray in between use for the residents and did not perform hand hygiene in between medication pass for Resident 16. These failures had the potential to result in cross contamination and spread of infection. Findings: During a medication (med) pass observation on 10/22/24 at 9:20 a.m. with LVN 1, LVN 1 prepared Resident 2's medications in a medicine cup, put them in the med tray and administered the medications to Resident 2 in her room. LVN 1 proceeded to the bathroom to wash his hands and took the med tray along. LVN 1 set the med tray on top of the sink and washed his hands, then took the med tray and exited Resident 2's room. LVN 1 placed the med tray on the med cart without sanitizing the med tray and continued to prepare the next resident (Resident 4)'s medications in the same med tray. During a med pass observation on 10/22/24 at 10:10 a.m. in the front of t Resident 16's room, LVN 1 was observed preparing Resident 16's medications. LVN 1 needed to get a medication from the med room refrigerator. LVN 1 proceeded to the med room, opened the med room door, opened the refrigerator lock and the refrigerator door. LVN 1 brought out the medication bottle and dispensed a tablet from it into the med cup. LVN 1 then proceeded to the med cart and continued with the med pass without performing hand hygiene. LVN 1 set the med tray down on Resident 16's bedside table and administered medications to Resident 16. LVN 1 proceeded to the bathroom, set the med tray on the sink, washed his hands, then washed the med tray with soap and water and dried it with the paper towel in the bathroom and exited Resident 16's room. During an interview on 10/22/24 at 2:15 p.m. with LVN 1, LVN 1 acknowledged he did not sanitize the med tray between the residents' med pass, and he should have sanitized it with cavicide disinfectant spray per their policy. LVN 1 stated he was supposed to perform hand hygiene before continuing with the med pass after he came back from the med room. LVN 1 stated it was important to follow infection control practices to prevent infection transmission. During an interview on 10/24/24 at 11:50 a.m. with the Infection Preventionist (IP), staff was supposed to follow the facility's infection control standards for hand hygiene when administering medications. IP also stated, staff should wipe down equipment moved from any resident's room with cavicide spray before and after going into the room. During a review of the facility's Policy and procedure (P&P) titled Cleaning and Disinfection of Resident-Care items and Equipment, dated September 2022, the P&P indicated, .Reusable items are cleaned and disinfected or sterilized between residents . During a review of the facility's P&P titled, Handwashing/Hand Hygiene dated August 2019, the P&P indicated, .Use an alcohol-based hand rub .or, alternatively, soap (antimicrobial or non-antimicrobial) soap and water for the following situations .Before preparing or handling medications .