STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056376	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A Grace Sub Acute & Skilled Care	1250 S. Winchester Boulevard San Jose, CA 95128

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 36623 Based on observation, interview, and record review, the facility failed to provide accommodation of needs for one of 22 residents (Resident 81) when Resident 81 did not have the appropriate staff call device (call button) that she would be able to use if she needed to call for assistance. This failure had the potential to result in the resident not getting assistance timely and delay necessary care and services. Findings: Review of Resident 81's clinical record indicated she was admitted to the facility with diagnoses including respiratory failure and quadriplegia (complete or partial paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). Review of Resident 81's Nursing Admission Screening/History, dated 9/16/24 indicated the resident was alert x 4 (alert to person, place, time and event). Review of Resident 81's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/2/24 indicated her Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (cognitively intact). Review of Resident 81's physician order, dated 5/30/24 indicated she had an order for bilateral resting hand splints at all times except ADL's (activities of daily living) for contracture prevention. During an observation on 10/15/24 at 9:23 a.m., Resident 81 was in bed. Resident 81 had hand splints on her hands and arms. Resident 81's call button was on the bed next to her. During a concurrent interview with Registered Nurse K (RN K), he stated Resident 81 yells out when she needs help. During an interview on 10/16/24 at 1:59 p.m. the maintenance director (MD) stated the facility has other call devices available. He stated if a resident was not able to push on the call button using their fingers and the nusring staff could put a special call device if the resident needs it. During an interview with Resident 81 and an interpreter on 10/15/24 at 10:31 a.m., Resident 81 stated she calls out when she needs help. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 2:14 p.m., nurse supervisor M (NS M) stated Resident 81 has not been assessed for an appropriate call device. She stated there are other call devices available. NS M stated she thinks a call device that could be turned on by pressing it with her head would be good for Resident 81. During an observation on 10/17/24 at 11:10 a.m., Resident 81 was in bed. Resident 81 had hand splints on her hands and arms. Resident 81's call button was on the bed next to her. During a concurrent observation and interview on 10/17/24 at 2:03 p.m., when the Director of Nursing (DON) was asked if Resident 81's call button was appropriate for the resident and the DON asked if Resident 81 whether could move her thumbs. Resident 81 moved her arms slowly up and down and stated that she was not able to. The DON stated we have other call devices, including a padded call device or a call device that could be placed by her head. Review of the facility's policy, Assistive Devices and Equipment, revised 1/2020 indicated, Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include . Call light devices. The policy also indicated appropriateness for resident condition is one of the factors that are addressed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623 Based on interview and record review, the facility failed to ensure a baseline care plan was completed within 48 hours of admission for two of 22 sampled Residents (Resident 66 and Resident 25). This failure had the potential for the residents and/or responsible party (RP) to be unaware of the plan of care. Findings: During a review of Resident 66's Baseline Care Plan (BCP), dated 10/04/2024, the BCP indicated Resident 66 was admitted on [DATE]. It also indicated the following were left blank: Therapy Services, BCP Completion Date, Date Reviewed With Resident/Representative, Staff Name and Signature, Resident signature, Representative Name and Signature. During a review of Resident 25's BCP, dated 10/10/2024, the BCP indicated Resident 25 was admitted on [DATE]. It also indicated the following were left blank: Safety, BCP Completion date, Date Reviewed With Resident/Representative, Resident signature, Representative Name and Signature. During an interview with Nurse Supervisor M (NS M) on 10/18/24 at 11:20 a.m., NS M stated the admission nurse would start the BCP upon admission and should have been completed within 72 hours. During a concurrent interview and record review with MDS Coordinator G (MDS G) on 10/18/24 at 11:58 a.m. , MDS G confirmed the above findings and stated baseline care plans would be completed within 72 hours upon admission. During a concurrent interview and record review with Director of Nursing (DON) on 10/18/24 at 2:13 p.m., the DON confirmed the above findings. The DON stated all areas of the BCP should have been completed within 72 hours of admission for Resident 66 and Resident 25. During a review of the facility's policy and procedure titled (P&P), Care Plans - Baseline, dated December 2016, the P&P indicated, 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within Seventy-Two (72) hours of the resident's admission. 2. The interdisciplinary team will review the healthcare practitioner's order (e.g., dietary needs, medication, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care and needs including, but not limited to the following: a. Initial goals based on admission orders; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services . 4. The resident and their representative will be provided a summary of the baseline care plan .

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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** 27000 Based on observation, interviews, and record review, the facility failed to ensure professional standards of practice were followed for five out of 22 sampled residents (Residents 25, 35, 75, 93, and 98) when: For Residents 25, 35, 93, and 98, there were incomplete physicians orders, which had the potential for unsafe implementation of the orders and untimely treatment or intervention residents' medical conditions. For Resident 75, the staff took the blood pressure (BP) on the same arm where the resident has the AV fistula (arteriovenous fistula, connection that's made between an artery and a vein for dialysis access), did not monitor her intake and output (the measurement of the fluids that enter the body and the fluids that leave the body). The failures had the potential to cause injury and unmonitored medical condition. Findings: 1. A review of Resident 93's clinical record indicated an order for Admelog [insulin lispro, a short-acting insulin to lower blood sugar] Injection Solution 100 UNIT/ML [milliliter] . Inject 3 ml [milliliters] subcutaneously [injection under the skin] as needed for DM [diabetes mellitus], dated 7/19/2024. The order had a dose of 3 ml which would be equal to 300 units of insulin; and did not have a frequency and parameters, such as blood sugar (BS) above certain readings, when to give it. During a concurrent interview and record review with Registered Nurse B (RN B) on 10/15/24 at 10:29 a.m., he reviewed Resident 93's Admelog order and stated he would give it if the BS was above 130 milligrams/deciliter (mg/dL) as BS above 130 mg/dL would be considered high. RN B stated the 3 ml is a questionable dose and confirmed the order had no dosing frequency nor parameters for when to give it. During a concurrent interview and record review with the Director of Nursing (DON) on 10/15/24 at 12:14 p.m. , she reviewed Resident 93's Admelog order and stated, It is totally unclear, and the dose is wrong as 3 ml (or 300 units) would be too high. 2. A review of Resident 35's clinical record indicated he had the following orders for lorazepam (medication for agitation or anxiety): - Lorazepam 1 mg, Give 1 tablet by mouth as needed for Anxiety for 90 days, dated 4/20/24; it was discontinued on 5/17/24; - Lorazepam 1 mg, Give 1 tablet by mouth as needed for Anxiety for 90 days, dated 5/17/24; it was discontinued on 7/16/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above orders did not include the dosing frequency (how often to give it). A review of Resident 35's medication administration records (MARs) and the Controlled Drug Record for lorazepam indicated the nursing staff administered 28 lorazepam doses from 4/30/24 to 7/16/24 while the orders did not include a dosing frequency. There was no documented evidence the nursing staff clarified the order with the physician. During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 10/15/24 at 4:16 p.m., she confirmed the above finding and acknowledged the nursing staff carried out the order and administered the medication while the order did not have the frequency. 3. A review of Resident 98's physician orders included the following insulin orders: - Insulin glargine (long-acting insulin), inject 17 units subcutaneously every 12 hours for DM, dated 9/19/2024 - Insulin lispro, inject as per sliding scale (a set of instructions for administering insulin dosages based on specific BS readings) . If BS < 60 follow hypoglycemic [low blood sugar] protocol, dated 9/20/2024. There was no written hypoglycemic protocol in Resident 98's clinical record. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) C on 10/17/24 at 11:19 a.m., when asked what he would do if the resident had a BS reading below 60, he stated he would call the doctor and give the resident some juice if she could drink; and if not, he would given Glucagon (an injectable medication to treat low BS). When asked if there were prescribed orders for hypoglycemic protocol, LVN C stated he could not find any. During a concurrent interview and record review with the DON on 10/17/24 at 11:35 a.m., she reviewed Resident 98's clinical record and confirmed there were no prescribed or an established hypoglycemia protocol. She stated, There should be an order for the protocol for staff to carry out. 4. A review of Resident 25's physician's orders included the following: - Insulin Glargine, inject 5 unit subcutaneously at bedtime for DM, dated 10/11/2024 - Insulin Lispro, inject per sliding scale . FSBS [finger-stick BS] <70 Refer to hypoglycemia orders, dated 10/11/2024 There was no prescribed hypoglycemia orders in Resident 25's medical record. During a concurrent interview and record review with the MDSC on 10/17/24 at 3:20 p.m., she confirmed despite having 2 insulin orders, there were no prescribed or an established hypoglycemia protocol in place for the nursing staff to follow in case the resident had BS readings below 70. She stated she just had the order clarified with the doctor about an hour before this interview. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures (P&P) titled, Medication Therapy, revised 4/2007, indicated, Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks . All medication orders will be supported by appropriate care and practices . All decisions related to medications shall include appropriate elements of the care process, such as . Consideration of the clinical relevance of symptoms and abnormal diagnostic test results . Upon or shortly after admission, and periodically thereafter, the staff and practitioner . will review an individual's current medication regimen, to identify whether . b. The dosage is appropriate; c. The frequency of administration and duration of use are appropriate . A review of the facility's P&P titled Medication and Treatment Orders, revised 7/2016, indicated in part, Orders for medications must include . Dosage and frequency of administration . Clinical condition or symptoms for which the medication is prescribed . If clarification is necessary, the nurse shall contact the prescriber. 36623 5. During a review of Resident 75's face sheet (summary page of a patient's important information), printed 10/16/24 indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (treatment that helps body to remove extra fluid and waste products from blood). During a review of Resident 75's Physician order dated, 7/5/24 indicated monitor dialysis access AV (arteriovenous) fistula (connection made between an artery and a vein for dialysis access) left forearm for s/sx (signs and symptoms) of infection, swelling, redness, bleeding, or any drainage QS (every shift). Notify MD (medical doctor) as needed. During a review of Resident 75's Care Plan indicated an intervention, Do not draw blood or take B/P (blood pressure) on left arm shunt/fistula. During a Review of Resident 75's Blood Pressure Summary for 10/2024 indicated, Resident 75's BP was taken on the left arm from 10/1/14 to 10/15/24. During a concurrent interview and record review with Licensed Vocational Nurse D (LVN D) on 10/16/24 at 3:50 p.m., LVN D confirmed Resident 75's BP summary indicated the resident's blood pressures were taken on her left arm. LVN D stated Resident 75 has an AV shunt/fistula on the left arm and she cannot get her blood pressure taken on her left arm. LVN D stated taking blood pressures on the arm with AV fistula can cause injury to Resident 75. During a concurrent interview and record review with LVN E on 10/17/24 at 1:15 p.m., LVN E confirmed Resident 75's BP summary indicated his blood pressures were taken on the left arm. She stated licensed nurses are responsible for taking and recording the blood pressure. LVN E stated taking blood pressure on the arm with an AV fistula might cause bleeding. During a concurrent interview and record review with Director of Nursing (DON) on 10/17/24 at 4:43 p.m., the DON confirmed Resident 75's BP summary indicated the resident's blood pressure was taken on her left arm from 10/1/24 to 10/15/24. DON stated Resident 75 has an AV fistula on her left arm. She stated taking blood pressures to the left arm could put the resident at risk for bleeding. (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 interview and record review with LVN L on 10/18/24 at 10:37 a.m., LVN L confirmed Resident 75's BP summary is correct and accurate. LVN L stated he worked with Resident 75 and when Resident 75 was eating using her right hand, he checked the blood pressure on her left arm. LVN L stated Resident 75 had AV fistula, but he cannot remember which arm. LVN L stated taking blood pressure to arm with AV fistula might cause bleeding. During a review of Resident 75's Physician order dated, 5/24/24 indicated, 1000 cc (cubic centimeter, unit of volume)/(per) day Fluid restriction AM (morning) = 180 cc, PM (evening) = 90 cc, NOC (night) = 0 cc, BF (breakfast) = 240 cc, L (lunch) = 240 cc, D (dinner) = 240 cc. During a concurrent interview and record review with Licensed Vocational Nurse D (LVN D) on 10/16/24 at 3:50 p.m., LVN D confirmed Resident 75 was on a fluid restriction, but there was no monitoring for Resident 75's fluid intake and output. LVN D stated there was no intake and output in Resident 75's records. During a concurrent interview and record review with LVN E on 10/17/24 at 1:15 p.m., LVN E confirmed there was no monitoring for intake and output for Resident 75. LVN E stated dialysis residents should have monitoring for intake and output. During a concurrent interview and record review with the Director of Nursing (DON) on 10/17/24 4:43 p.m., the DON confirmed there was no order to monitor intake and output for Resident 75. During a review of the facility's undated policy and procedures titled, Dialysis, Coordination of Care & Assessment, indicated do not perform blood pressures on arm with shunt. The policy also indicated to monitor fluid balance through recording and assessment of intake and output.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 36623 Based on observation, interview, and record review, the facility failed to offer and/or attempt alternatives prior to the use of side rails (or bed rails, adjustable rigid bars attached to the side of a bed [examples include safety rails, grab bars, and assist bars]) for 18 of 22 sampled residents (Residents 66, 38, 75, 77, 13, 4, 9, 5, 73, 57, 29, 54, 98, 6, 99, 28, 82, and 16) and 77 nonsampled residents. This failure had the potential to place the residents at risk of entrapment and serious injury. Findings: 1. During an observation in Resident 66's room on 10/14/24 at 8:41 a.m., Resident 66 was sitting in bed. Resident 66's bed had both upper half side rails. Review of Resident 66's physician order, dated 10/04/24 indicated he had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 66's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 66's Side Rail Assessment, dated 10/07/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 66's Informed Consent for the Use of Bed Rails, dated 10/04/24 indicated alternatives were not attempted. 2. During an observation in Resident 38's room on 10/14/24 at 8:48 a.m., Resident 38 was in bed. Resident 38's bed had both upper half side rails. Review of Resident 38's physician order, dated 4/21/24 indicated he had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 38's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 38's Side Rail Assessment, dated 9/11/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 38's Informed Consent for the Use of Bed Rails, dated 4/21/22 indicated alternatives were not attempted. 3. During an observation in Resident 75's room on 10/14/24 at 8:55 a.m., Resident 75 was in bed. Resident 75's bed had both upper half side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 75's physician order, dated 1/27/23 indicated she had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 75's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 75's Side Rail Assessment, dated 9/16/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 75's Informed Consent for the Use of Bed Rails, dated 1/27/23 indicated alternatives were not attempted. 4. During an observation in Resident 77's room on 10/14/24 at 9:24 a.m., Resident 77 was in bed. Resident 77's bed had both upper half side rails. Review of Resident 77's physician order, dated 11/23/23 indicated he had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 77's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 77's Side Rail Assessment, dated 8/20/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 77's Informed Consent for the Use of Bed Rails, dated 2/23/23 indicated alternatives were not attempted. 5. During an observation in Resident 13's room on 10/14/24 at 9:47 a.m., Resident 13 was in bed. Resident 13's bed had both upper half side rails. Review of Resident 13's physician order, dated 2/15/24 indicated he had an order for (1/2) Both Upper Side Rail up for postural support every shift. Review of Resident 13's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 13's Side Rail Assessment, dated 8/12/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 13's Informed Consent for the Use of Bed Rails, dated 3/21/21 indicated alternatives were not attempted. 6. During an observation in Resident 4's room on 10/14/24 at 10:00 a.m., Resident 4 was in bed. Resident 4's bed had both upper half side rails. Review of Resident 4's physician order, dated 9/27/21 indicated he had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 4's Side Rail Assessment, dated 9/16/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 4's Informed Consent for the Use of Bed Rails, dated 9/27/21 indicated alternatives were not attempted. 7. During an observation in Resident 9's room on 10/14/24 at 10:04 a.m., Resident 9 was in bed. Resident 9's bed had both upper grab bars. Review of Resident 9's physician order, dated 10/11/23 indicated he had an order for grab bars/Side Rails up for positioning and easy bed mobility. Review of Resident 9's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 9's Side Rail Assessment, dated 7/26/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 9's Informed Consent for the Use of Bed Rails, dated 10/11/23 indicated alternatives were not attempted. 8. During an observation in Resident 5's room on 10/14/24 at 10:04 a.m., Resident 5 was in bed. Resident 5's bed had both upper grab bars. Review of Resident 5's physician order, dated 6/05/24 indicated he had an order for both upper grab bar/Rail up for positioning and easy bed mobility. Review of Resident 5's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 5's Side Rail Assessment, dated 8/23/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 5's Informed Consent for the Use of Bed Rails, dated 6/01/24 indicated alternatives were not attempted. 9. During an observation in Resident 73's room on 10/14/24 at 10:45 a.m., Resident 73 was lying in bed. Resident 73's bed had both upper half side rails. Review of Resident 73's physician order, dated 5/23/24 indicated he had an order for (1/2) Both Upper Side Rail up for postural support every shift. Review of Resident 73's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 73's Side Rail Assessment, dated 8/27/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 73's Informed Consent for the Use of Bed Rails, dated 5/22/24 indicated alternatives were not appropriate due to use of LAL [low air loss mattress]. 10. During an observation in Resident 57's room on 10/14/24 at 12:42 p.m., Resident 57 was lying in bed. Resident 57's bed had both upper half side rails. Review of Resident 57's physician order, dated 11/04/23 indicated he had an order for (1/2) Both Upper Side Rail up for postural support every shift. Review of Resident 57's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 57's Side Rail Assessment, dated 8/05/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 57's Informed Consent for the Use of Bed Rails, dated 11/02/23 indicated, Alternatives not appropriate due to use of LAL [low air loss mattress]. 11. During an observation in Resident 29's room on 10/14/24 at 1:55 p.m., Resident 29 was in bed. Resident 29's bed had bilateral half side rails. Review of Resident 29's physician order, dated 12/13/23 indicated she had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 29's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 29's Side Rail Assessment, dated 4/17/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 29's Informed Consent for the Use of Bed Rails, dated 11/13/23 indicated alternatives were not attempted. 12. During an observation in Resident 54's room on 10/14/24 at 1:55 p.m., Resident 54 was in bed. Resident 54's bed had bilateral half side rails. Review of Resident 54's physician order, dated 1/13/24 indicated he had an order for (1/2) Both Upper Side Rail up for postural support. Review of Resident 54's Side Rails care plan indicated an intervention, Identify and use appropriate alternative prior to installing side rails. Review of Resident 54's Side Rail Assessment, dated 8/20/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 54's Informed Consent for the Use of Bed Rails, dated 1/20/24 indicated alternatives were not appropriate. 13. During an observation in Resident 98's room on 10/14/24 1:55 p.m., Resident 98 was in bed. Resident 98's bed had bilateral half side rails. Review of Resident 98's physician order, dated 10/8/24 indicated she had an order for (1/2) Both Upper Side Rail up for postural support. Review of Resident 98's Side Rail Assessment, dated 9/18/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 98's Informed Consent for the Use of Bed Rails, dated 9/18/24 indicated alternatives were not attempted. 14. During an observation in Resident 6's room on 10/15/24 at 9:42 a.m., Resident 6 was in bed. Resident 6's bed had both upper (1/4) side rails. Review of Resident 6's physician order, dated 8/06/24 indicated he had an order for (1/4) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 6's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 6's Side Rail Assessment, dated 8/30/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 6's Informed Consent for the Use of Bed Rails, dated 8/06/24 indicated alternatives were not attempted. 15. During initial facility observations on 10/14/24, between 9:00 a.m. and 3:30 p.m., it was noted that Residents 99, 28, 82, and 16 each had bilateral half side rails raised. Review of Resident 99's physician order, dated 9/27/24 indicated he had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 99's Side Rails care plan indicated an intervention, Identify and use appropriate alternatives prior to installing side rails. Review of Resident 99's Side Rail Assessment, dated 8/14/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 99's Informed Consent for the Use of Bed Rails, dated 9/27/24 indicated alternatives were not attempted. 16. Review of Resident 28's physician order, dated 3/5/22 indicated he had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's Side Rails care plan indicated an intervention, Identify and use appropriate alternative prior to installing side rails. Review of Resident 28's Side Rail Assessment, dated 8/26/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 28's Informed Consent for the Use of Bed Rails, dated 3/5/22 indicated alternatives were not attempted. 17. Review of Resident 82's physician order, dated 2/5/24 indicated he had an order for (1/2) Both Upper Side Rail up for positioning and easy bed mobility. Review of Resident 82's Side Rails care plan indicated an intervention, Identify and use appropriate alternative prior to installing side rails. Review of Resident 82's Side Rail Assessment, dated 9/3/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 82's Informed Consent for the Use of Bed Rails, dated 2/5/24 indicated alternatives were not attempted. 18. Review of Resident 16's physician order, dated 1/11/20 indicated he had an order for May have both 1/2 Upper Side Rails up for repositioning and easy bed mobility. Review of Resident 16's Side Rails care plan indicated an intervention, Identify and use appropriate alternative prior to installing side rails. Review of Resident 16's Side Rail Assessment, dated 9/16/24 indicated there was no documentation that the facility offered and/or attempted alternatives prior to the use of side rails. Review of Resident 16's Informed Consent for the Use of Bed Rails, dated 4/7/19 indicated alternatives were not attempted. During an interview with the Director of Nursing (DON) on 10/16/24 at 2:00 p.m., the DON confirmed about the attempted alternatives prior to the use bed rails were findings. The DON stated that alternatives were not considered necessary, as the side rails were used for support, mobility, and positioning. The survey team expanded the sample and identified via observation and record review an additional 77 residents had side rails. Review of the Informed Consent for the Use of Bed Rails for the 77 residents indicated there was no documentation that the facility attempted alternatives prior to the use of side rails. During an interview on 10/18/24 at 11:55 a.m., the Director of Nursing (DON) confirmed most residents in the facility have side rails. She stated usually if they see that side rails will be beneficial for the resident, then they use the side rails. The DON stated if the facility determines alternatives are not appropriate for a resident, that is the reason why the facility did not attempt alternatives prior to the resident using side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Proper Use of Side Rails, revised 12/2016 indicated less restrictive interventions will be incorporated in care planning and documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails.

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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. 27000 Based on interview and record review, the facility failed to ensure accurate accountability of controlled drugs (medications that can be easily abused and are under strict government control) and document medication administration as in accordance with the facility policy and procedures (P&P) for 3 out of 5 residents (Residents 35, 39, and 85). The failure had the potential for medication errors and controlled drug abuse or diversion (when healthcare providers obtain or use prescription medicines illegally). Findings: During an interview with the Director of Nursing (DON) on 10/15/24 at 3:40 p.m., she explained that each time a resident requested an as-needed controlled medication, the nurse assesses the resident, reviews the physician's order, signs it out of the CDR, administers the medication to the resident, documents the medication administration on the MAR, and re-assesses the resident for effectiveness of the medication within one hour. 1. A review of Resident 39's clinical record indicated a physician's order, dated 12/11/23, for diazepam (a controlled medication to treat anxiety or other medical conditions) 5 milligrams (mg, unit of measurement), give 1 tablet every 4 hours as needed for intermittent jerking. On 10/15/24 at 3:50 p.m., in the presence of the DON, an interview and record review was conducted with the Minimum Data Set Coordinator (MDSC). A review of Resident 39's CDR for diazepam 5 mg and the June, August, and September 2024 medication administration records (MARs) indicated the nursing staff signed out of the CDR but did not document on the MAR to show the medication was administered to the resident, on 5 occasions, as follows: - 6/23/24 at 4 a.m. - 6/27/24 at 8 p.m. - 6/27/24 at illegible time - 8/7/24 at 8 p.m. - 9/12/24 at 8:30 p.m. During the interview and record review above, the MDSC confirmed this finding. She reviewed the nursing progress notes and stated there was documentation showing diazepam was given one time on 6/27/24 and on 9/12/24. However, both the DON and MDSC stated the nursing staff is expected to document the medication administration on the MAR so the computer system would prompt the re-assessment in one hour, and also to prevent the medication from being given again too soon. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 35's clinical record indicated a physician's order for lorazepam (medication for agitation and anxiety) 1 mg, give 1 tablet by mouth as needed for Anxiety for 90 days, dated 4/20/24. The order did not specify how frequent it should be administered. During a concurrent interview and record review with the MDSC on 10/15/24 at 4:16 p.m., a review of Resident 35's CDR for lorazepam 1 mg and the May and July MARs indicated, on 9 occasions, the nursing staff signed out one tablet on the CDR but did not document their administration on the MAR, as follows: - 5/1/24 at 2 p.m. - 5/2/24 at 2 p.m. - 5/7/24 at 3 p.m. - 5/11/24 at 3 p.m. - 5/13/24 at 3 p.m. - 5/17/24 at 3 p.m. - 5/25/24 at 3 p.m. - 7/15/23 at 3 p.m. - 7/30/24 at 8 a.m. During the interview and record review above, the MDSC verified the finding, and confirmed 9 lorazepam was not accounted for. 3. A review of Resident 85's clinical record indicated a physician's order, dated 11/26/2023, for oxycodone (a potent controlled medication for pain) 5 mg, 1 tablet every 6 hours as needed for moderate to severe pain. During a concurrent interview and record review with the MDSC on 10/15/24 at 4:29 p.m., a review of Resident 85's oxycodone 5 mg CDR and the July and August 2024 MARs indicated the nursing staff removed one tablet on the following dates and times without documenting in the respective administration on the MAR: - 7/22/24 at 4:30 a.m.; - 7/23/24 at 10:00 p.m.; - 7/24/24 at 6:00 a.m.; - 8/1/24 at 6:00 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/15/24 at 4:35 p.m., the MDSC verified: three tablets of diazepam 5 mg for Resident 39; nine tablets of lorazepam 1 mg for Resident 35; and four tablets of oxycodone 5 mg for Resident 85, were unaccounted. She stated the nurses didn't document medication administration when they are supposed to. A review of facility's P&P titled Medication Administration Controlled Substances, dated 1/2023, indicated in part, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage . a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose . Administer the controlled medication and document dose administration on the MAR.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 27000 Based on interview and record review, the consultant pharmacist (CP) failed to identify and report irregularities to the facility during the monthly regimen review (MRR) for two out of 20 sampled residents (Residents 5 and 93). The failure resulted in an unsafe order without being clarified for Resident 93, and Resident 5 not receiving the medication in accordance with the manufacturer's specifications to optimize drug therapy. Findings: 1. A review of Resident 93's clinical record indicated an order for Admelog [insulin lispro, a short-acting insulin to lower blood sugar] Injection Solution 100 UNIT/ML [milliliter] . Inject 3 ml [milliliters] subcutaneously [injection under the skin] as needed for DM [diabetes mellitus], dated 7/19/2024. The order had a dose of 3 ml which would be equal to 300 units of insulin; and did not have a frequency and parameters, such as blood sugar (BS} above certain readings, when to give it. During a concurrent interview and record review with Registered Nurse B (RN B) on 10/15/24 at 10:29 a.m., he reviewed Resident 93's Admelog order and stated he would give it if the BS was above 130 milligrams/deciLiter (mg/dL) as that would be considered high. RN B stated the 3 ml is a questionable dose and confirmed the order had no dosing frequency nor parameters when to give it. During a concurrent interview and record review with the Director of Nursing (DON) on 10/15/24 at 12:14 p.m. , she reviewed Resident 93's Admelog order and stated, It is totally unclear, and the dose is wrong as 3 ml (or 300 units) would be very high. When asked whether the CP identified this as an irregularity during the monthly MRR since July 2024, the DON stated she could not find any recommendation related to this. During a telephone interview with the CP on 10/17/24 at 3:35 p.m., when asked whether she had identified and reported to the facility the irregular Admelog order for Resident 93, the CP responded she did not. She stated, Looks like I did not see it. 2. A review of Resident 5's clinical record indicated she was admitted to the facility with diagnoses including chronic kidney disease (CKD, long-term condition where the kidneys are damaged and can not filter blood properly). Resident 5's physician's orders included an order for: - Calcium Acetate (Phoslo; a phosphate binder, medication to prevent high blood phosphate levels in patients who are on dialysis due to severe kidney disease) 667 mg, give 2 tablets by mouth three times a day for CKD, dated 6/3/2024. It was scheduled to be administered at 9 a.m., 1 p.m., and 5 p.m. According to the Prescribing Information from the manufacturer for calcium acetate, dated 3/2011, it indicated, Calcium acetate . when taken with meals, combines with dietary phosphate to form an insoluble calcium phosphate complex, which is excreted in the feces, resulting in decreased serum phosphorus concentration. It indicated to take the medication with each meal. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility scheduled breakfast at 7 a.m.; lunch at 12 noon; and dinner at 5 p.m. Thus, the calcium acetate administration time was not scheduled at the same time with breakfast and lunch. During an interview and record review with RN B on 10/16/24 at 11:37 a.m., he stated the facility meal scheduled breakfast around 7:30 a.m., lunch at noon, and dinner is at 5 p.m. He stated Resident 5 had breakfast around 7 to 7:30 a.m. that morning, and he administered the calcium acetate to Resident 5 at 8:35 a.m. (about one hour after breakfast). On 10/16/24 at 11:18 a.m., an interview was conducted with Resident 5, who had a Brief Interview for Mental Status (BIMS, a scale to determine a patient's cognitive understanding) of 15, conducted on 8/23/24, indicating she had intact cognition. When asked whether she took her Phoslo with food or whenever the nursing staff gave it to her, she stated, Whenever they give it to me. She said she did not know it has to be given with food. During a concurrent interview and record review with the DON on 10/16/24 at 12:09 p.m., she acknowledged the calcium acetate should be given with meals. She reviewed Resident 5's calcium acetate administration schedule and confirmed they were not consistent with meal times. A review of the Resident Details (a document showing the actual medication administration time) with the DON showed Resident 5's calcium acetate doses were not given during meal times 35 times out of 39 administrations from 10/3/24 to 10/15/24. A review of Resident 5's laboratory test, dated 3/6/24, indicated her phosphorous level was at 5.8 (high; the normal range is 2.5 - 5.0). During a telephone interview with the CP on 10/17/24 at 3:59 p.m., when asked whether she made a recommendation for Phoslo to be administered with meals, she stated, There was no recommendations after June this year for the Phoslo to be taken with meals. A review of the facility policy and procedures titled Medication Regimen Reviews, dated 5/2019, indicated, The consultant pharmacist performs a medication regimen review (MRR) for every resident . The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example . medications ordered in excessive doses . incorrect medications, administration times .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 27000 Based on observation, interview, and record review, the facility failed to ensure two out of 22 sampled residents (Residents 35 and 98) were free from unnecessary medications when Resident 35 received warfarin (a blood thinner to prevent blood clots) for a wrong indication; and Resident 98's lidocaine patch (a topical medication applied to the skin for pain) was not administered in accordance with the manufacturer's specifications. This deficient practice resulted inadequate indication for medication use; and the potential for adverse effects of medication. Findings: 1. A review of Resident 35's clinical record indicated he was admitted to the facility with diagnoses including chronic embolism and thrombosis of other specified veins (conditions that involve blood clots and can lead to serious complications) and saddle embolus of pulmonary artery with acute cor pulmonale (condition occurs when a large blood clot becomes lodged at the intersection where the main pulmonary artery divides and branches off into the left and right lungs). A review of Resident 35's physician's orders indicated the resident has been receiving warfarin, a blood thinner that required frequent blood testing and dosage adjustment based on the test results. He had the following orders: - Warfarin 1 mg, give 1.5 tablets by mouth at bedtime for pulmonary edema (condition where too much fluid builds up in the lungs, making it difficult to breathe), dated 9/13/24; - Warfarin 1 mg, give 1.5 tablets by mouth at bedtime for pulmonary edema, dated 9/20/24; - Warfarin 1 mg, give 1.5 tablets by mouth at bedtime for pulmonary edema, dated 9/25/24; During an interview with Resident 35 on 10/16/24 at 4:09 p.m., he stated he had been receiving warfarin for a massive saddle PE (saddle pulmonary embolism, a rare, life-threatening condition that occurs when a large blood clot gets lodged in the pulmonary artery, blocking blood flow to both lungs) that required very long hospitalization . During a concurrent interview and record review with the Director of Nursing (DON) on 10/17/24 at 11:45 a.m. , she reviewed Resident 35's warfarin orders and confirmed the diagnosis for warfarin should be pulmonary embolism, not pulmonary edema. 2. A review of Resident 98's clinical record indicated she was admitted to the facility with diagnoses including back pain. A review of her physician's orders indicated an order for lidocaine patch 4%, apply to back topically one time a day for pain management, dated 9/21/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 11:19 a.m., Licensed Vocational Nurse C (LVN C) was asked to show the lidocaine patch that was administered to Resident 98 earlier that morning. LVN C provided a lidocaine 4% patch box labeled Lidocaine Pain Relief Patch. The manufacturer's directions in the back of the box indicated to not use longer than a 12-hour period. A review of Resident 98's medication administration record (MAR) with LVN C indicated a new patch was scheduled to be administered at 9 a.m., and the removal of the used patch was scheduled at 0859 a.m. (same time as the new patch application). LVN C stated he applied a new patch this morning at around 9 a.m. and removed the previous day's patch at the same time. During a concurrent interview and record review with the DON on 10/17/24 at 11:35 a.m., she stated the facility had a template for lidocaine patch application: it is supposed to be on at 9 a.m. and off at 9 p.m. (12-hour period). She reviewed Resident 98's lidocaine order and stated, It wasn't used for this patient, and confirmed it should have been used. During a telephone interview with the Consultant Pharmacist (CP) on 10/17/24 at 3:35 p.m., she stated, Lidocaine is supposed to be 12 hours on, 12 hours off. A review of the facility's policy and procedures titled, Medication Therapy, revised 4/2007, indicated, Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks . Medication use shall be consistent with an individual's condition . All medication orders will be supported by appropriate care and practices . All decisions related to medications shall include appropriate elements of the care process, such as . The frequency of administration and duration of use are appropriate .

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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. 27000 Based on observation, interview, and record review, the facility had a medication error rate of 5.56% when two medication errors occurred out of 36 opportunities during the medication administration for 2 out of 6 residents (Residents 67 and 93). The failures resulted in the nursing staff not following the facility's policy and procedures (P&P) and had the potential for the residents not receiving full therapeutic effects or complications of medications. Findings: 1. During the medication administration observation on 10/14/24 at 9:15 a.m., Licensed Vocational Nurse (LVN) A was observed preparing and administering 15 medications to Resident 67. Included in the medications was an oral inhaler called Alvesco (medication for asthma). After shaking the Alvesco inhaler, LVN A gave it to the resident and asked her to press on the inhaler and inhale deeply. After she finished, LVN A asked Resident 67 to repeat by giving herself another puff without allowing some time in between the inhalations. There was about 4 or 5-second time lapse between the 2 puffs. During an interview shortly after the observation, on 10/14/24 at 9:37 a.m., LVN A was asked whether he should have allowed time between the 2 puffs of inhaled medication, he stated, Not typically. He also stated he was not familiar with spacing out inhaled medications. A review of Resident 67's clinical record indicated a physician's order, dated 10/10/24, for Alvesco Inhalation 160 micrograms/actuation (unit of measurement), inhale 2 puffs orally two times a day for asthma prevention and control. During an interview with the Director of Nursing (DON) on 10/14/24 at 3:07 p.m., she stated, For patients with multiple inhalations, they [the nurses] should allow 1-2 minutes between inhalations. A review of the facility's P&P titled Administering Medications through a Metered Dose Inhaler, dated 10/2010, indicated, Repeat inhalation, if ordered. Allow at least (1) minute between inhalations of the same medication . 2. During the medication administration observation on 10/14/24 at 10:09 a.m., Registered Nurse (RN) B was observed preparing 10 medications, 1 liquid and 9 solid medications, for Resident 93. The resident was receiving medications via the gastrostomy tube (or G-tube, tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). RN B crushed each solid medication separately and diluted each with about 10 milliliters (mL, unit of measurement) of water. He also added some water to the liquid medication to dilute it. On 10/14/24 at 11 a.m., after attaching a 60-mL syringe to the resident's G-tube, RN B was observed flushing the G-tube with about 50 mL of water. Then he poured each of the medication in the syringe, one by one, without flushing with water between the 10 medications. He flushed the tubing with about 60 mL of water after the last medication. Shortly after the observation, on 10/14/24 at 11:19 a.m., RN B confirmed he did not rinse or flush the tubing with water between the medications. He said he was supposed to. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 10/14/24 at 3:07 p.m., she stated the nursing staff was to flush the resident's enteral tube with about 50 mL of water before medication administration, 10 mL after each medication, and do a final flush with 50 mL of water. A review of the facility's P&P titled Administering Medications through an Enteral Tube, revised 11/2018, indicated at the beginning of administration, Stop feeding and flush tubing with at least 50 mL warm water . If administering more than one medication, flush with at least 10 mL warm water . between medications . When the last of the medication begins to drain from the tubing, flush the tubing with 50 mL of warm water .

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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** 37409 Based on observation, interview, and record review, the facility failed to provide meals with food items according to preferences and dislikes for two of 44 residents (55 and 67). This failure had the potential to result in meal dissatisfaction, decreased intake, and leading to compromised nutritional and medical status for the residents. Findings: Review of Resident 55's Admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 67's Admission Record indicated she was admitted to the facility on [DATE]. During a tray line observation with the dietary supervisor (DS) on 10/15/24, at 12:35 p.m., Resident 55's lunch ticket indicated he preferred to have a cheeseburger every day, but a cheeseburger was not served for him. Resident 67's lunch ticket indicated she disliked rice, but rice was served for her. During a concurrent interview with the DS, she confirmed that Resident 55's lunch ticket indicated he preferred to have a cheeseburger every day, but a cheeseburger was not served for him. Resident 67's lunch ticket indicated she disliked rice, but rice was served for her. The DS stated meals should have been served according to the residents' preferences and dislikes. Review of the facility's 2023 policy, Food preferences, indicated, Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group.

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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** 37409 Based on observation, interview, and policy review, the facility failed to ensure food was stored, prepared, and served in accordance with professional standards for food safety when: 1. Undated food items, food past their used by date, bananas with black spots, partially soft and ruined tomatoes, dry green onion were found in the refrigerator and on the shelves in the kitchen; 2. A tube of Auto-Chlor test strips (used to test the chemical concentration of cleaning solutions to ensure that sanitizers are used appropriately in dishwashers, sinks, and buckets) was expired; and 3. Dietary supervisor (DS) did not sanitize the contaminated thermometer before checking the temperature of the lemonade. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness and cross-contaminated food for the 44 residents eating at the facility. Findings: 1. On [DATE], at 9:15 a.m., during an observation of the kitchen's storage shelves and in the walk-in refrigerator, with the registered dietician (RD) and the dietary supervisor (DS), the following were observed: a. A sugar container, but there was no use by date; b. Six tomatoes were partially soft and had signs of rotting; c. Four bunches of green onion were dry; d. One gallon of premium sweet pickle relish with a use by date of [DATE]; e. Open bag of five pounds of raisins with no open date and no use by date; f. One brown rice container, one white rice container, and one barley container with no use by date; g. One imperial country style gravy mix received on [DATE]; h. Eight ounces of ground cloves with use by date [DATE]; i. Eighteen bananas with black spots; j. Open container of 20 ounces of whole sesame seed with no open date; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. Open container of 16 ounces of cayenne pepper with no open date; l. Open container of 16 ounces of whole Mediterranean oregano with no open date; m. Open container of five pounds of ground black pepper with no open date; n. Open container of five pounds of granulated onion with no open date; During a concurrent interview with the RD, the RD reviewed the facility's Dry Goods Storage Guidelines and confirmed that the sugar container should have a use by date on it. The RD stated the gravy mix was good for one year, and it was expired The RD also stated the above food should have open date and use by date. He stated the expired food should not be on the shelves and should have been discarded. Review of the facility's 2023 policy, Labeling and Dating of Foods, indicated, Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines . Review of the facility's 2023 policy, Storing Produce, indicated 1. Check boxes of fruit and vegetables for rotten, spoiled items . Throw away all spoiled items. 2. During an observation with the DS at the dishwasher in the kitchen on [DATE], at 11:15 a.m., a tube of Auto-Chlor test strips had an expiration date of ,d+[DATE]. During a concurrent interview with the DS, she confirmed that the tube of Auto-Chlor test strips was expired in ,d+[DATE]. The DS stated the tube should be discarded. 3. During a tray line observation on [DATE], at 12:05 p.m., the glasses of the drinks were placed in a bin with ice on top of their lids. The DS was checking the temperature of the lemonade. The DS held the thermometer in her hand; she tossed the ice on top of the lid of the lemonade glass with her index finger of the same hand, and the tip of the thermometer touched the bin several times, then the DS dipped the thermometer into the lemonade to check its temperature without sanitizing the thermometer. During a concurrent interview, the DS stated she should sanitize the contaminated thermometer before dipping it into the lemonade to check its temperature. Review of the facility's 2023 policy, Thermometer Use and Calibration, indicated . Cleaning and Sanitizing: . Wipe the clean thermometer with the sanitizing solution using a clean cloth or paper towel. Let the thermometer air dry before use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 32398 Based on observation, interview, and record review, the facility failed to ensure proper infection prevention techniques were followed when: 1. two oxygen concentrators had dirty filters, 2. a nurse did not wear appropriate personal protective equipment (PPE), two times during medications pass, for one of six residents who was on enhanced barrier precautions (a set of infection control measures that use gowns and gloves during high-contact care activities to reduce the spread of multidrug-resistant organisms), and 3. during personal care, the urine collection bag for one of 17 residents with a urinary catheter (a tube which is used to allow urine to drain if you have an obstruction in the tube that carries urine out of your bladder), was placed on the mattress of the bed. These failures had the potential of spreading facility acquired infections to vulnerable residents who are already immunocompromised. Findings: 1. During an observation on 10/14/24 at 9 a.m., the oxygen concentrator filter, in room R2, had a layer of greyish dust on it. During an observation and subsequent interview with the ADON on 10/16/24 at 10:14 a.m., when asked about the oxygen concentrator filter in room R2, the ADON stated I will clean it. During an observation on 10/15/24 at 9:42 a.m., the oxygen concentrator filter, in Room R1, had a layer of whitish dust on the filter. During an observation and subsequent interview with the assistant director of nursing (ADON) on 10/16/24 at 10:17 a.m., the ADON looked at the oxygen concentrator filter in room R1 and stated the filter needed to be cleaned. She stated she needs to check the facility's policy to see how often the filters should have been cleaned. During an interview with the administrator (ADM) 10/17/24 at 10:45 a.m., the ADM stated that they had cleaned the filters. During a review of the facility's policy & procedure (P&P) titled, Oxygen Equipment Maintenance - Oxygen Concentrator Filter, revised 10/2010, the P&P indicated General Guidelines | Assigned EVS staff is responsible for the scheduled, weekly cleaning and/or changing of the oxygen concentrators' filters. 27000 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During the medication administration observation with Registered Nurse (RN) J on 10/14/24 04:13 PM, RN J was observed donning on a pair of gloves at the medication cart and entering Resident 47's room to assess the resident's blood pressure (BP). She also wore a surgical mask, but did not wear a protective gown. Four large signs/posters were observed on Resident 47's room door. One of the large white posters read, PLEASE check-in with Charge Nurse before Entering Room. Wash hand BEFORE and AFTER Entering Room. The orange poster read, ENHANCE BARRIER PRECAUTIONS . PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities . Device care or use . feeding tube . Shortly after the BP assessment, on 10/14/24 at 4:17 p.m., RN J returned to the medication cart and started preparing four medications for the resident. On 10/14/24 at 4:32 p.m., RN J returned to the resident's room again without a gown. She changed into the new gloves and proceeded to administer the medications through the resident's gastrostomy tube (G-tube, tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). During the interview on 10/14/24 at 4:45 p.m., after being shown the posters on the resident's room, RN J stated she should have gowned up before entering the resident's room each time. A review of Resident 47's care plan, dated 2/6/24, for Enhanced Barrier/Standard Precautions indicated: [Patient 47] tested positive for CP-C.R.E (Carbapenemase-Producing Carbapenem-Resistant Enterobacterales, a type of bacteria that are resistant to antibiotics and can cause serious infections) - CDPH [California Department of Public Health] recommends the use of ESP [enhanced standard precautions], primarily the use of gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high risk of MDRO [multi-drug resistant organism] colonization and transmission; - Perform hand hygiene and don PPE before beginning activity; - Gloves to protect hands; - Gown to protect body, clothes; - Mask/goggles/shield to protect face, eyes; - Place appropriate sign at room entry - Remove, discard PPE, and perform hand hygiene in room when activity complete. During an interview with the Director of Nursing (DON) and the Assistant DON (ADON) on 10/15/24 at 3:35 p. m., they stated, for residents on EBP, the staff providing care, such as BP measurement and medication administration, need to wear a mask, gown, and gloves before entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Categories of Transmission-Based Precautions - EBP, dated 9/2024, indicated the following under Enhanced Standard Precautions/Enhanced Barrier Precautions: Wear gowns and gloves when performing high-contact tasks . This includes . Device care, for example . feeding tube. 36623 3. During an observation in Resident 73's room on 10/16/2024 at 11:28 a.m., Certified Nursing Assistant (CNA F) placed Resident 73's urinary drainage bag on his bed. The urine from the tube was observed flowing back toward the resident when turning Resident 73. During an interview with Treatment Nurse H (TN H) on 10/16/2024 at 12:11 p.m., TN H confirmed CNA F placed the urinary drainage bag on the bed of Resident 73 while he was doing the wound treatment. TN H stated Resident 73 would be at risk to have infection if the urine from the urinary drainage bag flows back into the bladder. During an interview with CNA F on 10/16/2024 at 12:40 p.m., CNA F confirmed the above observation and stated she put the urinary drainage bag on the bed when performing care with Resident 73. CNA F stated placing the drainage bag on the bed has the potential for infection. During an interview with infection preventionist (IP I) on 10/16/2024 at 4:14 p.m., IP I stated the urinary drainage bag should always be placed below the bladder. IP I stated urine that back flows has the potential to cause infection. During an interview with Director of Nursing (DON) on 10/17/2024 at 4:43 p.m., the DON stated urinary drainage bags should always be placed below the level of bladder to prevent infection. During a review of the facility's policy and procedure titled, Catheter Care, Urinary, date revised September 2014, indicated, The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 32398 Based on observation, interview, and record review, the facility failed to ensure one of 27 initial pool residents (Resident 1) had access to a staff call device (call button), in case of needing help or for an emergency. This failure had the potential of Resident 1 becoming seriously harmed or even lead to death. Findings: During an observation in Room R3 on 10/14/24 at 8:40 a.m., the call button for bed A was observed hanging on the wall above the head of the bed, not within reach of Resident 1. Resident 1 stated she can not reach the call button, and would want to call. During an observation in Room R3 on 10/14/24 at 12:28 p.m., the call button was still hanging on the wall. During an observation in Room R3 on 10/14/24 3:17 p.m., the call button was still on the wall, out of reach of Resident 1. During an observation and subsequent interview with registered B (RN B) on 10/14/24 at 3:19 p.m., RN B took the call button off of the wall and handed it to Resident 1. RN B stated Resident 1 should have had the call button within reach. During a review of the facility's policy & procedure (P&P) titled Assistive Devices and Equipment, revised 01/2020, the P&P indicated, 1. Certain devices and equipment that assist with resident mobility, safety, and independence are provided for residents. These may include (but are not limited to): . d. Call light devices.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42819 Based on observation, interview, and record review, the facility failed to maintain a safe, functional, and sanitary environment for one of 22 sampled residents (Resident 28) due to cracked walls near Resident 28's bathroom door and at the bottom left side of the toilet in the bathroom. This deficient practice had the potential to adversely affect the health and safety of residents in the facility. Findings: During an observation and interview with Resident 28 on 10/14/24 at 3:30 p.m., in Resident 28's room, Resident 28 stated about the cracked walls near her bathroom door and at the bottom, left side of the toilet in the bathroom. Resident 28 also stated that the walls were damaged and needed to be repaired. Resident 28 further stated that the facility was aware of the cracked walls near the bathroom door and the bottom left side of the toilet since last year. During a concurrent interview and record review with the maintenance director (MD) on 10/16/24 at 2:00 p.m. , upon review of the maintenance log with the MD, the maintenance log indicated it was reported to maintenance. The MD confirmed that maintenance staff had started the repairs but missed the areas near the bathroom door and the bottom of the toilet. The MD stated he would inform the maintenance staff to complete the repairs. Resident 28's quarterly minimum data set (MDS, a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 28's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (a score of 0 to 7 indicates severe cognition impairment; 8 to 12 moderate impairment; 13 to 15 patient is cognitively intact). Review of facility's policy, Maintenance Service, revised 12/2009, indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in good repair and free from hazards .