STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056437	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Ridge Care Center	1501 Skyline Drive Monterey, CA 93940

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview, and record review, the facility failed to implement their policy on self-administration of medication (resident takes medication without staff assistance) for one of 25 sampled residents (Resident 27) when the facility did not determine that the resident was clinically appropriate and safe to self-administer medications; did not obtain a physician's order to self-administer medications; and did not develop a care plan to address self-administration of medications. These failures had the potential for unsafe and improper administration of medications. Findings: Review of Resident 27's medical record indicated he was admitted on [DATE] with diagnoses including diabetes mellitus (abnormally high blood glucose [sugar] levels), peripheral vascular disease (narrow blood vessels reduce blood flow to the limbs), obesity, hypothyroidism (thyroid gland does not produce enough thyroid hormone), hyperlipidemia (abnormally high levels of fats [lipids] in the blood). Resident 27's Minimum Data Set (MDS, an assessment tool), dated 4/18/25, indicated he had a brief interview for mental status (BIMS) score of 9 (a score of 8 to 12 indicates moderate impairment). During an observation in Resident 27's room on 5/12/25 at 8:23 a.m., there were five medication bottles on Resident 27 ' s bedside dresser. Two of the bottles outer labels indicated Simethicone Tablets 80 mg (mg - a unit of measure). One bottle was labeled PB8 Probiotic, another bottle was labeled Maximum Strength Ultra-Zyme, and a third bottle was labeled Say Yes to Beans. During a concurrent interview with Resident 27, he stated Yes I have stomach issues and these help me. During an observation and concurrent interview with the director of nursing (DON) on 5/12/25 at 3:08 p.m., the DON went to Resident 27 ' s room and confirmed he had the above-mentioned medications at his bedside. The DON stated a physician ' s order, and a medication self-administration assessment should be done prior to resident ' s self-administration of medications. The DON further stated a care plan should be developed indicating Resident 27 is safe to self- administer medications. The DON reviewed Resident 27's medical record and confirmed there was no assessment to self-administer medications, and no care plan developed. The DON further confirmed there was no physician's order for Resident 27 to self-administer medications or to keep medications at the bedside. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility 's policy titled Administering Medications, revised April 2019, indicated Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to ensure that the residents would know and be reminded of the results of the previous state recertification surveys when 4 out of 4 residents who attended the resident council meeting, (Residents 18, 51, 65 and 244), did not know about the results of the previous state recertification surveys or where the survey results binder was located. These failures jeopardized the right of the residents to know and examine the results of the previous state recertification surveys and the plan of corrections that the facility did for those failures. Findings: During the resident council meeting (gathering where residents of a facility come together to discuss issues) on 5/13/25 at 11:00 a.m., 4 residents, (Residents 18, 51, 65 and 244), attended the meeting. During a concurrent observation and interview with Resident 18 during the resident council meeting on 5/13/25 at 11:30 a.m., Resident 18 was in his elctric wheelchair, alert, oriented and verbally responsive. He verbalized that he was not aware about the results of the previous state recertification surveys or where the survey results binder was located. Review of Resident 18's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 18 was readmitted to the facility on [DATE] with the primary diagnosis of incomplete paraplegia (a form of paralysis that affects the lower body, specifically the legs and trunk, but not the upper body or arms). During a concurrent observation and interview of Resident 51 on 5/13/25 at 11:30 a.m., Resident 51 was in her wheelchair in the activity room, alert, oriented, verbally responsive and participating in the resident council meeting. Resident 51 stated that she was not aware about the results of the previous state recertification surveys or where the survey results binder was located. Review of the admission record of Resident 51 indicated, Resident 51 was readmitted to the facility on [DATE] with the primary diagnosis of other idiopathic peripheral autonomic neuropathy (peripheral nerve damage where the cause is unknown or cannot be determined). During a concurrent observation and interview of Resident 65 on 5/13/25 at 11:30 a.m., Resident 65 was alert, oriented, calm, comfortable and verbally responsive and participating actively in the resident council meeting. Resident 65 also stated that he was not aware about the results of the previous state recertification surveys or where the survey results binder was located. Review of the admission record of Resident 65 indicated, Resident 65 was readmitted to the facility on [DATE] with the primary diagnosis of unspecified cord compression (a condition where the spinal cord is squeezed by external pressure). (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview of Resident 244 on 5/13/25 at 11:30 a.m., Resident 244 was alert, oriented, comfortable and verbally responsive and participating actively in the resident council meeting. Resident 244 stated that he was not aware about the results of the previous state recertification surveys or where the survey results binder was located. Review of the admission record of Resident 244 indicated, Resident 244 was readmitted to the facility on [DATE] with the primary diagnosis of other idiopathic peripheral autonomic neuropathy. During an interview with the director of activities (DOA) on 5/16/25 at 1:38 p.m., the DOA acknowledged that she did not know about the results of the previous state recertification surveys or where the survey binder for the results of the previous surveys was located. The DOA then stated that she would go and ask, where it could be located. During an interview with the administrator (ADM) on 5/16/25 at 1:41 p.m., the ADM verified that the DOA should know where the survey binder for the results of the previous surveys was located so she could inform and remind the residents about that. The ADM then stated that he would in-service the DOA about it. During an interview with the director of nursing (DON) on 5/16/25 at 1:47 p.m., the DON also verified that the DOA should know where the survey binder for the results of the previous surveys was located and would check on it. Review of the facility's policy and procedure titled, Survey Results, revised on April 2017 indicated, Survey reports and plans of correction are readily accessible to the resident, family members, resident representatives and to the public. Residents may examine the results of the most recent survey of the facility conducted by Federal or State surveyors, as well as any plans of correction in effect. A copy of the most recent survey report and any plans of correction are kept in a binder and placed in easily accessible location .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46553 Based on interview and record review, the facility failed to provide an advance directive (AD, a written instruction, such as a living will or durable power of attorney for health care when the individual is incapacitated) or Physician Orders for Life-Sustaining Treatment (POLST, document that specifies the medical treatments the resident wants to receive during serious illness) was completed for one of two sampled residents (Residents 75). These failures could lead to the delivery of unnecessary or inappropriate medical services, which are against the residents' goals and wishes. Findings: Review of Resident 75's clinical record indicated Resident was admitted on [DATE]. Further review of Resident 75's clinical record indicated there was no POLST form completed for Resident 75. During an interview and concurrent record review with the director of nursing (DON) on 5/15/25 at 1:10 p.m., the DON confirmed there was no copy of POLST form in Resident 75's clinical records. The DON stated it should be there, maybe it was misplaced. Review of the facility's policy titled Advanced Directives, revised 12/2016, indicated Advance Directives will be respected in accordance with state law and facility policy. 7. Information about whether or not the resident has executed an advanced directive an advance directive shall be displayed prominently in the medical record. A review of the title Physician Order for Life Sustaining Treatment (POLST) dated 4/1/2017, indicated, Directions for Health Care Provider, completing POLST. Use of original form is strongly encouraged . A copy should be retained in patient's medical record .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on interview and record review, the facility failed to accurately complete the discharge Minimum Data Set (MDS, an assessment tool) for one of three residents (Resident 92). Failure to accurately assess Resident 92's discharge status resulted in an inaccurate record. Findings: Review of Resident 92's discharge summary report indicated he was discharged home with home health services on 2/20/25. Review of Resident 92's discharge MDS, dated [DATE], indicated he was discharged to the acute hospital. During an interview and concurrent record review with the Minimum Data Set Coordinator (MDSC) on 5/14/25 at 10:18 a.m., the MDSC confirmed Resident 92 was discharged to his home on 2/20/25. The MDSC verified that Resident 92's discharge MDS was incorrectly coded and stated that Resident 92 was discharged home, not to the acute hospital as was coded on Resident 92's 2/20/25 discharge MDS. Review of the Centers for Medicare and Medicaid Services (CMS) 10/2019 Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions) indicated for section A2100, Discharge Status, Code 01, community, if discharge location is a private home.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, resident-centered care plan for one out of five residents investigated for their activities, (Resident 51), when Resident 51 did not have a care plan for her activities. This failure had the potential for the resident to not receive the appropriate interventions necessary to maintain her highest level of well-being. Findings: During a concurrent observation and interview of Resident 51 during the resident council meeting (gathering where residents of a facility come together to discuss issues) on 5/13/25 at 11:00 a.m., Resident 51 was in her wheelchair in the activity room, alert, oriented, verbally responsive and participating actively in the resident council meeting discussion. Resident 51 stated that she's the current resident council president and she attends the meetings regularly. Review of the admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) of Resident 51 indicated, Resident 51 was readmitted to the facility on [DATE] with the primary diagnosis of other idiopathic peripheral autonomic neuropathy (peripheral nerve damage where the cause is unknown or cannot be determined). Review of the order summary report of Resident 51 dated 5/14/25 indicated, Resident 51 may participate in activities, not in conflict with treatment plan, ordered on 7/16/24. Review of Resident 51's care plans indicated, Resident 51 did not have an activity care plan. Resident 51 did not have the necessary interventions for her activities and did not have any updates whether her current activities were effective. During a concurrent review of Resident 51's care plan's and interview with the director of activities (DOA) on 5/15/25 at 10:29 a.m., the DOA verified that Resident 51 did not have an activity care plan. The DOA further verified that she would update the care plan of Resident 51, to include her activity care plan and the interventions for her activities. During an interview with the director of nursing (DON) on 5/15/25 at 1:47 p.m., the DON verified that Resident 51 should have an activity care plan and would follow up on it. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised on December 2016 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan will: include measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice for two of 25 sampled residents (Residents 59 and 301) when: 1. The facility failed to follow the physician's order for Resident 59 by not applying the prescribed wound care dressing and offloading boots while the resident was in bed. 2. For Resident 301, the licensed nurse incorrectly transcribed the physician's order for Chlorhexidine Gluconate mouth rinse. These failures had the potential to compromise the residents' health and well-being. Findings: 1. A review of Resident 59's clinical record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses including generalized muscle weakness, presence of a left artificial knee joint, and bilateral primary osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down) of the knee. A review of Resident 59's physician's order dated 3/26/2025 indicated that the left heel cover was with foam dressing every day shift every Tuesday, Thursday, and Saturday. A further review of 59's physician order dated 3/22/2025 indicated that blue booties should be on at all times while in bed every shift to prevent further skin breakdown. During a concurrent observation and interview with the Licensed Vocational Nurse (LVN) A on 5/14/2025 at 10:59 a.m., Resident 59 was lying in bed, the foam dressing was not on his left heel, and the booties were not applied on both feet. LVN A confirmed the above observation. During a concurrent observation and interview with the Treatment Nurse (TN) on 5/14/2025 at 11:15 a.m., Resident 59 was observed lying in bed with dark purple discoloration on his left heel. The TN stated that the area was consistent with a deep tissue injury. The TN also confirmed that the foam dressing and booties, which were intended to prevent further skin breakdown, had not been applied. 2. A review of Resident 301's clinical record indicated Resident 301 was admitted to the facility on [DATE] with diagnoses including diabetes (a disease that causes high blood sugar), infection and inflammatory reaction due to other cardiac and vascular devices, and methicillin-susceptible staphylococcus aureus infection (MSSA, a type of bacterial infection caused by Staphylococcus aureus bacteria that are susceptible to treatment with methicillin and other beta-lactam antibiotics) as the cause of diseases classified elsewhere. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's acute hospital discharge summary dated 5/7/2025 indicated Resident 301 had a recent dental extraction. The discharge medication, including Chlorhexidine Gluconate (Peridex, Chlorhexidine Gluconate 0.12% Oral Rinse, provides antimicrobial activity during oral rinsing.) 15 ml (milliliters, a measuring unit) as directed twice daily. A review of Resident 1's physician's order dated 5/8/2025 indicated Chlorhexidine Gluconate Liquid 4%: give 15ml by mouth two times a day for post dental extraction mouth rinse. During a concurrent record review and interview with the Director of Nursing (DON) on 05/12/2025 at 3:26 p. m., the DON reviewed Resident 301's physician's order and stated that the nurse had incorrectly transcribed the hospital discharge medication Chlorhexidine Gluconate mouth rinse. The mouth rinse should have been Chlorhexidine Gluconate 0.12%, and Chlorhexidine Gluconate 4% should have been used for wound care. During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 5/15/2025 at 2:46 p.m., the MDSC stated that he had transcribed Resident 301's hospital discharge order for Chlorhexidine Gluconate (Peridex) incorrectly as 4%, when it should have been 0.12%. During a phone interview with the Consultant Pharmacist (CP) on 05/16/2025 at 9:23 a.m., the CP stated that Chlorhexidine Gluconate 4% is intended for external use in wound care, while the appropriate concentration for a mouth rinse is 0.12%. The CP further stated that using the 4% solution as a mouth rinse may cause a bitter taste, dry mouth, and oral irritation. A review of drug resource, DailyMed (https://dailymed.nlm.nih.gov), indicated, indicating that Peridex, (Chlorhexidine Gluconate 0.12%) Oral Rinse provides antimicrobial activity during oral rinsing . chlorhexidine gluconate solution 4% Purposes of use: Surgical hand scrub - Healthcare personnel handwash - Skin wound and general skin cleanser. For external use only, when using this product - keep out of eyes, ears, and mouth .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview, and record review, the facility failed to ensure the adequate provision of pharmaceutical services when: 1. Chlorhexidine Gluconate mouth rinse was unavailable for administration for five consecutive days for one of 25 sampled residents (Resident 301). 2. The pharmacy linked the different medications and incorrect administration instructions for one of the 25 sampled residents (Resident 36). This link resulted in the licensed nurse administering the wrong medication to Resident 36. These failure had the potential to worsen the resident's condition or lead to complications. Findings: 1. During a medication administration observation on 5/12/2025 at 10:00 a.m. in Resident 301's room, Licensed Vocational Nurse (LVN) A was observed administering the resident's morning medications. The Chlorhexidine Gluconate Oral Rinse was not administered. During an interview with LVN A on 5/12/2025 at 10:20 a.m., LVN A confirmed that she did not administer the Chlorhexidine Gluconate Oral Rinse to Resident 301, and she stated the Chlorhexidine Gluconate Oral Rinse was not available since the order date 5/8/2025. A review of Resident 301's acute hospital discharge summary dated 5/7/2025 indicated that the resident had a recent dental extraction. A review of Resident 301's physician's order dated 5/8/2025 indicated Chlorhexidine Gluconate Liquid 4%, to be given as a 15 ml (milliliters, a measuring unit) oral rinse twice daily for post-dental extraction care. A review of Resident 301's medication administration record (MAR) for May 2025 showed that Chlorhexidine was not administered during the morning and evening shifts from 5/8/2025 through 5/12/2025. During an interview with the facility Medical Director (MD) on 5/12/2025 at 3:28 p.m., the MD stated that the facility had sent the order for Chlorhexidine Gluconate Oral Rinse to the pharmacy on 5/8/2025 and the pharmacy should have communicated with the facility regarding the non-delivery of the medication. During an interview with the Assistant Director of Nursing (ADON) on 5/15/2025 at 2:00 p.m., the ADON confirmed that the Chlorhexidine Gluconate Oral Rinse was delivered to the facility on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication administration observation on 5/13/2025 at 11:25 a.m. in Resident 36's room, Licensed Vocational Nurse (LVN) B was observed administering insulin before lunch. Resident 36's blood glucose level was 241 mg/dL(milligrams per decilitre), and LVN B administered 4 units of Novolog Solution 100 units/mL (insulin aspart, a rapid-acting human insulin analog indicated for glycemic control in individuals with diabetes mellitus), per the sliding scale. However, the Electronic Medication Administration Record (eMAR) indicated that 4 units of insulin lispro were administered before lunch. During an interview with LVN B on 5/13/2025 at 11:30 a.m., she reviewed Resident 36's physician's order and confirmed that the active order was injecting insulin lispro per the sliding scale. She explained that she administered insulin aspart instead because insulin lispro was not available. She stated that two additional orders had been linked under the original lispro sliding scale order-one for insulin aspart with a sliding scale and one for insulin lispro at a fixed dose of 12 units. LVN B stated that nurses had the option to choose between these linked orders, and due to the unavailability of lispro, she chose to administer aspart. During a phone interview with the Consultant Pharmacist (CP) on 5/16/2025 at 9:39 a.m., the CP stated that although both insulin lispro and insulin aspart are rapid-acting insulins, they are different medications. Lispro acts more quickly than aspart. The CP further stated that insulin aspart should not be administered under an order for insulin lispro. If insulin aspart is to be used as a substitute, a new physician order needs to be obtained. During an interview with the Assistant Director of Nursing (ADON) on 5/15/2025 at 2:06 p.m., the ADON stated that he entered the original order for insulin lispro with a sliding scale before meals on 8/24/2024, and it had not been revised since. On 5/12/2025, when insulin lispro became unavailable, the pharmacy linked an insulin aspart sliding scale order under the existing lispro order. Additionally, the pharmacy also linked an inappropriate fixed-dose lispro order of 12 units, which Resident 36 did not have. The ADON confirmed that the pharmacy's action to auto-link these orders was inappropriate because insulin lispro and insulin aspart are different medications, and Resident 36 did not have an order for a fixed dose of 12 units of lispro. A review of the facility's Order Audit Report dated 5/15/2025 indicated the following two medication orders were auto-linked by the pharmacy under the original insulin lispro sliding scale order: a. Insulin Aspart 100 units/mL Solution, inject up to 12 units per sliding scale subcutaneously before meals (auto-linked on 5/12/2025). b. Insulin Lispro 100 units/mL Solution, inject 12 units subcutaneously before meals for diabetes mellitus (auto-linked on 4/5/2025). During a phone interview with the Pharmacy Manager (PM) on 5/16/2025 at 3:23 p.m., the PM declined to answer questions related to the medication errors involving Residents 301 and 36. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled Organization Aspects Provider Pharmacy Requirements , revised August 2014, indicated, The provider pharmacy agrees to perform the following pharmaceutical service, including but not limited to . Accurately dispensing prescriptions based on authorized prescriber orders, .provide routine and timely pharmacy service as contracted . all other new medication orders are received and available for administration on the next routine delivery . screen each new medication order for an appropriate indication or diagnosis . if diagnosis or indication is not available, notifying the nursing staff of the need to obtain the information from the prescriber prior to administering the drug .

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	056437	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Ridge Care Center	1501 Skyline Drive Monterey, CA 93940

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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. 46001 Based on observation, interview, and record review, the facility had a medication error rate of 7.14 % when two medication errors were observed out of 28 opportunities during medication administration for two out of six residents (Residents 301 and 36). 1. Chlorhexidine mouth rinse was not administered as ordered for Resident 301, 2. Insulin was not administered as ordered for Resident 36 before lunch. These failures resulted in residents not receiving medications as prescribed, which had the potential to result in residents not receiving the full therapeutic benefit of their medications and/or experiencing negative health outcomes. Findings: 1. During a medication administration observation on 5/12/2025 at 10:00 a.m. in Resident 301's room, Licensed Vocational Nurse (LVN) A was observed administering Resident 301's morning medications. The Chlorhexidine Gluconate Oral Rinse was not administered. During an interview with LVN A on 5/12/2025 at 10:20 a.m., she confirmed that the Chlorhexidine Gluconate Oral Rinse was not administered because it had not been available since the order was placed on 5/8/2025. 2. During a medication administration observation on 5/13/2025 at 11:25 a.m. in Resident 36's room, LVN B was observed administering insulin before lunch. Resident 36's blood sugar was 241 mg/dL, and LVN B administered 4 units of Novolog Solution 100 units/ml (insulin aspart, a rapid-acting human insulin analog indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus) according to the sliding scale. However, the medication administration record indicated that 4 units of insulin lispro were administered before lunch. A review of Resident 36's physician's order dated 8/24/2024 indicated Humalog Solution 100 uint/ml (insulin lispro, a rapid-acting human insulin analog indicated to improve glycemic control in adult and pediatric patients with diabetes mellitus) injected as per sliding scale subcutaneously before meals for diabetes, give 15 minutes before meals. During a concurrent interview and record review with LVN B on 5/13/2025 at 11:30 a.m., LVN B reviewed Resident 36's physician order and confirmed that the order was to administer insulin lispro per sliding scale before meals. LVN B stated she administered insulin aspart instead because insulin lispro was unavailable, believing the two insulins were equivalent. During a phone interview with the Consultant Pharmacist (CP) on 5/16/2025 at 9:39 a.m., the CP stated that although both insulin lispro and insulin aspart are rapid-acting insulins, but they are different medications. the nurse should not administer insulin aspart under an order for insulin lispro. If insulin aspart is to be used as a substitute, a new physician order needs to be obtained. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Medication Administration, revised April 2019, indicated, Medications are administered in accordance with prescriber orders .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to ensure palatability and nutritive value of cooked foods were maintained when: 1. Three of forty-nine facility residents, (Residents 33, 61 and 51), received food from the kitchen and complained that the food tasted bland (lacking taste or flavor); and, 2. Minced/moist (dietary modification where food is prepared to be soft, moist and easily swallowed with minimal chewing required) country fried steak, soft/bite-sized (foods that are soft, tender, moist and easily broken down by chewing) country fried steak, vegetable or veggie patties and mashed potatoes (made by mashing boiled or steam potatoes) were held in the heated oven for an extended period. These failures resulted in decreased food palatability that could lead to decrease in food consumed by residents, and the food held in the heated oven for extended period could lose nutritive value, that could lead to decreased nutrient intake for the ninety-five facility residents receiving food from the kitchen. Findings: 1. During a concurrent observation and interview of Resident 33 on 5/12/25 at 9:53 a.m., Resident 33 was in his bed, alert, oriented, calm and verbally responsive. Resident 33 stated that his food did not taste good and that it tasted bland. Review of the admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) of Resident 33 indicated, Resident 33 was readmitted to the facility on [DATE] with the primary diagnosis of hemiplegia (complete paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following unspecified cerebrovascular disease (group of conditions that impact the brain's blood vessels and blood flow) affecting left non-dominant side. Review of the order summary report of Resident 33 dated 5/14/25 indicated, Resident 33 had an order of regular diet (normal diet without restrictions), regular texture (no modifications), with thin liquids consistency (liquid that is easy to pour and no additives), ordered and started on 12/16/24. During a concurrent observation and interview of Resident 61 on 5/12/25 at 9:56 a.m., Resident 61 was in his bed, alert, oriented, comfortable and verbally responsive. Resident 61 stated that the food tasted bland. Review of the admission record of Resident 61 indicated, Resident 61 was admitted to the facility on [DATE] with the primary diagnosis of unspecified fracture (break or crack in a bone) of right femur (thigh bone), subsequent encounter for closed fracture (type of bone fracture where the broken bone does not penetrate the skin) with routine healing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the order summary report of Resident 61 dated 5/14/25 indicated, Resident 61 had an order of controlled carbohydrate diet (CCHO, type of diet in which the individual consumes a consistent daily amount of carbohydrates), regular texture, with thin liquids consistency, no melon with any meal, side salad with lunch and dinner and extra cold cereal with breakfast, ordered and started on 9/17/24. During a concurrent observation and interview of Resident 51 during the resident council meeting (gathering where residents of a facility come together to discuss issues) on 5/13/25 at 11:00 a.m., Resident 51 was in her wheelchair in the activity room, alert, oriented, verbally responsive and participating in the resident council meeting. Resident 51 stated that the meat was dry, overcooked and tasted bland. Review of the admission record of Resident 51 indicated, Resident 51 was readmitted to the facility on [DATE] with the primary diagnosis of other idiopathic peripheral autonomic neuropathy (peripheral nerve damage where the cause is unknown or cannot be determined). Review of the order summary report of Resident 51 dated 5/14/25 indicated, Resident 51 had an order of controlled carbohydrate diet, regular texture, with thin liquids consistency, ordered and started on 7/16/24. During the test tray observation and tasting with dietary supervisor (DS) and director of dietary services (DODS) on 5/14/25 at 1:41 p.m., they brought 2 trays with 4 test plates containing: a. puree (smooth, typically creamy, mixture made by blending or mashing food until it reaches a uniform, soft texture) country fried steak and peas and mashed potatoes; b. minced/moist country fried steak and peas and mashed potatoes; c. soft/bite-sized country fried steak and peas and mashed potatoes and d. regular country fried steak and peas and mashed potatoes. During the food tasting on 5/14/25, from 1:43 p.m. to 1:46 p.m., tasted all the foods of the 4 test plates in the 2 trays. The puree country fried steak, minced/moist country fried steak, soft/bite-sized country fried steak and regular country fried steak, they all tasted bland. During the concurrent interviews with the DS and DODS after they both tasted all the foods of the 4 test plates in the 2 trays on 5/14/25 at 1:48 p.m., they both verified that the puree, minced/moist, soft/bite-sized and regular country fried steaks, they all tasted bland. During an interview with the registered dietitian (RD) on 5/14/25 at 3:00 p.m., RD acknowledged that all foods should be palatable. RD then stated that she would do an in-service training with the staffs about it. Review of the facility's policy titled, Food and Nutrition Services, revised October 2017, indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During the food preparation observation in the kitchen with cook B (CK B) on 5/14/25 at 9:57 a.m., CK B stored the already cooked minced/moist country fried steak, soft/bite-sized country fried steak, veggie patties and mashed potatoes in the oven, heated at 200 degrees Fahrenheit (F, temperature scale). During the continued observation in the kitchen on 5/14/25 at 12:20 p.m., CK B started preparing the tray line, putting foods in the meal trays of the residents after checking the food temperatures, then placing them in the tray carts until they were ready for distribution. During a concurrent interviews with the DS and DODS on 5/14/25 at 1:50 p.m., both the DS and DODS verified that foods should be prepared near or within 1 hour from the tray line preparation to keep the taste and nutritive value of the prepared foods. They further verified that the already cooked minced/moist country fried steak, soft/bite-sized country fried steak, veggie patties and mashed potatoes were placed in the oven, heated at 200 degrees F at 9:57 a.m., and the tray line preparation started at 12:20 p.m. for lunch. They then stated that they would change the time, they would start preparing the foods. During an interview with the RD on 5/14/25 at 3:00 p.m., the RD verified that foods should be prepared near or within 1 hour of the tray line preparation and serving to keep or preserve the taste and nutritive value of the foods. Review of the facility's undated policy titled, Section E: Dining Service: Mealtimes Overview, indicated, The Food and Nutrition Services Department will provide accurate, efficient and consistent meal service with nutritious and attractive food served at the appropriate temperature and in a pleasant atmosphere . Food is to be on the tray line no longer than 20 minutes before meal service starts or put out at time to ensure proper food temperatures and quality . Review of the State Operations Manual (SOM, a federal document from the Centers for Medicare and Medicaid Services that provides rules and guidance for state surveys of healthcare institutions), Appendix PP: Guidance to Surveyors for Long Term Care Facilities, dated 2/3/23, indicated, . Foods are . not held at hot temperatures for hours prior to meal service because prolonged hot temperatures can result in a loss of vitamins .

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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. 44185 Based on observation, interview, and record review, the facility failed to ensure cooking and kitchen equipment were maintained and kept in accordance with professional standards for food safety when: 1. There were unsanitary cooking equipment stored in the kitchen; and, 2. Ice scoop for the ice machine was placed on top of a dusty and uncleaned tray. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness (illness resulting from contaminated food) and cross-contaminated food for the ninety-five residents who received food from the facility kitchen. Findings: 1. During the initial kitchen tour observation with the dietary supervisor (DS), on 5/12/25 at 8:08 a.m., observed 8 large pans with brownish to blackish discolorations and rusty spots in them that were still stored there. During an interview with DS on 5/12/25 at 8:09 a.m., the DS acknowledged that the 8 large pans had brownish to blackish discolorations and rusty spots. The DS then stated that it should not be kept there and would have them replaced. During an interview with the registered dietitian (RD), on 5/14/25 at 3:00 p.m., the RD verified that the 8 large pans with brownish to blackish discolorations and rusty spots should not be kept there and should have been replaced. The RD then stated that she would follow-up on that concern. Review of the facility's policy and procedure titled, Sanitization, revised on November 2022 indicated, The food service area is maintained in a clean and sanitary manner . All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning . 2. During the initial kitchen tour observation on 5/12/25 at 8:15 a.m., surveyor checked the ice machine and observed that the ice scoop was placed on top of a dusty and unsanitary tray. During an interview with DS on 5/12/25 at 8:16 a.m., the DS acknowledged that the ice scoop was placed over a dusty and unsanitary tray and should not be put there. The DS then removed the ice scoop with the unsanitary tray from the ice machine and said it will be cleaned. During an interview with RD on 5/14/25 at 3:00 p.m., the RD verified that the ice scoop should not be placed over a dirty tray and would talk to the staff about it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility's policy titled, Recommended Food Storage Practices: Ice, indicated, . Scoops shall be stored separately from the ice machine in a sanitary container that allows for water drainage away from the scoop .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46553 Based on observation, interview and record review, the facility failed to implement infection control and prevention practices when: 1. The Licensed Vocational Nurse A (LVN) did not perform hand hygiene between every task; 2. Resident 15's nasal cannula (NC, flexible tubing inserted into the nostrils and attached to an oxygen [a colorless and odorless gas that people need to breathe]) was undated and the nebulizer (a small machine that turns liquid medicine into a mist, allowing you to breath it in directly into your lungs through a mouthpiece or mask) mask was not properly stored after use; 3. Resident 308's nasal cannula was undated; the humidifier was outdated, and the oxygen filter was dusty with whitish grayish colored substance in the filter; 4. Dark brownish substances were observed in the medication storage room cabinet. 5. The licensed nurse did not change gloves between tasks. These failures had the potential for development and transmission of communicable disease and infection in the facility. Findings: 1. During an observation on 5/12/25 at 12:18 p.m., the LVN A observed came out in one of the resident's rooms without sanitizing her hands, then went to another resident room to answer the call light. Then the LVN took the empty cup used by another resident on top of the medication carts and threw the remaining fluid in the sink at the nurse station, then went to another residents room. During an interview with LVN A on 5/12/25 at 1:54 p.m., LVN A confirmed the above observation of not performing hand hygiene after every task. The LVN further stated they should do hand hygiene between every task, because of infection control. During a review of the facility's policy and procedure (P&P) titled, Handwashing/ Hand hygiene, revised date 2019, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. 2. During a concurrent observation and interview on 5/12/25 at 8:58 a.m., Resident 15's nasal cannula tubing was undated. Another nasal cannula hanging on Resident 15's wheelchair was undated and not properly stored. Resident 15's nebulizer mask was observed undated and was not properly stored. Resident 15 stated the nebulizer was last used on Sunday. During a concurrent observation and interview with Director of Nursing (DON) on 5/12/25 at 12:27 p.m., the DON confirmed the nasal cannula, and the nebulizer mask was undated and not properly stored. DON further stated it should be placed inside the black bag for prevention of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Respiratory Therapy- Prevention of Infection, undated, the P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .7. Change the oxygen cannula and tubing every seven days , or as needed. 8. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use . Infection Control Consideration Related to Medication Nebulizer / Continuous Aerosol . 7. Store the circuit in plastic bag, marked with date and resident's name between uses. 3. Review of Resident 308's clinical record indicated Resident 308 was admitted to the facility on [DATE] with diagnoses including Respiratory disorders (any disorders or illness that affects the lungs and the respiratory system), Emphysema (a lung disease and a type of chronic obstructive pulmonary disease, any air filled enlargement in the body's tissue, Chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung) with exacerbation. Review of Resident 308's order summary report, dated 5/12/25 indicated Resident 308 had orders for change humidifier bottle and tubing every Friday every day shift every Fri. During an observation on 5/12/25 at 12:39 p.m., Resident 308's nasal cannula tubing was undated, the humidifier was dated 4/18/25. The oxygen concentrator filter (a medical device that concentrates oxygen from environmental air and delivers it to a resident in need of supplemental oxygen. The filter is at the back of the oxygen concentrator.) was dusty, with an accumulation of whitish grayish colored substances on the filter. During a concurrent observation and interview with DON on 5/12/25 at 1:01 p.m., the DON confirmed the nasal cannula was undated, the humidifier was outdated, and the oxygen concentrator filter was dusty, with an accumulation of whitish grayish colored substances on the filter. During a review of the facility's policy and procedure (P&P) titled, Respiratory Therapy- Prevention of Infection, undated, the P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Infection Control Consideration Related to Medication Nebulizer / Continuous Aerosol: 3.Mark bottle with date and initials upon opening and discard . 8. Wash filters from oxygen concentrators every seven days . 46001 4. During an observation and interview with the DON on 5/12/2025 at 11:00 a.m., dark brownish substances were observed all over the top of the medication storage cabinets in the south medication storage room. The DON confirmed the above observation and stated the staff should keep the medication storage cabinet clean. During an interview with the housekeeping manager (HM) on 5/15/2025 at 10:28 a.m., the HM stated that staff should have kept the medication storage cabinet clean. A review of the facility policy and procedures titled Storage of Medications, revised November 2020, indicated . the nursing staff is responsible for maintaining medication storage and preparation area in a clean, safe and sanitary manner . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A review of Resident 345's clinical record indicated Resident 345 was admitted to the facility on [DATE] with diagnoses including aftercare following joint replacement surgery, and infection and inflammatory reaction due to unspecified internal joint prosthesis (an artificial device that replaces a missing body part), subsequent encounter. A review of Resident 345's physician's order dated 5/10/2025 indicated Cefepime HCl (Cefepime Hydrochloride, a fourth-generation cephalosporin antibiotic) intravenous solution Reconstituted 2 gm (gram, a unit of mass in the metric system) intravenously every 8 hours for intraprosthetic infection (an infection occurs within a prosthetic device) for 6 weeks. Started on 5/11/2025. During a concurrent medication administration observation and interview on 5/14/2025 at 2:07 p.m., the Minimum Data Set Coordinator (MDSC) was observed preparing and administering intravenous (IV) Cefepime 2 gm for Resident 345. The MDSC used the same pair of gloves throughout the process-preparing the medication, hanging the IV bag on the pole, reaching into his pant pocket to retrieve an alcohol wipe, opening the wipe, scrubbing the IV hub, flushing with 10 mL of normal saline (NS), and connecting the IV line to the resident's midline catheter (a type of intravenous catheter). The MDSC acknowledged that he performed multiple tasks without changing gloves. During an interview with the Director of Nursing (DON) on 5/16/2025 at 3:00 p.m., the DON stated that nurses should change gloves between tasks to prevent cross-contamination and reduce the risk of infection. A review of the facility undated policy and procedures titled glove use indicated, . to prevent the spread of infection . when gloves are indicated, use disposable single-use gloves .