STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34714 Based on observation, interview, medical record and document review, the facility failed to provide services for activities of daily living for 2 (Resident 36 and 73) of 35 sampled residents when: 1. For Resident 73, fingernails were long and had black debris under the fingernails. 2. For Resident 36, feet were dry and toenails long. 3. For Resident 36, nursing staff did not get resident up in his wheelchair for a substantial period of time. These failures resulted in basic needs necessary for a quality of life not being met. Findings: 1. During an observation on 5/20/24, at 9:42 a.m., Resident 73 was sitting in a wheelchair in the hallway. Resident 73 had black debris under his fingernails to both hands. Resident was not interviewable. During an observation and concurrent interview on 5/21/24, at 9:50 a.m., Resident 73 was sitting in a wheelchair in the hallway. Resident 73 had black debris under his fingernails of both hands. The licensed vocational nurse (LVN 1) stated his fingernails were dirty. LVN 1 stated she expected Resident 73's nails fingernails to be cleaned because Resident 73 was alert, used his hands to eat and touched things. LVN 1 stated dirty nails were an infection control issue. During a review of Resident 73's facility Face Sheet, the Face Sheet indicated an admitted [DATE] with diagnoses of dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities) and failure to thrive. During a review of Resident 73's quarterly Minimum Data Set (MDS- assessment tool used to guide care), dated 3/11/24, the MDS indicated a BIMS score of 99 (meaning resident was uninterviewable) with severely impaired cognition. Further review of the MDS, section GG for functional abilities and goals indicated Resident 1 was dependent on staff for maintaining personal hygiene. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facilities policy and procedure (P&P), titled, Fingernail Care, dated 5/22/24, the P&P indicated care of fingernails promotes circulation to the hands and helps prevent small tears around the nails that could lead to infections. Procedure directions included to assist resident position the fingers in a basin of water, soak 5 minutes, clean under the fingernails with an orange stick and dry the hands thoroughly. 2. During a review of Resident 36's facility Face Sheet, the Face Sheet indicated Resident 36 was admitted on [DATE], with diagnoses of dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities) hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side) and diabetes (long-term disease in which the body cannot regulate the amount of sugar in the blood.). The Face Sheet included Resident 36's Responsible Party (RP) was his significant other in making health care decisions. During a review of Resident 36's quarterly MDS, dated [DATE], the MDS indicated Resident 36's Brief Interview for Mental Status (BIMS) score was 99 (meaning resident was uninterviewable) with severely impaired cognition. Further review of the MDS, section GG for functional abilities and goals indicated Resident 1 was dependent on staff for washing, drying self and maintaining personal hygiene. Also, Section F for preferences for customary routine and activities indicated family or significant other be involved in care discussions. During an observation on 5/22/24, at 9:50 a.m., Certified Nursing Assistant (CNA 4) prepared care items at Resident 36's bedside and provided Resident 36 a bed bath. During an observation and interview on 5/22/24, at 10:23 a.m., CNA 4 verified she gave Resident 36 a bed bath earlier this morning. CNA 4 removed Resident 36's socks and Resident 36 had long and thick toenails. Resident 36's skin around and between his toes were dry, cracked and flaky. CNA 4 stated she did not provide foot care. CNA stated she was not allowed to cut Resident 36's toenails and will inform the nurse. Review of the policy and procedure (P&P), titled, Foot Care, dated 5/22/24, the P&P indicated to promote cleanliness and prevent infection, procedures included to immerse foot in soap and water, rinse with washcloth, blot gently to dry thoroughly, especially between toes .A licensed nurse, therapist, or podiatrist must trim toenails of a diabetic resident Apply lotion to moisten dry skin or dust with water-absorbent powder between toes. 3. During an observation on 5/20/24, at 9:59 am., Resident 36 lay in a 30 degree angle in bed on his back. During an observation on 5/21/24, at 9:30 a.m., Resident lay in a 30 degree angle in bed on his left side. During an observation and concurrent interview on 5/22/24, at 10:23 a.m., Resident 36 lay in bed on his right side. CNA 4 stated Resident 36 did not get up out of bed because activities were temporarily ceased as a precaution from a covid (infectious disease) outbreak in the building. CNA 4 stated the outbreak was over two months ago. CNA 4 stated she was not informed Resident 36 could get up and was unaware that activities resumed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24, at 1:56 p.m., with the activities manager (AM) and activities assistant (AA), the AM stated activities were announced everyday in the morning and afternoon for CNAs to get residents up for activities. The AA stated, we go around and get residents and bring them to activities. The AA stated the CNAs were expected to get Resident 36 ready and up in a wheelchair, however, the CNAs don't always get Resident 36 up and ready.The AA stated she knew that Resident 36's RP would like him to get up. During a review of the Progress Notes, dated 2/12/24, Social Services (SS) noted the RP was upset when when Resident 36 missed watching the super bowl when the RP requested Resident 36 get up, including attending activities. Review of the Self Care Deficit care plan, dated 8/16/2018, indicated Resident 36 be out-of-bed to chair twice a day. During a telephone interview on 5/23/24, at 12:10 p.m., the RP stated Resident 36 needed to get up out of bed and sit in a geriatric (large padded chairs with wheeled bases, and are designed to assist seniors with limited mobility) chair that the facility provided. The RP stated it was the year 2020 that she recalled Resident 36 sat up and was out of bed. RP stated she did not expect Resident 36 to get up twice a day, but once in while and it's good for him. RP stated she had informed the facility staff.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46658 Based on observation, interview and record review, the facility failed to provide accurate pain assessment and pain management for one of 60 sampled residents (Resident 18) when Resident 18's left foot pain was not accurately and regularly assessed using an appropriate pain scale (numerical expression of pain severity out of ten, 0, no pain, 1-3 mild pain, 4-7 moderate pain and 8-10 severe pain) and pain medications were not provided in a timely manner. This failure resulted in Resident 18 having 9/10 to 10/10 left foot pain which was not relieved for over one hour and was not accurately assessed during administration of pain medications delaying additional pain interventions. Findings: A review of Resident 18's admission record indicated an admitted ,d+[DATE] for a diagnosis of Crohn's disease (disease affecting the digestive tract), peripheral vascular disease (disorder of the blood vessels causing reduced blood flow) and unspecified atrial fibrillation (a disease of the electrical conduction of the heart). A record review of Resident 18's minimum data set (MDS, a resident assessment tool used to identify resident problems to be addressed in an individualized care plan), dated 4/28/24, indicated Resident 18 had a brief interview for mental status (BIMS, a scoring system used to determine resident's cognitive status in regard to attention, orientation and ability to register and recall information. A BIMS score of 13-15 indicates an intact cognitive status) score of 14. The MDS indicated Resident 18 could understand and was understood by others. A record review of Resident 18's physician's order set, Physician Order Report, dated 5/23/24, was reviewed. The order set indicated Resident 18, from 4/24/24 to 5/21/24, had an order for hydrocodone-acetaminophen (a medication for pain relief) 5-325 mg (milligram, unit of measurement) once a day PRN (as requested by resident) for foot pain and general pain. The order set indicated Resident 18 had acetaminophen (a medication for pain relief) 500mg tablet every six hours PRN for pain. The order set indicated on 5/21/24, Resident 18 had an order for hydrocodone-acetaminophen 5-325 mg one tablet scheduled for twice a day for foot pain and general pain. The order set indicated Resident 18 had orders for daily treatment and pain evaluation of left ankle pressure ulcer (localized damage to skin and underlying soft tissue over a boney prominence), left heel deep tissue injury (Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes). During an observation on 5/21/24, at 9:18 a.m., Resident 18 was heard moaning in his bed and appeared to be in pain. At 9:22 a.m., Resident 18 had the call light on. At 9:23 a.m., Certified Nursing Assistant 5 (CNA 5) came into the room and Resident 18 asked for pain medication. CNA 5 then left the room. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/21/24, at 9:25 a.m., with Resident 18, Resident 18 was in his room in bed with the covers on. Resident 18 stated pressure ulcers on his left foot caused constant 9/10 throbbing pain which frequently increased to 10/10. Resident 18 stated the 10/10 pain caused him to moan and groan. Resident 18 stated the facility provided norco once a day and Tylenol every six hours for the last month for pain management. Resident 18 stated the pain management did not take away the throbbing pain, and the pain was unbearable. During the interview, Resident 18 occasionally paused and groaned. Resident 18 stated his pain had always been a 9-10/10 since the end of April 2024. Resident 18 stated the staff never assessed or reassessed after giving him pain medication and never assessed the severity of the pain. Resident 18 stated repeated requests for better pain relief did not result in changes to the pain management regimen. During an observation and interview on 5/21/24, at 9:32 a.m., with CNA 5 and Resident 18, CNA 5 entered the room and stated she had informed Resident 18's nurse about the request for pain medication. CNA 5 did not ask Resident 18's pain level. Resident 18 was in bed. Resident 18 allowed CNA 5 to remove the sock over Resident 18's left foot as long as she did it gently because the left foot was painful when manipulated roughly. Dressings for pressure ulcers at the heel, ankle, and a gangrenous left big toe was observed. Resident 18 pointed at the left foot and indicated the throbbing pain originated at the left foot. Resident 18 stated blood flow to the extremity was diminished and the foot might need to be amputated. A record review of Resident 18's medication administration record (MAR) titled, Medications Administration History, dated 4/22/24-5/22/24, was reviewed. The MAR indicated Resident 18 received hydrocodone-acetaminophen on 5/21/24, at 7:53 a.m. for gen pain (general pain) and did not include the severity of the pain. A reassessment was not recorded in the MAR. During a continuous observation on 5/21/24, from 9:28 a.m. to 10:31 a.m., Resident 18 remained in bed moaning from pain frequently. At 10:26 a.m., Licensed Vocational Nurse 3 (LVN 3) came into the room to administer Resident 18's acetaminophen 500 mg. LVN 3 was heard informing Resident 18 had acetaminophen 500 mg available, but did not assess the pain level or offer non-pharmacological pain relief. Resident 18 took the medication and LVN 3 left the room. During an interview on 5/21/24, at 10:32 a.m., with Resident 18, Resident 18 stated LVN 3 did not assess the pain level and did not offer to contact the physician about the current pain level. Resident 18 stated the left foot pain was 9/10, throbbing and the acetaminophen would not be effective pain relief. During an interview on 5/21/24, at 11:20 a.m., with LVN 3, LVN 3 stated Resident 18 had hydrocodone-acetaminophen 5-325 mg once a day and could have acetaminophen every six hours. LVN 3 stated Resident 18 had received hydrocodone-acetaminophen 5-325 mg earlier in the day and only had acetaminophen 500 mg available for pain relief. LVN 3 stated when she gave Resident 18 the acetaminophen earlier, Resident 18 had generalized pain which was rated at 4/10. LVN 3 stated Resident 18 did not have left foot pain. LVN 3 stated 4/10 pain was considered mild pain and acetaminophen was adequate for Resident 18's level of pain. LVN 3 stated CNA 4 had informed her of the 4/10 pain about 30 minutes prior to administering the medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/21/24, at 11:30 a.m., with LVN 3 and Resident 18, Resident 18 was in his room in bed occasionally moaning in pain. LVN 3 went to reassess Resident 18's level of pain. Resident 18 stated a pain level of 9/10 at left foot. Resident 18 stated requests for better pain management had been ongoing for a month and if nothing changed, Resident 18 would leave the facility. LVN 3 stated she would inform the attending provider to re-evaluate Resident 18's pain management. During an interview on 5/21/24, at 11:35 a.m., with CNA 4, CNA 4 stated she had informed LVN 3 about Resident 18's request for pain medication, but did not inform LVN 3 about the severity of Resident 18's pain. CNA 4 stated she probably should have inquired with Resident 18 about the pain severity but did not. A record review of Resident 18's MAR titled, Medication Administration History, dated 4/22/24-5/22/24, was reviewed. The MAR indicated Resident 18 received acetaminophen 500 mg on 5/21/24, at 7:53 a.m. for gen pain. The entry did not indicate the severity of the pain. A record review of Resident 18's MAR titled, Medication Administration History, dated 4/22/24-5/22/24, was reviewed. The MAR indicated on 5/21/24, Resident 18 started to receive hydrocodone-acetaminophen 5-325 mg. The MAR indicated LVN 3 administered a dose of hydrocodone-acetaminophen 5-325 mg on 5/21/24 at 5:00 p.m. The entry did not indicate LVN 3 had assessed or reassessed Resident 18's pain before or after administration of the medication. A record review of Resident 18's MAR, dated 4/22/24 to 5/22/24, indicated LVN 3 had administered acetaminophen 500 mg on 5/21/24 at 10:31 a.m. and had documented PRN Reason: Pain Comment: c/o gen pain. The documentation did not indicate Resident 18's foot pain or its severity. During an observation and interview on 5/22/24, at 1:59 p.m., Resident 18 was in bed with the covers on. Resident 18 stated a pain level of 8/10 on the left foot. Resident 18 used his call light to ask for more pain medication. A record review of Resident 18's MAR titled, Medication Administration History, dated 4/22/24-5/22/24, was reviewed. The MAR indicated Resident 18 received hydrocodone-acetaminophen 5-325 mg on 5/21/24, at 9:00 a.m. The entry did not indicate the LVN 4 had assessed Resident 18's pain. The MAR indicated Resident 18 received acetaminophen 500 mg at 2:01 p.m. but a pain assessment identifying the location and severity of the pain was not recorded. During a concurrent interview and record review on 5/22/24, at 4:00 p.m., with Licensed Vocational Nurse 4 (LVN 4), Resident 18's pain assessments were reviewed. LVN 4 stated she had assessed a 6/10 pain when she gave Resident 18 the scheduled acetaminophen-hydrocodone medication in the morning. LVN 4 stated she did not document the assessment and was unable to show how to document the assessment retrospectively. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/23/24, at 1:15 p.m., with the Assistant Director of Nursing (ADON), Resident 18's medical records titled Pain Evaluations, dated 5/22/24 and 4/22/24, MAR and progress notes were reviewed. The Pain Evaluation form was used to document the location, severity, duration, time of pain onset, non-verbal indications of pain and effectiveness of pain interventions. The ADON stated after review of Resident 18's medical record, Pain Evaluations for Resident 18 was only found for the two dates. The ADON stated staff were expected to document Resident 18's pain assessments at least daily on this form, in progress notes, or in the MAR when they gave the medication. After review of Resident 18's medication administration record for pain medications, the ADON stated nursing staff did not accurately document Resident 18's pain level using a pain scale in the MAR. The ADON stated the nursing staff can put in an accurate pain assessment in the MAR but did not. The ADON stated Resident 18's progress notes did not indicate nursing staff had documented pain assessments in the progress notes. During a review of facility policy and procedure (P&P) titled, Pain Management, undated, the P&P indicated staff regularly assess resident pain by using a pain rating scale: 0-No pain, 2-mild pain, 4 to 6-Moderate Pain, 8 to 10 severe, which will also assist in determining the appropriate type of pain therapeutic regimen interventions. The P&P indicated staff record the finding on the pain management flow sheet .observe .for signs and symptoms of pain . review the resident's response to treatment for pain daily. Adjust the care plan as needed to manage pain. During a review of the Merck Manual article titled, Evaluation of Pain, dated 3/2022, the article indicated clinicians should evaluate the cause, severity and nature of the pain .should include timing .quality .severity, location .exacerbating and relieving factors. The article indicated pain severity be assessed with formal measures to include verbal category scales (eg. mild, moderate, severe), Numeric scales, The Visual Analog Scale. For a numeric scale patients are asked to rate their pain from 0 to 10 (0=no pain; 10= the worst pain ever).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49648 Based on observation, interview and record review, the facility failed to ensure expired medications and COVID (a virus like the cold or flu) test kits were discarded when they were kept with ready to use medications in medication storage areas. This failure had the potential to result in residents receiving abnormal COVID test results, less potent or less effective doses of the medication which can lead to new health problems or adverse reactions. Findings: During an observation and interview on 05/21/24 at 2:18 p.m., with Registered Nurse (RN) Supervisor, in Nursing Station One refrigerator, an Emergency kit (E-kit- a small quantity of medications that can be used when pharmacy services are not available) was observed with two red tag clips. Expiration (EXP) date on this E-kit was observed to be 04/24. Opened this, E-kit had and it was observed to have the following expired meds in it: -Levemir 100 unit (u)/milliliter (ml) (medication used for high blood sugar) (EXP: 06/23) -Novolog 100 u/ml (medication used for high blood sugar) (EXP:02/23) -Novolin R 100 u/ml (fast acting medication to lower blood sugar) (medication used for high blood sugar) (EXP:03/24) -Novolin N 100 u/ml (slow acting medication to lower blood sugar) (medication used for high blood sugar) (EXP: 02/23) During an interview on 05/21/24 at 2:18 p.m. with Registered Nurse (RN) Supervisor at Nursing Station One, RN Supervisor stated that they saw that the E-kit found in Nursing Station One refrigerator had expiration date of 04/24. RN Supervisor stated that the Levemir had expiration date of 06/23, Novolog had expiration date of 02/23, Novolin R had an expiration date of 03/24 and Novolin N had an expiration date of 02/23). RN Supervisor stated that they did not know when this E-kit was opened or if the pharmacy was contacted contacted called to exchange it. RN Supervisor stated that anything that expired medications and E-kits medications should not be stored in the E-kit there stored in the medication storage room. During an interview on 05/21/24 at 2:24 p.m. with Assistant Director of Nursing (ADON), at Nursing Station Three's Medication Room, ADON stated that they are aware that there are expired E-kits in the facility. ADON stated those that were identified had a white paper taped on them that stated, DO NOT USE; NEW E-KITS ORDERED: 05/20/2024 and contacted the pharmacy to switch them out. ADON stated that they were supposed to come and switch them out today, but they will follow up with pharmacy. ADON stated that was not aware of the one in Nursing Station One's refrigerator. ADON stated this is a large facility with a lot of Residents and if there is need for emergency drugs there is a Pyxis (automated medication machine) that they can access. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 05/21/24 at 2:45 p.m. with RN Supervisor, Super Nursing Station Three's Medication Room, there was an expired medium green E-kit bin (04/24) that contained 42 intravenous (IV) antibiotics (medications given in the vein to treat bad infections), 12 IV fluids (used to hydrate through veins) and four heparin syringes (blood thinner). During a concurrent observation and interview on 05/21/24 at 3:01 p.m. with RN Supervisor, at Nursing Station Three's Medication Room, nine expired unbranded COVID tests kids were noted. RN Supervisor stated that they still used the tests despite expiration date. RN Supervisor stated that is still results and seems ok. RN Supervisor stated she was unsure as to if they were still effective past expiration date. During a review of the facility's policy and procedure (P&P) titled, Storage of Medication, dated 2007, indicated, Procedures: 14) Outdated, contaminated, discontinued or deteriorated medications .are immediately removed from stock.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36087 Based on interview and record review, for one of two sampled residents (Resident 178), the facility failed to respond to a pharmacist's Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident) recommendations when facility did not act upon pharmacy recommendations for Resident 178's psychoactive medications behavior and side effects monitoring and Lisinopril pulse monitoring. These failures had the potential for missed opportunities to prevent, identify, report, and resolve medication-related problems, medication errors, and/or other irregularities for Residents 178. Findings: A review of Resident 178's Resident Face Sheet indicated Resident 178 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a progressive disease that affects memory, thinking, and behavior) and dementia (memory loss). A review of Resident 178's Minimum Data Set (MDS, a resident assessment tool used to provide care), dated 2/24/24, indicated resident was usually able to make self-understood and was usually able to understand others. The MDS indicated Resident 178 had a severely impaired cognition. Further review of the MDS also indicated resident received antipsychotics (drugs used to treat psychotic disorders) and antidepressants (drugs used to treat clinical depression). A review of Resident 178's Prescription Orders, indicated: 1. Seroquel (quetiapine, a drug used to treat major depressive disorder), received date and start date 4/12/24, give 25 milligram (mg) half a tablet (12.5 mg) twice a day for dementia with agitation, manifested by (m/b) restlessness and striking out. 2. Escitalopram oxalate (a drug used to treat depression and generalized anxiety disorder), received date and start date 4/4/24, give 5 mg 1 tablet once a day for major neurocognitive disorder, moderate to anxiety m/b sad facial expression. 3. Lamotrigine (drug used to treat seizures and bipolar disorder), received date 5/16/24 and start date 5/17/24, give 25 mg 2 tablets twice a day. 4. Lisinopril (drug used to treat hypertension [HTN]) received date and start date 4/4/24, give 20 mg 1 tablet once a day for HTN, hold for systolic blood pressure more than (>) 100, or heart rate (pulse) less than (<) 60. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's clinical record titled, Consultant Pharmacist's Medication Regimen Review, for recommendations created between 4/1/2024 and 4/27/2024, indicated for Resident 178, Please be sure we have behavior and side effect monitoring for all three (3) orders being used as psychoactive orders (lamotrigine, quetiapine, and escitalopram), and The lisinopril has a holding parameter for pulse. This drug does not slow the pulse. Please ask if this holding parameter can be discontinued (dc'd). A review of Resident 178's electronic Medication Administration Record (eMAR), dated 5/1/24 - 5/22/24, did not indicate licensed nurses monitored and documented resident's behavior and side effects regarding psychoactive orders received as ordered. Further review of the eMAR also indicated Resident 178's Lisinopril continued to show a holding parameter each time the medication was received. During a concurrent interview and record review on 5/23/24, at 9:10 a.m., with the Assistant Director of Nursing (ADON), Resident 178's eMAR was reviewed. ADON stated there were no behavior or side effects monitored for the psychoactive orders (lamotrigine, quetiapine, and escitalopram) received by the resident. ADON stated monitoring and documenting the behavior and adverse effects were significant in finding out whether the medications taken were effective or not. During a follow up interview on 5/23/24, at 10:37 a.m., with the ADON, ADON stated Resident 178 was being monitored for pulse when taking Lisinopril. ADON stated pulse monitoring will be discontinued for Lisinopril as recommended by the pharmacist. A review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Assessment & Monitoring, undated, indicated, .Monitoring for drug side effects leads to early identification and reporting . The behavior of residents receiving antipsychotic medication will be monitored by the licensed nurse every shift using the behavior monitoring record. The side effects (and black box warning for psychotropic medications with such classifications) will be monitored by the licensed nurse every shift using the side effect monitoring record. If side effects are identified, the licensed nurse will notify the attending physician accordingly for further orders/recommendations .Record behavior, interventions, and the effectiveness of interventions taken in the behavior monitoring record . A review of the facility's P&P titled, Medication Regimen Review and Reporting, dated 2007, indicated, . Resident specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician .

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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. 49648 Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate below five percent (5%). During the medication pass on 05/21/24, three medication errors were observed out of thirty-five opportunities for two out of three residents, resulting in an error rate of 8.57%. This failure had the potential to result in more than minimal changes in the health and safety of Residents 78 and 155's conditions. Findings: During a review of the facility's policy and procedure (P&P) titled Medication Pass Guidelines [undated], it was indicated that Physician's Orders - Medications are administered in accordance with written orders of the attending physician. During a review of the facility's policy and procedure (P&P) titled Nursing Care Center Pharmacy Policy & Procedure Manual-Medication Administration, dated 2007, it was indicated Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR) . Medications are administered in accordance with the written orders of the prescriber. During an observation on 5/21/24, at 8:12 a.m., in Resident 78's room, Licensed Vocational Nurse (LVN) 1 was observed using a clean syringe to flush Resident 78's gastrointestinal tube (GT). This tube, which is inserted through a surgically created hole in the abdomen to deliver food, medications, and fluids directly into the stomach, was flushed with 30 milliliters (ml) of tap water prior to the administration of medication via the GT. During an observation on 5/21/24, at 8:29 a.m., in Resident 78's room, LVN 1 was observed using the same syringe to flush Resident 78's GT with 30 milliliters (ml) of tap water after administering medication via the GT. During a concurrent interview and record review on 5/21/24, at 11:35 a.m. with LVN 1, Resident 78's Physician Orders dated February 18, 2024, were reviewed. The Physician Orders indicated that the GT should be flushed with 50 milliliters (ml) of water prior to and after medication administration. LVN 1 stated that they were not aware of this order and were accustomed to flushing the GT with 30 ml both before and after administering medication. LVN 1 mentioned that she is from a nurse registry, an agency that offers healthcare-related contracts to facilities, and this practice has always been their standard procedure. She added that she will be more aware of the provider's orders in the future. During a concurrent interview and record review on 5/21/24, at 11:37 a.m. with LVN 1, Resident 78's Physician Orders dated 5/20/24, were reviewed. The Physician Orders indicated that Famotidine should be given at bedtime (9:00 p.m.). LVN 1 stated that they only saw the 9:00 and did not notice the p.m. or bedtime specification. LVN 1 stated that they will contact the provider to inform them that they administered the Famotidine to Resident 78 in the morning instead of at night. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/21/24, at 8:15 a.m., in Resident 78's room, LVN 1 was observed using a syringe to administer Famotidine, a medication used to prevent and treat heartburn due to stomach acid, via the GT. During a review of the facility's policy and procedure (P&P) titled Nursing Care Center Pharmacy Policy & Procedure Manual-Oral Inhalations, dated 2007, it was indicated under Procedures For steroid inhalers, provide the resident with a cup of water and instruct him/her to rinse the mouth and spit water back into the cup. Additionally, during a review of the website https://www.breyna.com/ dated 2023, it provided important safety information regarding Breyna, indicating Important Safety Information: Breyna may cause serious side effects, including .Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using BREYNA to help reduce your chance of getting thrush. During an observation on 5/21/24, at 9:25 p.m. in Resident 155's room, Registered Nurse (RN) 1 was observed administering Breyna, an inhaler used to control and prevent symptoms of asthma and other ongoing lung conditions, to Resident 155. RN 1 instructed Resident 155 to take a deep breath in and let it out, then put the inhaler into your mouth, when you breathe in press your inhaler. RN 1 further advised Resident 155 to hold it for as long as they could to ensure the medication reached their lungs. Resident 155, expressing familiarity with inhaler use, stated they knew what they were doing. RN 1 then instructed Resident 155 to rinse their mouth after using the inhaler. Resident 155 questioned this instruction, stating they had not done so before. RN 1 explained that rinsing was necessary because the medicine tasted bad. When Resident 155 asked again for the reason behind rinsing after inhaler use, RN 1 reiterated that it was necessary and emphasized that it was because the medicine tasted bad. During a concurrent interview and review on 5/21/24, at 11:28 a.m. with RN 1, Resident 155's Physician Orders dated January 18, 2024, were reviewed. The Physician Orders indicated 2 puffs twice a day and to rinse mouth after each use. RN 1 admitted to not knowing the reason for rinsing the mouth after inhalation and was unable to provide the manufacturer's instructions for Breyna.

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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. 46658 Based on observation, interview and record review, the facility failed to ensure safe, sanitary storage of food when: 1. A thawed pork loin tied closed with a disposable glove was found on a dirty plastic platform and was not labeled with a thaw or use by date, 2. The same thawed pork loin was later found in the freezer and red liquid was leaking from the package. This failure had the potential to place all residents getting meals from the kitchen to be at risk for foodborne illness potentially leading to hospitalization or death. Findings: 1. During an observation on 5/20/24, at 9:30 a.m., the kitchen walk-in refrigerator was inspected. A pork loin was resting on a plastic platform. The pork loin had a disposable glove tied to one end of the package to close the package. The plastic platform had accumulated debris on the surfaces which the pork loin was resting. The pork loin did not have a label indicating the thaw or use by date. During a concurrent observation and interview on 5/20/24, at 9:40 a.m., with Certified Dietary Manager (CDM), in the walk-in refrigerator the CDM stated the pork loin was previously frozen and thawing in the walk in refrigerator. The CDM stated the pork loin did not have a label with the thaw or use by date and did not know when the pork loin was pulled out to thaw. During a record review of facility policy and procedure (P&P) titled, Sanitation and Infection Control subject Refrigerated Storage, dated 2023, the P&P indicated, all meat and perishable food .placed in the refrigerator for thawing must be labeled and re-dated with the date the item was transferred to the refrigerator, with pull by date and used by date. During a review of Food and Drug Administration (FDA) code book titled, FDA Food Code 2022, dated 2022, indicated, food packages shall be in good condition and protect the integrity of the contents so that food is not exposed to adulteration or potential contaminants The code book indicated gloves are used for only one task .used for no other purpose, and discarded when damaged or soiled. The code book indicated temperature controlled food such as meats shall be clearly marked to indicate the date or day by which the food shall be consumed .or discarded when held at a temperature of 41F or less for a maximum of 7 days . food shall be discarded if it .is in a container or package that does not bear a date or day. 2. During an observation on 5/20/24, at 11:15 a.m., the kitchen walk-in freezer was inspected. The pork loin previously in the walk-in refrigerator was found in the walk-in freezer. Palpating the pork loin indicated it was partially refrozen. The same disposable glove was tied to the end of the pork loin and red liquid had leaked out from the packaging. The pork loin had a label affixed to the packaging indicating a prep date of 5/17/24 and use by date of 8/17/24. (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 5/20/24, at 11:18 a.m., with kitchen manager, the kitchen manager saw the pork loin in the walk-in freezer and stated it was inappropriate to refreeze the pork loin. The kitchen manager removed the pork loin and disposed of it in the garbage. During a record review of facility P&P titled, Sanitation and Infection Control Subject Freezer Storage, dated 2023, the P&P indicated, frozen food that has been thawed in the refrigerator should be used within 72 hours .thawed foods may not be refrozen. During a review of Food and Drug Administration (FDA) code book titled, FDA Food Code 2022, dated 2022, the code book indicated, drippage during the freezing process, partial thawing or incomplete seals on the package increase the risk of cross-contamination. The code book indicated, improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/or produce toxins, if the food is then refrozen, significant numbers of bacteria and/or all preformed toxins are preserved.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49648 Based on observations and interviews, the facility had three Resident rooms (Rooms 35, 41 and 43) with multiple beds that provided less that 80 square feet (sq. ft) per resident who occupied these rooms. This deficient practice had the potential to result in inadequate space for the delivery of care to each residents in each of these rooms and/or for storage of the resident's belongings. Findings: During an observation 05/22/24 at 3:15 p.m., following rooms and corresponding sq. ft per bed were identified: Room Activity Room Size 35 Resident room [ROOM NUMBER].6 sq. ft 41 Resident room [ROOM NUMBER].6 sq. ft 43 Resident room [ROOM NUMBER].6 sq. ft Room Activity Floor Area 35 Bed A Resident room [ROOM NUMBER].2 sq. ft 35 Bed B Resident room [ROOM NUMBER].2 sq. ft 35 Bed C Resident room [ROOM NUMBER].2 sq. ft 41 Bed A Resident room [ROOM NUMBER].2 sq. ft 41 Bed B Resident room [ROOM NUMBER].2 sq. ft 41 Bed C Resident room [ROOM NUMBER].2 sq. ft 43 Bed A Resident room [ROOM NUMBER].2 sq. ft 43 Bed B Resident room [ROOM NUMBER].2 sq. ft 43 Bed C Resident room [ROOM NUMBER].2 sq. ft During an interview on 05/22/24, at 3:18 p.m., with Resident 134, Resident 134 stated it felt a little cramped but manageable and did not really bother her. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 05/22/24, at 3:23 p.m., with Environmental Manager (EM), EM stated though there was one closet for Residents in rooms 35, 41 and 43, the facility had tried to create more space where residents could place their belongings. During an interview on 05/22/24, at 3:28 p.m., with Certified Nursing Assistant (CNA) 7, CNA 7 stated he was from a registry company (staff personnel provided by a placement service on a temporary or on a day-to-day basis, in a facility), but had worked here before. CNA 7 stated he had worked and is currently working with the residents in rooms [ROOM NUMBERS]. CNA 7 stated the room size was adequate to provide care and for the resident's belongings. CNA 7 stated he had not had issues with resident transfers (moving a Resident from one place to another). During an interview on 05/22/24, at 3:32 p.m., with CNA 8, CNA 8 stated in some of the rooms there used to be a lot of specialty beds but since there are none now, there were no issues since all the beds were the same size. During an observation on 05/22/24, at 3:35 p.m., of Resident rooms 35, 41 and 43, no heavy medical equipment was observed that might interfere with each Resident's care. During an observation on 05/23/24, at 10:40 a.m., of Resident rooms 35, 41 and 43 no heavy medical equipment was observed that might interfere with each Resident's care. There were no complaints from any residents in Rooms 35, 41 and 43 regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in these rooms. Granting of room size waiver is recommended.