STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056447	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Hills Health Care Center	1768 B Street Hayward, CA 94541

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49983 Based on interview and record review, the facility failed to report alleged abuse or mistreatment for Resident 32 to the appropriate authorities. This failure had the potential to result in the event not being investigated completely, which could lead to further events of abuse or mistreatment. Findings: During an interview on 8/14/24 at 9:41 a.m. with Resident 32, Resident 32 stated approximately one year ago, a Certified Nursing Assistant (CAN) 1 touched her in a way that she felt was inappropriate. Resident 32 stated she felt very, very uncomfortable about the incident and she reported the event to facility staff a short time after it happened. Resident 32 stated after the event, she did not like having CNA 1 near her because she felt uncomfortable. During a record review of the Electronic Medical Record (EMR) for Resident 32, the Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) was reviewed. The MDS, dated [DATE], indicated Resident 32 had a Brief Interview for Mental Status score of 15 (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.). During a concurrent interview and record review on 8/14/24 at 10:47 a.m. with the Director of Nursing (DON), the EMR for Resident 32 was reviewed. The progress notes in the EMR indicated that on 5/26/23, Resident 32 expressed concern about an event when a male care staff member jiggled her abdomen while he was performing pericare (the process of cleaning the genital and anal areas of the body) on her. The DON stated that after the event, she spoke with CNA 1 and CNA 1 denied the event. The DON stated the interview with CNA 1 was the only investigation done into the event. The DON stated that there is no documentation of follow up with Resident 32 after the event documented in the EMR. The DON stated that the facility did not inform the ombudsman (an official who advocates for the rights of residents in nursing homes) or the California Department of Public Health (CDPH, a California government agency that investigates incidents in nursing homes) about this incident and they should have been notified. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview with CNA 1 on 8/14/24 at 1:42 p.m., CNA 1 stated that he did not remember being interviewed about the incident. During an interview on 8/16/24 at 10:27 a.m. with Administrator (ADM), ADM stated the event was reported to CDPH and the ombudsman on 8/14/24. During a review of the facility's policy and procedure (P&P), titled Abuse Investigation & Reporting OP2 0304. 03, undated, the P&P indicated all alleged violations involving abuse, neglect, exploitation, or mistreatment will be reported to CDPH and the ombudsman.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49983 Based on interview and record review, the facility failed to complete the required Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) for one of three sampled residents (Resident 63). PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.) This failure had the potential to result in residents not receiving appropriate care for their mental disorders or intellectual disabilities. During a review of Resident 63's Admission Record, the Admission Record indicated Resident 63 was initially admitted to the facility in January 2024 with multiple diagnoses, including developmental disorder of scholastic skills (a type of intellectual disability) and other specified disorders of the brain. During a review of Resident 63's PASARR, dated 12/27/23, the PASARR indicated if the individual remains in the nursing facility longer than 30 days, the facility should resubmit a new screening on the 31st day. During an interview on 8/15/24 at 10:07 a.m. with the Director of Nursing (DON), DON stated the reason for doing the PASARR is to assess residents and make sure that residents get appropriate care. During a concurrent interview and record review on 8/15/24 at 12:20 p.m. with DON, DON stated the facility did not complete a PASARR for Resident 63 after Resident 63 had been at the nursing facility after 31 days. DON stated a PASARR should have been completed because Resident 63 had a diagnosis of an intellectual disability.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50120 Based on observation, interview and record review, the facility failed to provide pharmaceutical services to meet the needs of residents by failing to ensure the proper storage and destruction of narcotic (a drug that relieves pain and induces drowsiness) medication and the delivery of the correct dose of medication as ordered by the physician when: 1. Narcotic medication was stored in an unlocked drawer in Director of Nursing (DON) office, with 7 missing narcotic medications. 2. Narcotic medication was missing during a random narcotic audit for two of three sampled residents (Residents 24 and 64). 3. Resident 24 was undermedicated with diazepam (medication used to treat anxiety, muscle spasms, seizures, and alcohol withdrawal). 4. Resident 29 received the incorrect dose of Lactulose (medication used to treat constipation and to lower ammonia level in the blood for patients with liver disease). These deficient practices had the potential to result in drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) and inaccurate drug dosages which could result in adverse outcomes. Findings 1. During concurrent observation and interview on 8/12/24 at 3:35 p.m. with DON, DON showed a locked file cabinet located in her office desk, filled with Residents' narcotics from over a year ago. DON stated she works with the pharmacy consultant to destroy medications. There were additional narcotic medications above the locked cabinet, in a drawer in DON's office desk that was unlocked. There were seven narcotic medications identified on narcotic reconciliation for Resident 325 and Resident 326 that were missing. List of the medications in the unlocked drawer, waiting for destruction: a. Bubble pack of lorazepam .5 mg tablet, 21 tablets, date issued 4/24/24, for Resident 325. The count sheet showed 24 tablets, but the bubble pack had only 18 tablets. There were six tablets missing. b. Bubble pack of oxycodone (a narcotic used for moderate to severe pain) 5 mg tablet three tablets, date issued 6/17/2023, for Resident 46. There were three tablets but no count sheet. c. Bubble pack of lorazepam .5 mg 27 tablets, date issued 8/4/23, for Resident 326. There were 27 tablets but count sheet says 28 tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. One single pack of hydrocodone (a narcotic used to treat moderate pain) 5-325 tablet date issued 6/23/24, for Resident 40. One tablet bag, dated 6/23/24, was supposed to be wasted but was given to DON to waste. e. One single pack of klonopin (medication used to treat panic disorders and certain types of seizures) .5 mg, date issued 11/5/23 for Resident 327. One tablet was refused on 11/26/23 and was put in a small plastic bag and stapled to the count sheet. Record review showed resident was discharged on [DATE]. f. One single pack of tramadol (medication used to treat moderate to moderately severe pain) 50 mg tablet, date issued 1/3/24, for Resident 328. A half tab of tramadol 50 milligrams, dated 5/11/24, was given to DON for destruction. DON stated it was placed in the plastic bag and put in the unlocked drawer. g. One single pack of lorazepam .5 mg tablet from emergency kit (e-kit), date issued 2/20/23. A record review indicated one tablet had been taken from E kit but not used. One tablet was placed into a plastic bag and stapled to the count sheet with two nurses' signatures. During an interview on 8/12/24 at 3:35 p.m. with DON, DON stated the facility does not keep a log of the narcotic medication for destruction including name of resident, date, name of drug, dose of drug, quantity of drug, and name and signature of nursing handing over narcotic and nurse receiving narcotic scheduled for destruction. from whom, date, drug dose, quantity. The DON acknowledged the narcotic medications should have been stored in a locked cabinet until they could be destroyed with Pharmacy Consultant (PC). During an interview on 8/13/24 at 11:30 a.m. with PC, PC stated PC provides monthly oversight to the facility and usually spends two hours on narcotic destruction with DON. PC stated she was last at the facility in July 2024, but had no knowledge of the narcotics in an unlocked drawer of DON's office. PC stated the last time narcotic destruction occurred was in June 2024. 2. During a random review of residents receiving narcotic medication and interview on 8/14/24 at 9:50 AM with DON, the narcotic reconciliation did not match up with the Medication Administration Record (MAR) for Resident 24 and Resident 64. a. During a review of Resident 24's Controlled Drug Record, hydrocodone/APAP 5/325 milligrams was signed out on 5/15/24 without documentation on the MAR. DON stated it should be documented on the MAR to account for the medication. b. During a review of Resident 64's Controlled Drug Record, hydrocodone/APAP 5/325 milligrams was signed out on 7/19/24, 7/29/24, 7/30/24, 8/2/24, and 8/13/24 without documentation on the MAR. DON stated it should be documented on the MAR to account for the medication. During a concurrent interview and record review on 8/14/24 at 10:32 a.m. with DON, DON verified two out of three patients were missing documentation of narcotics and the narcotics are not accounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent interview and record review on 8/14/24 at 9:25 a.m. with DON, Resident 24's MAR was reviewed. The MAR indicated an order for diazepam 5 milligrams every six hours PRN. Nursing staff were administering only half of the physician prescribed order, 6 times. (Order was changed to one tablet 5 milligrams every six hours PRN on 6/30/24, but nurses were giving only 2.5 milligrams on 7/24/24 at 5:51 a. m., 7/25/24 at 8:27 a.m., 7/26/24 at 11:00 a.m., 7/20/24 at 7:10 a.m., 7/28/24 at 8:00 a.m., and 7/30/24 at 6:24 a.m. only one tablet 2.5 mg given to resident when 2 tablets totaling 5.0 mg should have been given. DON double-checked the order and said the present order now is 5 milligrams 1 tablet every six hours PRN for anxiety. DON verify the nurses did not give the ordered 5 mg. 4. During a concurrent observation and interview on 8/13/24 at 10:54 a.m. with Licensed Vocational Nurse (LVN) 2, medication cart B, section A, contained a bottle of lactulose for Resident 29. LVN 2 stated she has been administering 10 ml and not 15 ml. The dosage on the bottle states 10 grams per 15 ml. A review of the Physician Order, dated 6/28/24, indicated lactulose 10 grams. During a review of the facility's policy and procedures (P&P) titled Disposal of Controlled Substances, dated 11/17, the P&P indicated: a. listed in schedules II, III, IV, V remaining the nursing care center after the order has been discontinued and retained in the nursing care center and is securely double locked area with restricted access until destroyed. A controlled medication disposition log or equivalent form shall be used for documentation. The consultant pharmacist or a pharmacist from the contracted pharmacy will verify accuracy and records shall be retained as per federal privacy and state regulations. This log shall contain the following information: Residents name, medication name and strength, prescription number, quantity, amount disposed date of disposition, and signatures of the required witnesses. b. Medications included in the Drug Enforcement Administration DEA classification as controlled substances are those classified as such by state regulation are subject to special handling storage disposal and record keeping in the nursing care center in accordance with federal and state laws and regulations. Controlled substances shall be destroyed by registered nurse employed by the care center and consultant pharmacist.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 50120 Based on interviews and record reviews the facility failed to ensure the Pharmacy Consultant (PC) provided the Medical Regimen Review (MRR) recommendations and Executive Summary to the facility within the timeframes established in the facility's policies and procedures for four out of four months and the facility did not act on the reports within 30 days for five of 10 sampled residents (Residents 56, 26, 2, 66, and 54). This failure had the potential to result in Residents not receiving therapeutic recommendation on drug therapies. Findings: During a telephone interview on 8/15/24 at 9:19 a.m., with PC and Regional Supervisor (RS), PC stated that PC visits the facility once a month and completes the MRR for the month and submits the report within 48 hours. During a telephone interview on 8/15/24 at 11:17 a.m., with the Medical Director (MD), MD stated the MRR reports and recommendations were being submitted late. MD also stated it is important to get the MRR reports in a timely manner so, medical and nursing staff can have informed recommendations regarding Resident's medication and treatment plan. During a telephone interview on 8/15/24 at 12:18 p.m., with Pharmerica Regional Supervisor (PRS), PRS stated that MRR reports and Executive Summaries need to be sent to the facility 48 hours after completion. During a review of the facility's MRR reports and Executive Summary, emailed to the facility, the email indicated the reports were sent to the facility on the following dates: a. MRR report, dated 4/24 was sent to the facility on [DATE]. b. MRR report, dated 5/24, was sent to the facility on [DATE]. c. MRR report, dated 6/24, was sent to the facility on [DATE]. d. MRR report, dated 7/24, was sent to the facility on [DATE]. During a record review of the Executive Summary of Consultant Pharmacists Medication Regimen Review, dated 5/31/24, the documents indicated there were 52 recommendations forwarded to the following disciplines: a. There were 12 written to the Interdisciplinary Team (IDT, A team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners) review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. There were 22 written for nursing review. c. There were 18 written for the physician review. During a record review of the Executive Summary of Consultant Pharmacists Medication Regimen Review, dated 6/30/24, there were 73 residents reviewed with recommendations forwarded to the following disciplines: a. There were 16 written for IDT review. b. There were 29 written for nursing review. c. There were 27 written for physician review. During a record review of the Executive Summary of Consultant Pharmacists Medication Regimen Review, dated 7/31/24, there were 29 recommendations forwarded to the following disciplines: a. There were three for IDT review. b. There were 17 for nursing review. c. There were nine for physician review. During an interview on 8/15/24 at 8:44 a.m., with DON and Nurse Supervisor (NS), they stated the MRR reports from the PC have been late. NS stated when the reports are received by the facility, they are acted upon with a checked receipt and their signature. They also stated that April and May reports were delayed and some of the recommendations were acted upon last night 8/14/24. During a concurrent record review and interview on 8/15/24 at 11:47 a.m. with NS, the facility's MRR reports were reviewed. The MRR reports identified a delay in acting upon the pharmacy's recommendations for Residents 56, 26, 2, 66, and 54. During a review of the MRR, dated 5/24, for Resident 56, the MRR included nursing recommendations to monitor for signs of dehydration, electrolytes, acute kidney injury and to monitor for edema, congestion, and weight changes. These recommendations were acted upon on 8/6/24. During a review of the MRR, dated 5/24, for Resident 26, the MRR included nursing recommendations to monitor for sign of dehydration, electrolytes, acute kidney injury, and to monitor for edema, congestion, weight changes. These recommendations were acted upon on 8/15/24. During a review of the MRR, dated 5/24, for Resident 2, the MRR included nursing recommendations for prednisone is best administered with food to minimize GI irritation, potassium supplement is best administered with food or after meals with a full glass of water or fruit juice, and furosemide to monitor for signs of dehydration, electrolytes, acute kidney injury, and to monitor for edema, congestion, and weight changes. These recommendations were acted upon on 8/15/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the MRR, dated 5/24, for Resident 66, the MRR included nursing recommendations to monitor for signs and symptoms of bleeding, bruising, and thromboembolism. These recommendations were acted upon on 8/15/24. During a review of the MRR, dated 5/24, for Resident 54, the MRR included nursing recommendations for escitalopram (medication for depression and generalized anxiety disorder) 10 milligram tablets at night to attempt gradual dose reduction to escitalopram 5 milligram tablet at night. These recommendations were acted upon on 8/1/24. During a review of the facility's policy and procedure (P&P) titled, Consultant Pharmacist Services Provider Requirements, the P&P indicated, Consultant Pharmacists will submit a monthly summary report to the nursing care center outlining specific findings based on the consultant pharmacist's MRR following the completion of the review. Consultant pharmacist will provide a report of activities, findings, and recommendations to the administrator and the DON on a monthly basis. This includes a consolidated report of all resident reviews and a summation of monthly finding. Individual resident recommendations are provided to the facility medical director, prescriber, DON upon completion or following MRR. During a review of the facilities P&P Medication Regiment Review and Reporting, the P&P indicated a record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians, and the care planning team within 48 hours of MRR completion. Resident specific MRR recommendations and findings are documented and acted upon by the nursing care center and or physician. Recommendations shall be acted upon within 30 calendar days.

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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. 50120 Based on observation, interview, and record review, the facility failed to ensure it was free from medication error rate of 5% or greater during the medication pass observation. The facility had a cumulative medication error rate of 30% consisting of nine errors where medications were not administered in accordance with physician's orders, in a sample size of 30 opportunities for error. These deficient practices had the potential to result in adverse consequences. Findings During an observation on 8/12/24 at 4:18 p.m. with Registered Nurse (RN) 1, RN 1 prepared medication for Resident 29 to be delivered via gastrostomy tube (G-tube, a tube inserted through a surgically created hole through the abdomen to deliver food/medications/fluids directly into the stomach) during evening medication schedule. During preparation, RN 1 placed clonazepam 1.5 milligrams, Ducolax stool softener 100 milligrams, Calcium 500 milligram oyster shell, Senna tablet 8.6 milligram, multivitamin with iron and folic acid, and Vitamin B1 100 milligrams and placed in a plastic bag and pounded the medication together until they turned to a powder. RN 1 then mixed powdered medications with the valproic acid liquid and warm water. RN 1 then extracted the liquid into a large syringe and administered the cocktail via resident's G-tube. He then followed with a flush of water and resumed G-tube feeding. During an interview on 8/12/24 at 5:33 p.m. with RN 1, RN 1 stated the pills are always crushed together when administering via G-tube and it is common practice. During an interview on 8/13/24 at 11:36 a.m. with Director of Staff Development (DSD), DSD stated when giving medications via G-tube, each pill should be individually crushed and diluted with water and given individually followed by a flush. DSD stated the pills should not be grounded all together, mixed together, and given at the same time via G-tube. During a record review on 8/12/24 of Resident 29's Physician Order Report, dated August 2024, Resident 29 was scheduled to receive MiraLAX and lactulose which were not given. During a concurrent observation and interview on 8/12/24 at 5:33 p.m. with RN 1, RN 1 stated that they did not give the Lactulose because he didn't have it in the medication cart. He looked in the medication cart and could not find the lactulose. I held the medication because I didn't have it. RN 1 stated that he will give the MiraLAX later and will order the lactulose through pharmacy. RN 1 stated that he did not know how long Resident 29 had been out of lactulose. During an observation on 8/13/24 at 9:25 a.m., Licensed Vocation Nurse (LVN) 1 administered medications to Resident 26. On reconciliation, LVN 1 did not administer multivitamin which was ordered for Resident 26. During a concurrent interview and record review on 8/13/24 at 10:41 a.m. with LVN 1, LVN 1 stated she forgot to give the multivitamin (MVI). I missed it. LVN 1 documented the MVI was given but remembers that it was not given to Resident 26 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures (P&P) titled Enteral Tubes, dated 9/18, the P&P indicated 10) crushed medications are not mixed together. The powder from each medication is mixed with water before administration. the souffle cup is rinsed with water to get all of the medication contained within the cup to facilitate the ordered dose. The standard of practice is that crushed medications should not be combined and given all at once via feeding tube 11) Enteral tubes are flush with at least 15 milliliters of water before administrating any medication and after all medications have been administered and 12) each medication is administered separately to avoid interaction and clumping. The enteral tubing is flushed with water between each medication to avoid physical interaction of the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50120 Based on observation, interview, and record review, the facility failed to ensure the safe storage, labeling, open date, expiration date, and disposal of medications and vaccinations. Medications and vaccines were not stored and maintained within standards for safety when: 1. Over the counter eye drops were not labeled with resident's name. 2. Two open inhalers did not have opened dates and one open inhaler was expired and still being used. 3. One aplisol multidose TB vial opened without a documented open date with instructions to discard product after 30 days of being opened. 4. Twenty-one vaccine syringes, stored in medication refrigerator, expired 6/30/2024. 5. Intravenous (IV) heparin flushes were expired 7/20/24 in the emergency kit (E-kit is a limited supply of medication and intravenous supplies for urgent use in a sealed box.) 6. One e-kit was unsealed and had a documented open date of May 2024. 7. Medication/vaccine refrigerator temperature was not monitored twice daily and not consistently monitored daily for eight out of eight months. These failures had the potential to result in residents being given medication and vaccines with questionable potency and efficacy. Findings: During a concurrent observation of medication cart A and an interview on 8/12/24 at 10:09 a.m. with Licensed Vocation Nurse (with LVN) 3, one bottle of over the counter eye drops was in the medication cart without resident's name, two inhalers were opened without an open date (expires 42 days after opening), and one blood glucose test strip bottle opened without an open date (good for six months after opening). LVN 3 stated the eye drops should have a resident's name as eye drops cannot be shared amongst residents. During an observation of floater medication cart B on 8/12/24 at 1:56 p.m. with LVN 2, there was one fluticasone/salmeterol inhaler with an expiration date of 7/10/24 and no open date. LVN 2 stated it has an open date of 7/10/24 and expired one month later, per manufacturer which would have expired on 8/10/24. LVN 2 acknowledged it had been used past the expiration date. LVN 2 stated that using expired medication may alter effectiveness of the medication. Floater medication cart B had one vial of artificial tears with a room number but not a Resident's name, dated 7/3/24. (continued on next page)

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	056447	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Hills Health Care Center	1768 B Street Hayward, CA 94541

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/12/24 at 11:50 a.m. of medication cart B, there was an inhaler with no open date and a notice to discard one month after open date. During a record review of Resident 69's Physican's Order, dated 6/17/24, the Physican's Order indicated an order for Wixela Inhub (fluticasone propion-salmeterol) inhalation blister with device 500-50 micrograms a dose ordered amount to administer 500-50 micrograms pharmacy directions, inhale one puff by mouth twice daily for chronic obstructive pulmonary disease, rinse mouth after use with water. Review of the Medication Administration Record (MAR)showed it was given twice a day, every day in August 2024. During an observation in the medication room [ROOM NUMBER]/12/24 at 10:32 a.m. with Director of Nursing (DON), the locked medication refrigerator had: a. One multidose vial of Aplisol Tuberculin Purified Protein Derivative (TPPD, solution used for skin testing to aid in the diagnosis of active or latent tuberculosis) without an open date. Manufacturer instructions indicate to discard 30 days after opening. b. Twenty-one syringes of flu vaccine with expiration dates of 6/24/24 and 6/30/24. c. Two COVID vaccines with an expiration date of 7/26/24. d. Four pneumovax vaccines with an expiration date of 2/16/24. e. Three intravenous (IV) heparin flushes with an expiration date of 7/20/24. During a concurrent medication room observation and interview on 8/12/24 at 10:40 a.m. with DON, there was an E-kit originally opened May 3, 2024. DON stated the E-kit should be replaced right away after opening. During an interview on 8/12/24 at 11:24 a.m. with Director of Staff Development (DSD), DSD stated aplisol should have been dated once opened and the expired flu vaccine should have been discarded. During interview on 8/14/24 at 10:37, DSD stated that eye drops should have the name of the resident and not the room number as the room changes. During a record review of the Refrigerator Temperature Log, dated 11/24 through 7/31/24, the Refrigerator Temperature Logs indicate 59 days with no temperature monitoring documented for a 24 hour period and the remaining days only had one temperature documented in a 24 hour period. The Refrigerator Temperature Log indicated recording the temperature needs to occur twice per day. During an interview on 8/13/24 at 11:25 a.m. with Pharmacy Consultant (PC), PC stated monthly oversight has been occurring since 2023, which includes checking the refrigerator temperature and expired medications and biologicals. PC stated monitoring the medication refrigerator temperature by staff should occur every shift. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/24 at 11:24 a.m. with DSD, DSD stated temperature of medication refrigerator should be documented twice a day, E-kits should be replaced right away within 72 hours, but pharmacy should be contacted immediately, and inhalers should not be used past the 30 days after opening. During a review of Policy and Procedures titled Medications and Medication labels, dated 5/16 the P&P indicted multi-dose vials shall be labeled to assure product integrity, considering the manufacturers' specification. Nursing staff should document the date opened. Non-prescription medications not labeled by the pharmacy are kept in the manufacturer's original container. Nursing care center personnel may write the resident's name on the container or label as long as the required information is not covered. During a review of P&P titled Emergency Pharmacy Service and Emergency Kits (E-Kit), dated 5/16, the P&P indicated upon removal of any medication or supply item from the emergency kit the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the re-sealed emergency kit until it is scheduled for exchange . the fax sheet will inform the pharmacy of items used from the emergency kit. This will notify the pharmacy to replace the kit or item as applicable per state law. During a review of P&P titled Medication Storage Policies and Procedure, dated 9/18, the P&P indicated medications requiring refrigeration or temperatures between 36 F and 46 F are kept in a refrigerator with a thermometer to allow temperature monitoring. A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49983 Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards of food service safety when: 1. Expired chocolate pudding was observed in the refrigerator. 2. Uncovered frozen soup with white crystals on top was observed in the freezer. These failures had the potential to result in food-borne illnesses or unpalatable food. Findings: During a concurrent observation and interview with the Dietary Manager (DM) on [DATE] at 9:39 a.m., frozen soup that was not securely covered was observed in the freezer. DM stated that the soup was open and appeared freezer burned. DM stated that a potential consequence of freezer burned food is that it might affect the taste of the food when served. During a concurrent observation and interview with the DM on [DATE] at 9:52 a.m., chocolate pudding was observed in the refrigerator with a preparation date of [DATE] and a use by date of [DATE]. DM stated that the chocolate pudding is expired. DM stated that expired foods should not be in the refrigerator or served to residents.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 49983 Based on observation, interview, and record review, the facility failed to clean dishes in a safe and sanitary method when the dishwasher did not reach the required temperature. This failure had the potential to result in 65 residents being served food on dishes that were not sanitized, which could lead to the spread of disease. Findings: During an observation on 8/13/24 at 10:41 a.m. in the kitchen, the highest temperature reached by the dishwasher was 110 degrees ( ) Fahrenheit (F, a unit to measure temperature). During a second observation on 8/13/24 at 10:44 a.m., the highest temperature reached by the dishwasher was 110 F. During a concurrent observation and interview on 8/13/24 at 11:11 a.m. with the Dietary Manager (DM), it was observed that the highest temperature reached by the dishwasher was 110 F. The Dietary Manager stated she would run the dishwasher again. During the second run of the dishwasher, the highest temperature reached was 110 F. The DM stated that the minimum safe temperature for the dishwasher is 120 F. During a concurrent interview and record review on 8/14/24 at 3:41 p.m. with the Maintenance Supervisor (MS), the Maintenance Log was reviewed. MS stated the dishwasher booster (a device that makes the water for the dishwasher hotter) was broken. MS stated the broken booster was not entered in the maintenance log and should be there. During an interview on 8/14/24 at 3:49 p.m. with the facility Administrator (ADM), ADM stated she had not been informed the dishwasher booster was broken and did not know the dishwasher was not reaching the minimum required temperature. During an observation on 8/16/24 at 11:00 a.m. in the kitchen, the highest temperature reached by the dishwasher was observed to be 105 F. During a concurrent observation and interview on 8/16/24 at 11:04 a.m. with DM of the dishwasher temperature, the highest temperature reached by the dishwasher was 105 F. DM stated the dishwasher temperature was not high enough. The DM stated she would run the dishwasher again and the highest temperature reached during the second run was 105 F. DM stated the minimum safe temperature for the dishwasher is 120 F. DM stated that the risk of the dishwasher not reaching the minimum temperature is that the dishes might not be cleaned or sterilized, which is not safe for the residents. During a review of the manufacturer's specifications for the ES2000 dishwasher, titled ES-2000 Dish machine, undated, the manufacturer specified the minimum operating temperature for the wash and sanitizing rinse was 120 F. During a review of the facility's policy and procedure (P&) titled Monitoring Water Temperature, OP3 0809. 01, undated, the P&P indicated the acceptable temperature range for the dishwasher was 120 F to 160 F. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled Repair Requisition, OP3 0801.01 A1, undated, the P&P indicated needed repairs should be documented and the original should be sent to MS and a copy to ADM.