STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105701	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Merritt Island	500 Crockett Blvd Merritt Island, FL 32954

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50401 Based on observation, interview, and record review, the facility staff failed to treat residents with dignity and respect as evidenced by addressing them as, feeders, and not allowing a resident's choice to ambulate freely while waiting for meals, for 4 of 17 residents on the locked memory care unit, (#104, #94, #122 and #61). Findings: 1. On 8/20/24 at 11:16 AM, Certified Nursing Assistant (CNA) K was overheard to question, [Activity Personnel M's name], are you going to feed [resident #104]? Activity Personnel M replied, Sure, who do you want me to feed? CNA K answered, Resident 104. Then CNA K repeated, Resident 104 is a feeder. A short time later, CNA K was asked whether it was appropriate for staff to call residents, Feeders, while speaking about the residents. CNA K replied, I said that? I didn't even realize I said it. She then stated she was aware it was a dignity issue to identify residents using that term. 2. On 8/20/24 at approximately 11:30 AM, Activity Personnel M repeatedly called out resident #94's last name when the resident was starting to leave the lunch area. Activity Personnel M stated she called the resident by her last name because the resident responded when called by her last name instead of her given name. She explained when she called a resident by their last name, it was just a way of referring to them. Activity Personnel M elaborated that this resident used to be on another unit and was called by her last name there as well. On 8/21/24 at 12:40 PM, Nurse Supervisor O stated she herself did not call resident #94 by her last name but referred to her with the prefix or courtesy title of Ms. in front of her last name. In the resident's medical record, it stated this resident preferred name was a shortened version of her first name. 3. On 8/20/24 at 3:50 PM, resident #122 was observed as she tried to leave the dining room area with one sock in her hand. Activity Personnel M asked the resident where she was going and encouraged her to instead stay seated. Resident #122 continued to leave and CNA K redirected resident #122 back to her seat to watch TV. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 4:10 PM, Activity Personnel M stated resident #122 had decreased balance and needed someone to walk with her. She explained, if there was another CNA close by, she would have asked them to stay with the other residents and would have walked with the resident. She was surprised to learn that another CNA was close-by who also redirected the resident to sit back down. 4. On 8/20/24 at 3:52 PM, resident #61, using her walker, headed toward the unit's exit door and stated she was looking for her jacket. CNA L stated, I will find your jacket, go sit in your chair. A short time later at 4:10 PM, resident #61 got out of her chair and started walking with her walker and again asked about her jacket. CNA L redirected resident #61 back to the chair and parked her walker to the side of the chair telling her dinner would be there soon even though it was over an hour until dinner was scheduled for that unit. CNA L stated she redirected the resident to sit in the chair instead of allowing her to walk around because she was afraid the resident would fall. On 08/22/24 at 1:38 PM, Nurse Supervisor N stated if a resident was able to walk on their own safely, CNAs were expected to let them walk or if not safe, instead walk with them. She stated resident #61 did not usually go far, was pretty safe to ambulate on her own, and realized her limitations. Nurse Supervisor N explained resident #61 didn't usually try to leave but would use her walker to go to her room. Nurse Supervisor N stated she trained the CNA's that it was important for residents to be able to walk and wander, otherwise they would get restless and eventually would forget how to walk. On 8/21/24 at 1:18 PM, the Lakeside Unit Manager stated if a resident got up to walk around, CNA's were expected to assist them as needed because walking around was good for them. It maintained their mobility and gave them a sense of well-being. On 8/22/24 at 3:45 PM, the Activities Director stated If you don't use it, you will lose it, when discussing the importance of residents being allowed to walk when they wanted to walk. On 8/22/24 at 3:21 PM, Nurse Supervisor N, stated she trained the CNAs to treat residents with dignity. She explained, some of the staff had worked on this unit for many years and perhaps had developed habits that were difficult to break. The facility's Policy on Dignity dated 2/27/20 stated residents would be cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality. This policy indicated residents would be called by their name of choice, in a manner to promote dignity and would be assisted in the activities of their choice.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to implement its abuse prohibition policy and procedures related to an allegation of mistreatment by 1 of 2 residents reviewed for abuse, of a total sample of 51 residents, (#146). Findings: Review of the medical record revealed resident #146, an [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy or a brain disorder, and adult failure to thrive. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 7/12/24 revealed resident #146 had clear speech and was usually able to express her ideas and wants. The resident's Brief Interview for Mental Status score was 15/15 which indicated she was cognitively intact. The MDS assessment revealed during the 14-day lookback period, resident #146 showed no evidence of acute onset mental status change. She exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. The document revealed the resident required substantial to maximal assistance to roll from left to right in bed and to maintain personal hygiene. She was totally dependent on staff for toileting hygiene and bathing. On 8/19/24 at 2:28 PM, resident #146 described an incident that occurred with a Certified Nursing Assistant (CNA) within the previous two to three days, during the day shift. The resident said, She was very rough while turning me. She does not tell me when she is doing anything. The resident explained the CNA habitually rolled her quickly from side to side without warning her or explaining what she was going to do, and was not gentle. When asked if she reported the incident to anyone, resident #146 confirmed she asked someone to get the head nurse to come to her room. The resident could not recall the name of the CNA who was rough with her nor the name of the nurse who responded. She stated she told the nurse the CNA was rough with her and she did not want that person assigned to her again. On 8/19/24 at 2:41 PM, the Riverside Unit Manager (UM) stated she was not aware of an allegation of rough treatment by resident #146. On 8/19/24 at 2:44 PM, resident #146 repeated the allegation as she informed the Riverside UM that a CNA was rough with her during care. The resident told the UM that the CNA had been rough with her several times before, but she finally had enough that day, and decided to tell a nurse. On 8/19/24 at 2:47 PM, when asked about the facility's policy to prevent abuse, the Riverside UM stated the nurse who resident #146 spoke with should have reported the information to the supervisor. She acknowledged any employee who was made aware of a grievance, concern, or an allegation of mistreatment, abuse, or neglect should report it to a supervisor immediately to ensure the information was properly passed along to facility administration. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 2:51 PM, the facility's Administrator was informed of resident #146's allegation of rough care by a CNA. He confirmed staff were expected to follow all policies and procedures for prevention of abuse and neglect. On 8/19/24 at 3:39 PM, the Administrator stated he interviewed resident #146 and she confirmed she felt abused while she was being repositioned in bed by a CNA. He explained the resident was able to describe the CNA, and after review of the schedule, the preliminary investigation showed the resident referred to CNA J. The Administrator said, [The resident] said a nurse came in and she explained everything to the nurse. It was not reported to us. He stated his expectation was the nurse should have reported the allegation so it could have been thoroughly investigated by the Risk Manager (RM). The Administrator verified residents did not have to use the word abuse to ensure an allegation was investigated. He explained at the very least, the concern should have triggered the grievance process, and it would have been escalated to an abuse investigation if indicated. On 8/19/24 at 5:32 PM, the Administrator stated the facility's investigation showed resident #146's assigned nurse on the day of the incident was Licensed Practical Nurse (LPN) B. He explained LPN B denied the resident told her she was abused by CNA J. He acknowledged even if the word abuse was not used, it was not LPN B's decision whether it was an abuse situation or not. He said, But the nurse wrote it up as a grievance on Friday and we just haven't had time to go over them yet. You guys showed up this morning. However, the Administrator reviewed the grievance log and confirmed resident #146's concern was not recorded on the document. On 8/20/24 at 10:07 AM, LPN B confirmed she was resident #146's assigned nurse on the day of the alleged abuse incident. She recalled she responded to the resident's call light and was also told by CNA J that the resident wanted to speak to her. LPN B stated the resident seemed a little confused and said she did not care for the CNA's personality as she, did not seem to be that nice. She denied the resident reported the CNA was rough with her. LPN B explained resident #146 sometimes had memory problems and was only alert and oriented 60% to 70% of the time. LPN B refuted the Administrator's statement and denied she wrote a grievance form on the day of the incident. She recalled the resident expressed the concern towards the end of the day shift, and instead of writing a grievance form, she called the facility's Social Services Director (SSD) and left a message for her regarding resident #416 not caring for CNA J's personality. LPN B then corrected herself and stated she actually had a telephone conversation with the SSD, who told her thanks for the information and she would take care of it. LPN B stated the SSD did not ask if CNA J was removed from resident #146's assignment. She acknowledged she did not document her conversations with either the resident or the SSD in the medical record. LPN B scrolled through her personal phone and provided the SSD's telephone number. On 8/20/24 at 10:23 AM, the facility's SSD stated the telephone number provided by LPN B was her personal cell phone number. However, she denied receiving a telephone call from LPN B regarding any issues concerning resident #146. She reviewed her cell phone log for Friday 8/16/24 and emphasized there were no calls from LPN B. The SSD stated she was not aware of the incident involving resident #146 and CNA J until the facility was informed by the State Survey Agency on 8/19/24. She verified resident #146 was cognitively intact and her complaint of unsatisfactory care or rough treatment should have been recorded and reported. The SSD explained there are evening supervisors in the building every day, and on the weekends there are both a weekend supervisor and a manager on duty. The SSD stated LPN B should have reported the resident's concerns to the supervisor on site. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure for Resident Mistreatment, Neglect and Abuse Prohibition, dated 1/24/23, revealed the facility was committed to protecting the physical and emotional well-being of every resident. The document indicated the definition of abuse was the willful infliction of injury or intimidation that resulted in physical harm, pain, or mental anguish. The document revealed mandated reporting was a legal obligation to formally report suspected or witnessed abuse or mistreatment of residents. Residents and staff would be able to report any concerns, incidents, or grievances, and supervisory and administrative staff would provide regular direct/indirect supervision of nursing home employees and resident care. The policy read, All employees are required to immediately report the facts of known or suspected instances of abuse to their direct supervisor on duty, Abuse Coordinator, Administrator, and/or Director of Nursing (either directly or anonymously), so that the facility responsibilities to protect residents and promptly investigate occurrences can be met.

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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** 36489 Based on observation, interview, and record review, the facility failed to implement the comprehensive care plan related to interventions to prevent falls and injuries for 1 of 5 residents reviewed for accidents, of a total sample of 51 residents, (#51). Findings: Review of the medical record revealed resident #51, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included syncope and collapse, dementia, anemia, vertigo, anxiety, and stroke. The Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 6/13/24 revealed resident #51 had a Brief Interview for Mental Status score of 6 which indicated she had severe cognitive impairment. The document revealed the resident exhibited fluctuating inattention and disorganized thinking that varied in severity. The MDS assessment indicated the resident displayed no behavioral symptoms and did not reject evaluation or care that was necessary to achieve the resident's goals for health and well-being. Resident #51 had functional limitation in range of motion with impairment of both lower extremities. She was dependent on staff for toileting hygiene, lower body dressing, and transfers between her bed and wheelchair. The MDS assessment revealed resident #51 had one fall with no injury since admission or the prior assessment. Review of the medical record revealed resident #51 had a care plan for risk for falls related to impaired mobility, weakness, history of falls, vertigo, and vision impairment, initiated on 6/15/22 and edited on 7/08/24. The goal was the resident would have a reduced risk for injury related to falls. The care plan approaches included keep the resident's bed in a low position for safety, apply hipsters while in bed, encourage use of geri-sleeves, provide a perimeter mattress with raised sides, and place bilateral floor mats when she was in bed. The care plan indicated staff could remove the hipsters to perform skin checks and hygiene. Hipster garments look like shorts with pads on the hip areas to protect bones from injuries associated with falls. Geri-sleeves are a stocking-type garment for the extremities that protects against injuries such as skin tears. On 8/20/24 at 1:16 PM, resident #51 was observed in her room with her bed in low position. A handwritten sign posted on the wall above the bed revealed instructions to ensure the bed was lowered to the floor as the resident experienced increased anxiety since she fell out of bed. Photographic evidence was obtained. There were two floor mats leaning against the wall next to the door and the resident did not wear geri-sleeves on her arms. Certified Nursing Assistant (CNA) A explained she completed personal hygiene care for the resident after lunch and left her in bed to rest. She acknowledged she did not place the floor mats on both sides of the bed before she left the room. When asked if the resident wore a hipster garment, CNA A said, We don't put the hipsters on anymore.they are uncomfortable. We told the daughter and she said it's ok. CNA A explained sometimes resident #51 would remove the geri-sleeves, but she did not respond when asked if she applied them this morning. CNA A stated the facility's system for communication of care directives for each resident was a paper form located in a plastic sleeve on the back of the room door. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Care Card/Information Sheet for resident #51 revealed a section designated for Fall Management that included one approach, use of a one-way glide device in her wheelchair. The document did not reflect any of the fall and injury prevention interventions listed in the comprehensive care plan. The active care plan approaches of right and/or left fall mats, low bed, and hipsters were not checked off on the document, and the need for geri-sleeves was not noted. On 8/20/24 at 1:23 PM, the Risk Manager (RM) confirmed the facility did not have a fully electronic care card system and CNAs were expected to obtain care instructions from the paper form that was kept in the resident's room. On 8/20/24 at 4:49 PM, CNA C stated she was on staff for over seven months and was resident #51's regularly assigned evening shift CNA. During joint observation of resident #51, she validated the resident still did not wear geri-sleeves and she had not attempted to apply them since her arrival at 2:00 PM. When asked if she usually applied the resident's hipsters, CNA C said, I don't know what they are. On 8/20/24 at 4:54 PM, the Riverside Unit Manager (UM) was informed of concerns regarding the CNAs' access to and knowledge of fall prevention interventions to ensure the care plan approaches were appropriately implemented for resident #51. She was told the resident's fall mats, hipsters, and geri-sleeves were not in place during the day shift, and the resident still did not have geri-sleeves or hipsters placed for the evening shift. The UM acknowledged if the regularly assigned CNA did not know what hipsters were, then she probably had not been providing the garment for the resident. She stated her expectation was staff would ask the assigned nurse for clarification if they did not understand care directives. On 8/20/24 at 4:56 PM, the Riverside UM entered resident #51's room and described the hipster garment to CNA C. They both searched the resident's shelves, dresser drawers, and closet, but neither staff member was able to locate hipsters. The UM stated CNAs were to follow instructions on the resident's care cards. She retrieved resident #51's care card and verified the comprehensive care plan interventions were not transcribed to the document. On 8/21/24 at 12:13 PM, the Lead MDS Coordinator explained fall prevention interventions were usually added to residents' care plans by the RM. She confirmed floor nurses and UMs could initiate care plan interventions and they were responsible for updating the CNA care card to reflect revised approaches. The Lead MDS Coordinator stated care plan interventions would not be effective if they were not documented and made available to direct care staff. On 8/21/24 on 1:54 PM, in a telephone interview, resident #51's daughter explained she was familiar with her mother's care as she visited at least five days a week and she was also the primary contact person. She confirmed her mother had a couple falls from bed so she created and placed the sign above her mother's bed to remind staff to keep it in a low position. The resident's daughter said, I still find the bed in a high up position sometimes. When asked if her mother tolerated the hipsters as an intervention to prevent injury, resident #51's daughter stated she did not understand the question. After being given a description of the garment, the daughter said, That all sounds good, but I have never heard of that. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 1:34 PM, the Director of Nursing (DON) stated her expectation was nurses would initiate appropriate fall prevention interventions immediately after a fall. She explained when the interdisciplinary team met to identify the root cause of a fall, interventions might be modified if necessary. The DON stated the RM was responsible for adding new interventions to residents' care cards and UMs were responsible for auditing the care cards to ensure accuracy. The DON acknowledged the purpose of a complete and accurate care card was to ensure residents received appropriate care. Review of the facility's policy and procedure for Comprehensive Care Plans (undated) revealed each resident would have an individualized, comprehensive care plan developed to meet his/her medical and nursing needs. The policy indicated the comprehensive care plan would incorporate identified problem areas, risk factors, wishes regarding care and treatment goals, and reflect current standards of practice. The document read, Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. The facility's policy and procedure for Using the Care Plan, dated 1/30/24, read, The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care and services to the resident. The policy indicated care cards would list necessary care plan interventions for CNA would be updated as needed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36489 Based on observation, interview, and record review, the facility failed to provide adequate activities of daily living (ADL) care related to personal hygiene for 1 of 1 resident reviewed for ADLs, of a total sample of 51 residents, (#146). Findings: Review of the medical record revealed resident #146, an [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy or a brain disorder, and adult failure to thrive. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 7/12/24 revealed resident #146 had clear speech and was usually able to express her ideas and wants. The resident's Brief Interview for Mental Status score was 15/15 which indicated she was cognitively intact. The MDS assessment revealed during the 14-day lookback period, resident #146 showed no evidence of acute onset mental status change. She exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. The document revealed the resident required substantial to maximal assistance to maintain personal hygiene. Review of the medical record revealed resident #146 had a care plan for ADLs, initiated on 7/14/23. The document indicated she was unable to complete ADLs independently due to weakness and dementia, preferred to wear gowns and kept her fingernails long. The goal was resident #146 would have her ADL needs met daily, with staff assistance. The approaches included, assist with hygiene as needed. A care plan for behaviors related to cognitive impairment, initiated on 7/26/23, had the goal that the resident would have fewer episodes of resisting care. The care plan approaches directed staff to divert the resident's attention, re-approach her later when agitated, discuss behaviors when unacceptable, reinforce positive behaviors, and anticipate her needs. On 8/19/24 at 11:16 AM, resident #146 lifted both hands to show that all fingernails were long and dirty. The resident's fingernails extended approximately one-half inch or more past her fingertips and there was a significant amount of a dark brown to black substance packed tightly under all fingernails. Resident #146 unsuccessfully attempted to use the tip of one fingernail to dislodge the substance under another fingernail. The resident explained she liked her fingernails long but would never keep them as dirty as they were if she had a choice. She emphasized she definitely did not want to eat with fingernails that looked the way they did. Resident #146 could not recall when she last received nail care and said, It has been a while. She stated the situation was not really the fault of staff as they were often too busy to do little things like clean her hands and trim her fingernails. The resident explained she planned to ask someone to give her a basin so she could soak her fingernails. Certified Nursing Assistant (CNA) A entered the room and stated she was not assigned to resident #146, but overheard the conversation, and would provide nail care for her. CNA A validated the resident's fingernails were long and very dirty. She confirmed all CNAs were responsible for personal hygiene care, and residents should receive nail care at least twice weekly on shower days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 2:27 PM, resident #146 unwrapped small chocolates and held them in her fingers as she ate them. She showed her fingernails and stated she was happy they were finally clean. The resident confirmed she liked her fingernails, to be a little long, but nothing like this. Resident #146 held a chocolate between her right thumb and index finger to demonstrate how difficult it was to grasp food, and keep the nails clean when her fingernails were that long. On 8/19/24 at 2:39 PM, the Riverside Unit Manager (UM) stated nail care should be done with daily ADL care, by staff on any shift. She said, There is no reason nail care should not be done regularly. On 8/19/24 at 2:42 PM, resident #146 informed the Riverside UM that a CNA soaked her fingernails earlier in the day. She told the UM the CNA had to, dig out the dirt, and she now wanted her fingernails trimmed shorter. The resident informed the UM she could pay for a manicure if necessary, but the UM reassured her that cleaning and trimming her nails were regular tasks to be performed by CNAs. Review of the CNA Shower Sheet/Skin Inspection forms for August 2024 revealed CNA documentation that resident #146 received bed baths on 8/07/24, 8/10/24, 8/13/24, and 8/17/24. The forms indicated the resident, refused nail care. Review of nursing progress notes for August 2024 revealed no evidence nurses were made of aware of multiple refusals of care by resident #146. There was no documentation to show nurses noted the condition of the resident's fingernails during daily interactions with her. The progress notes did not indicate nurses instructed CNAs to perform nail care or that they implemented any of the care plan approaches developed to address refusals of care. Review of the facility's policy and procedure for Supporting Activities of Daily Living, revised on 1/25/23, revealed residents who were unable to independently perform ADLs would receive the services necessary to maintain good grooming and personal hygiene.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to ensure an individualized activities program was provided for 1 of 2 residents reviewed for Activities, of a total sample of 51 residents, (#156). Findings: Review of the medical record revealed resident #156, an [AGE] year old female was admitted to the facility on [DATE] with diagnoses of left hip fracture, difficulty in walking, cognitive communication deficit, psychotic disturbance, dementia, Alzheimer's Disease, mood disorder, depression, and anxiety. The Minimum Data Set (MDS) Modified Admission assessment with an Assessment Reference Date (ARD) of 7/14/24 identified during the look back periods, resident #156 often required help with reading. The Brief Interview for Mental Status score of 3 out of 15 indicated the resident was severely cognitively impaired. The assessment showed she had inattention that fluctuated, and she often felt lonely or isolated from those around her. No behaviors or rejections of evaluation or care were noted. The resident's Functional Abilities and Goals of everyday activities showed she was dependent on staff to eat, complete Activities of Daily Living (ADL), mobility functions, walk or transport herself out of her room, and she was always incontinent of bladder and bowel functions. The Preferences for Customary Routine and Activities section documented it was very important for the resident to listen to music she liked, keep up with the news, do favorite activities, go outside for fresh air in good weather, and do things with groups of people. The Comprehensive Care Plan's focuses included impaired ambulation, inability to independently complete ADLs, decreased strength/endurance, adverse effects of psychotropic medications, memory problems, confusion and forgetfulness. Interventions included staff to encourage visits from family, friends, and volunteers and involve her in facility activities. Another focus for a risk for decline in mood/behavior related to depression had an intervention to assist in setting a structured routine; reinforce physical activity, socialization, and encourage visits from family, friends, and volunteers. The Recreation/Wellness Problem created by the Activities Director read, Dependent of staff for activities, cognitive stimulation, and social interaction . Approach adapt activities of preference to cognitive level and skill function. Allow patient/resident to be a spectator in activities. Invite to food related activities . Provide activities in an outside setting . Verbally check with patient/resident/or family frequently to determine satisfaction in activities. On 8/20/24 at 10:29 AM, resident #156 was observed alone in her room approximately 50 feet from the nurse's station. She was sitting in a wheelchair with her head down towards her lap. She looked up and asked, Where are all the girls? The handwritten Activity Admission 72 Hour Note completed by the Activities Director showed information was obtained from resident #156's family. It was noted the resident's former vocation was a realtor, and it was very important for her to have music (oldies), keep up with the news, go outside on walks, paint, play bingo, card games, and bridge, and see comedy. The form read, Loves to be around people . going out to lunch with friends . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 11:19 AM, the resident was observed in her room awake and lying in bed. The resident looked anxious and restless while she repeatedly pulled at the bed cover. On 8/21/24 at 11:24 AM, the Activities Director explained she was responsible for the facility's Activities program. She said the department coordinated and provided activities for residents, and she conducted interviews with residents and/or their family to develop and implement individualized care plans. On 8/21/24 at 11:35 AM, the Activities Assistant explained resident #156 sometimes participated in manicures and she enjoyed socializing with the ladies. She stated, She looks through a book or she watches TV (television). On 8/21/24 at 12:04 PM, five residents were observed in the Bayside dining room for lunch. Certified Nursing Assistants (CNAs) P and Q assisted the residents with eating. CNA P explained resident #156 ate in her room and he was provided a list of residents who needed assistance to get to the dining room for meals by the Bayside Unit Manager. On 8/21/24 at 12:15 PM, the Bayside Unit Manager said the Dietary Menu Development Coordinator provided a list of residents that ate in the dining room, and it was kept at the nurse's station for the CNAs. On 8/21/24 at 1:52 PM, CNA P explained he often had resident #156 on his assignments, and was not aware of what activities she liked. He could not recall any times she participated in group activities. The CNA stated, That's a good question; I usually get her up in a chair and have her in the hallway but today I had to go to the dining room. On 8/22/24 at 1:27 PM, the Dietary Menu Development Coordinator explained that Unit Managers provided a list of residents on their unit who ate in the group dining room to the Registered Dietician. She said she didn't have input for who goes on the list, and she only typed it up and gave it to the Unit Managers. Review of the list of residents who ate in group dining provided by the Bayside Unit Manager included 7 residents on the unit who participated in group dining. Resident #156 was not on the list. On 8/22/24 at 9:27 AM, an overhead announcement was heard for group activities on the Bayside Unit. At 10:13 AM, the Bayside Unit Manager said the Activities staff had not arrived yet for group activities. At 10:35 AM, no residents were observed in the unit's TV/group room/common area. On 8/22/24 at 10:38 AM, resident #156 was observed sitting in her room in a wheelchair pulling at her clothing. The TV was not on nor were there any reading materials observed within reach of the resident. The resident stated, I don't know if my daughter is coming. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with resident #156's daughter, she recalled that about one month prior, the Activities Director asked her a lot of questions about her mother's normal preferences and activities. She was distressed when she explained she had asked nursing staff to take her mother to the dining room and help her participate in group activities. She said two days prior, she wheeled the resident down to an exercise class. She said she watched through the window and saw her participating while she had her hands up and seemed to enjoy it. She stated, I have seen them maybe a total of three times get her out of her room and they put her in that room where the TV is and leave her there; it makes her feel better to be out of her room and socialize; they don't take her outside, she likes that very much; she always enjoyed going out and eating with friends; she is still able to socialize if she's in the right environment; even when I wheel her down the hall she starts talking to people and she lights up, I think, there's my mom. On 8/21/24 at 11:24 AM, the Activities Director said the CNAs were responsible for assisting residents out of their rooms for activities. She did not explain why resident #156 spent most of her time in her room. On 8/22/24 at 1:30 PM, the Bayside Unit Manager explained residents who needed assistance with eating or who preferred to, ate in the group dining area. She said it was important to assist the residents to ensure they were eating well, getting adequate nutrition, and they could socialize. She said resident #156 normally did not come out of her room and she ate her meals there because that was her daughter's preference. She stated, I'm not sure why she hasn't been in the day room; I will look into that. On 8/22/24 at 10:42 AM, the Social Services Director explained it was important for residents to have activities for emotional support and adjustment disorders. She said going outside, getting involved with activities, and socializing helped with residents' depression, eating, and sleeping. She stated, Isolation can cause people to be depressed or withdraw even more; it's important to stimulate them and try to get them involved in interactions. Review of the facility's standards and guidelines dated 2/27/20 and titled 2.8 Activities Programs read, . Our activities programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interest of each resident .Social activities are scheduled to increase self-esteem, to stimulate interest and friendships, and to provide fun and enjoyment .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to ensure oxygen was administered as ordered by the physician, in accordance with professional standards, for 2 of 3 residents reviewed for respiratory care, of a total sample of 51 residents, (#57 and #77). Findings: 1. Review of the medical record revealed resident #57, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included hypertensive heart disease with heart failure, history of COVID-19, and cardiomegaly or an enlarged heart. Resident #57 had a terminal condition, end-stage heart disease, with a projected life expectancy of six months or less. The Minimum Data Set (MDS) Annual assessment with assessment reference date (ARD) of 7/08/24 revealed the resident's Brief Interview for Mental Status (BIMS) score was 12 which indicated the resident had moderate cognitive impairment. The MDS assessment indicated resident #57 displayed no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. The document revealed the resident received oxygen therapy. According to the American Heart Association, oxygen therapy is one of the treatments used to improve the quality of life for persons with a diagnosis of heart failure. Delivery of concentrated oxygen to the lungs increases the amount of oxygen in the blood and improves shortness of breath, (retrieved on 8/26/24 from www.heart. org/en/health-topics/heart-failure/treatment-options-for-heart-failure/medications-used-to-treat-heart-failure). Review of the medical record revealed resident #57 had a care plan for the risk for complications related to cardiac disease, initiated on 8/21/20. The interventions included observe for signs and symptoms of cardiac complications such as chest pain and shortness of breath, and administer oxygen as ordered. A care plan for risk of complications related to respiratory disease, initiated on 7/17/24, revealed resident #57 was dependent on supplemental oxygen. The goal was the resident would not develop signs and symptoms of respiratory complications. The interventions instructed nursing staff to monitor for respiratory concerns including shortness of breath and administer oxygen as ordered. Review of resident #57's medical record revealed a physician order dated 8/20/20 for oxygen at 2 liters per minute (L/min) via nasal cannula, every shift, 7:00 AM to 7:00 PM, and 7:00 PM to 7:00 AM. On 8/19/24 at 11:06 AM, resident #57 was in bed and wore a nasal cannula. The tubing was connected to an oxygen concentrator at the right side of her bed, out of the resident's reach, which was set at a flow rate of 1 L/min. An Advanced Practice Registered Nurse entered the room and explained whenever she assessed the resident, the concentrator was usually set at 1 L/min. She suggested it was possible the attending physician's order was to titrate the resident's oxygen flow rate between 1 and 2 L/min. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 11:07 AM, Licensed Practical Nurse (LPN) D confirmed she was resident #57's assigned nurse. She checked the physician order for oxygen therapy and stated the resident's oxygen flow rate should be 2 L/min. She inspected the oxygen concentrator and validated the machine was set at a flow rate of 1 L/min. LPN D explained nurses were required to document on the resident's oxygen use once per shift and she would could do that at any time between 7:00 AM and 7:00 PM. LPN D verified she administered resident #57's scheduled morning medication earlier in the shift, but she did not check the oxygen concentrator while she was at the resident's bedside. On 8/20/24 at 4:32 PM, the Riverside Unit Manager (UM) validated it was important to follow physician orders for oxygen administration. She stated her expectation was the nurse would check the flow rate at the beginning of the shift or at the time of administration of morning medications. The UM explained resident #57 required oxygen therapy as she has a history of the respiratory virus, COVID-19, and had been dependent on oxygen for several years due to a diagnosis of heart failure. 2. Review of the medical record revealed resident #77, a [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included dementia, anemia, and insomnia. Resident #77 had a terminal condition, cerebral atherosclerosis, with a projected life expectancy of six months or less. The MDS Annual assessment with ARD of 6/14/24 revealed resident #77 had a BIMS score of 15 which indicated she was cognitively intact. The MDS assessment revealed the resident had no acute onset mental changes, no behavioral symptoms, and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. The document showed the resident received oxygen therapy. Review of the medical record revealed resident #77 had a care plan for risk for complications related to respiratory disease, initiated on 1/11/24. The goal was the resident would not develop signs or symptoms of respiratory complications. The approaches included observe for signs and symptoms of respiratory complications and administer oxygen as ordered. Review of resident #77's medical record revealed a physician order dated 3/14/24 for oxygen at 2 L/min via nasal cannula, to keep oxygen saturation levels above 92% every shift, 7:00 AM to 7:00 PM, and 7:00 PM to 7:00 AM. Review of the Medication Administration Record (MAR) for August 2024 revealed from 8/01/24 to 8/19/24 there was no documentation of resident #77's oxygen saturation levels. On 8/19/24 at 11:13 AM, resident #77 was seated in a wheelchair beside her bed. She had a nasal cannula in place connected to an oxygen concentrator located out of reach, behind the wheelchair. The oxygen flow rate was set at 3 L/min. On 8/19/24 at 11:20 AM, LPN D, resident #77's assigned nurse, reviewed the physician orders and stated the resident's oxygen flow rate was supposed to be 2 L/min. On 8/19/24 at 11:22 AM, LPN D validated resident #77's oxygen concentrator was incorrectly set at 3 L/min. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 4:38 PM, the Riverside UM reiterated nurses should check oxygen concentrators when they entered residents' rooms. She explained oxygen orders were listed on the electronic MAR and were easily visible when nurses prepared medications for administration. The UM stated resident #77 required oxygen therapy related to a history of COVID-19. On 8/22/24 at 12:24 PM, the Riverside UM confirmed the physician order for oxygen therapy indicated nurses were to assess resident #77's oxygen saturation levels every shift. The UM validated the resident's oxygen level was not routinely monitored prior to 8/19/24 when noted by State Survey Agency staff. She explained the MAR was revised on 8/20/24 to reflect the requirement for documentation of oxygen saturation levels every shift. On 8/22/24 at 1:30 PM, the facility's Director of Nursing (DON) provided a record of resident #77's oxygen saturation levels from June to August 2024. The document revealed between 6/01/24 and 8/17/24, the residents oxygen level was checked only seven times during the 11-week period. The DON acknowledged nurses did not obtain and document the resident's oxygen saturation levels as ordered. Review of the facility's policy and procedure for Oxygen Administration, dated 1/30/24, revealed the purpose was to provide guidelines for safe oxygen administration. The policy instructed nursing staff to review the resident's physician order or protocol for oxygen administration, check the tubing and start the flow of oxygen at the ordered rate. The document read, Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to administer medications according to physician orders to prevent medication errors for 2 of 5 residents reviewed during the Medication Administration task, of a total sample of 51 residents, (#33 & #62). There were 4 errors in 29 opportunities for a medication error rate of 13%. Findings: 1. Review of the medical record revealed resident #33, a [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included unspecified pain and constipation. Resident #33 had a care plan for risk of developing pain related to a thigh wound, acid reflux, and a potential for abnormal bowel pattern, initiated on 7/03/23. The goal was the resident would experience pain reduction or relief. The care plan approaches instructed nurses to administer pain medications according to the physician's order. Review of the Physician Order Report revealed resident #33 had an order dated 3/13/24 for Colace 100 milligrams (mg) twice daily for constipation, scheduled at 9:00 AM and 5:00 PM. The document showed an order dated 3/21/24 for Ibuprofen 400 mg twice daily for pain, scheduled at 9:00 AM and 5:00 PM. On 8/19/24 at 4:24 PM, Licensed Practical Nurse (LPN) D stood at her medication cart. She stated she was ready to administer resident #33's scheduled 5:00 PM medication. She removed a blister pack from the drawer and placed one tablet of Ibuprofen 400 mg in a medication cup. She reviewed the electronic Medication Administration Record (MAR), closed her computer screen, and entered the resident's room to administer the tablet. After resident #33 swallowed the tablet, LPN D returned to the medication cart to record the medication administration task as completed. During the process of reconciling resident #33's physician orders with the MAR, there was a discrepancy identified. The MAR showed LPN D's initials to validate she administered two medications, the scheduled 5:00 PM doses of one tablet Ibuprofen 400 mg and one capsule Colace 100 mg. On 8/20/24 at 4:23 PM, the Riverside Unit Manager (UM) was informed resident #33's medical record showed LPN D administered his Colace 100 mg capsule although it was not given during observation of medication administration. She stated the nurse could have realized she forgot the medication and then returned to administer it at a later time. The UM provided a record of the actual administration time of Colace 100 mg. Review of the detailed Administration History revealed LPN D documented administration of both scheduled medications, Ibuprofen 400 mg and Colace 100 mg, on 8/19/24 at 4:27 PM. The UM stated her expectation was nurses would administer scheduled medications as ordered, and accurately record administration at the time it occurred. On 8/22/24 at 3:05 PM, LPN D validated she administered only one tablet during the medication administration observation on 8/19/24. She was unable to explain why she documented administration of two drugs instead of one. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed resident #62, an [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included atrial fibrillation, hypertension, anemia, generalized muscle weakness, and long-term use of anticoagulant or blood thinner medication. Resident #62 had a care plan for risk for abnormal bleeding or hemorrhage because of anticoagulant use, initiated on 3/20/23 and reviewed/revised on 5/21/24. The goal was the resident would be free from signs and symptoms of abnormal bleeding. The approaches included administer anticoagulant medication as prescribed. Review of the medical record revealed a care plan for risk of complications related to cardiac disease diagnoses including hypertension and atrial fibrillation, initiated on 3/20/23. The goal was the the resident would not develop signs or symptoms of cardiac complications. The approaches instructed nurses to administer medications as ordered. Resident #62 had a care plan for receiving crushed medication related to difficulty swallowing whole tablets, initiated on 10/25/23. The goal was the resident would tolerate crushed medications without difficulty. The approaches included crush medications as ordered and, Meds may be crushed (if med crushable) and administered as a single oral bolus as the benefits outweigh the risks of individual administration [due to] difficulty swallowing. Review of the Physician Order Report revealed resident #62 had physician orders dated 5/07/24 for Dabigatran etexilate 150 mg twice daily for atrial fibrillation, one tablet Daily Multivitamin supplement once daily, and Ferrous sulfate 325 mg once daily for anemia. On 8/20/24 at 9:35 AM, LPN E prepared to administer resident #62's scheduled morning medications. She retrieved blister packs from a drawer of the medication cart and place medication including one capsule Dabigatran etexilate 150 mg, one tablet Daily Multivitamin with Minerals, and one tablet Ferrous sulfate 325 mg in a medication cup. LPN E explained resident #62 had difficulty swallowing and her medication had to be crushed and given in food, either applesauce or pudding. She proceeded to crush all the tablets and placed them in another medication cup, then she opened the capsule and sprinkled its contents on top of the crushed tablets. LPN E mixed the medication into the resident's preferred food and administered the medication. On 8/20/24 at 11:21 AM, and 11:47 AM, after reconciliation of resident #62's medication orders with the MAR, LPN E was asked to compare the resident's order for a Daily Multivitamin to the bottle she had in the medication cart. She read the bottle and confirmed she administered a Multivitamin with Minerals. She checked the unit's medication room and stated there was no plain multivitamin available. LPN E stated she had not noticed the discrepancy during medication administration. She acknowledged it was essential to read containers carefully and compare them to physician orders prior to administration. She was asked to retrieve the bottle of Dabigatran and joint review of the label revealed the instruction, Swallow capsule whole. LPN E stated she had not noticed the warning. She verified she should have called the physician regarding the resident's inability to swallow the capsule and requested another form or type of medication. LPN E checked the bottle of Ferrous Sulfate and stated there were no instructions regarding not crushing the drug. When prompted to pour a Ferrous Sulfate tablet from the bottle, she noted it had a shiny coating. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 11:50 AM, LPN E contacted the facility's pharmacy to clarify medication administration instructions for resident #62 related to her inability to swallow medications whole. During the conversation on speakerphone between pharmacy representatives and LPN E, she was told Dabigatran capsules should not be opened and Ferrous Sulfate tablets should not be crushed. The pharmacy representative recommended contacting the resident's physician to obtain appropriate orders. On 8/20/24 at 1:26 PM, the Central Supply staff stated the facility's formulary included only Multivitamins with Minerals tablets, not Daily Multivitamins. He explained if a resident needed a plain multivitamin, nurses would have to get it ordered from the pharmacy or he could obtain it from a local pharmacy. On 8/20/24 at 4:09 PM, the Riverside UM acknowledged all nurses should follow the facility's policies and procedures and accepted standards of nursing practice for medication administration. She stated her expectation was nurses would read all medication labels carefully and follow the five rights of medication administration. The UM confirmed resident #62's nurses should have identified potential concerns related to crushing her medication and opening the capsule, and called the physician, researched drug manufacturers' instructions, or called the pharmacy. Review of the facility's policy and procedure for Medication Administration - General Guidelines, revised in January 2018, revealed medications would be administered as prescribed in accordance with good nursing principles and practices. The document listed the five rights of medication administration as the right resident, right drug, right dose, right route, and right time. The policy instructed staff to practice a triple check method that involved first selecting the medication and checking the label, container, and contents for integrity, and comparing it to the MAR. The second check was to be done during preparation of the dose by removing the drug from container and verifying it against the label and MAR. The third check was to occur during completion of dose preparation when nurses would re-verify the label against the MAR. The policy read, If it is safe to do, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing. The document instructed nurses to check with the pharmacist before opening capsules or crushing tablets to identify alternative medications if indicated.

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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 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** 36489 Based on observation, interview, and record review, the facility failed to secure one (1) treatment cart to prevent unauthorized access and promote resident safety, (Riverside), and failed to properly store medications and bottles of liquids in four (4) medication carts and one (1) treatment cart, (Bayside, Oceanside, and Riverside), for 6 of 8 carts inspected during the Medication Storage task, of a total of 14 medication/treatment carts. Findings: 1. On 8/19/24 at 10:15 AM, the 300 hallway treatment cart was observed between rooms [ROOM NUMBERS], on the Riverside Unit. The drawers faced the hallway and the lock protruded from the cart to indicate it was unlocked. All drawers opened smoothly and the contents of each drawer were easily accessible. On 8/19/24 at 10:18 AM, Licensed Practical Nurse (LPN) F verified the treatment cart was unlocked, which allowed all drawers to be opened. She looked to the left of the cart and confirmed there was at least one confused resident in the hallway by the cart. She acknowledged there were other confused residents near the nurses' station. Observation of the treatment cart drawers revealed they contained medications and treatment supplies including scissors, prescription ointments and lotions, and wound cleanser solutions which could be toxic if ingested. LPN F confirmed she had the key for the treatment cart and was responsible for its security. She explained she had not accessed the treatment cart since the start of the shift at 7:00 AM. She stated the cart was probably unlocked since the overnight shift. LPN F acknowledged medication and treatment carts should never be unlocked and unattended. She said, We want to prevent patients or anybody else getting into the carts. Most items are by prescription which means only the nurse should have access to them. 2. On 8/20/24 at 9:53 AM, LPN E retrieved a bottle of liquid protein supplement from the Riverside Unit 300 hallway medication cart. There was a significant amount of hardened sticky residue in lines that extended from the top of the plastic bottle to its base. The dried liquid was noted on all sides of the container. LPN E attempted to scrape the residue off the plastic bottle and said, It's so bad. It's hard to come off. She stated each nurse was responsible for cleaning any spills that occurred when the thick liquid was poured from the bottle. 3. On 8/21/24 at 1:26 PM, Registered Nurse (RN) I confirmed she was responsible for the Bayside Unit high-600 hallway medication cart. During inspection of the cart, RN I discovered two boxes of skin protectant in the bottom right drawer. She confirmed treatment supplies were not to be stored in a medication cart. In another drawer, a plastic bottle of liquid protein had dark, dried, spilled residue stuck to the sides. RN I started to pick at the hardened substance on the bottle but she was unable to get it all off. She explained all nurses were responsible for cleaning bottles after use. Observation of the drawer revealed there was residue from the bottle of liquid protein in a circular shape. RN I stated she noticed the substance stuck in the bottom of the drawer, and although she tried to scrape it off with scissors, she was never able to get it out. (continued on next page)

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	105701	A. Building B. Wing	08/22/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 8/21/24 at 1:39 PM, RN I stated she would return the two boxes of skin protectant to the Bayside Unit 600 hallway treatment cart. She opened the bottom drawer of the treatment cart to show a bottle of Betadine antiseptic solution lying on its side. A large amount of the dark brown liquid contents of the bottle had spilled in the drawer and there was residue dried onto the sides of the bottle. RN I reached in and discovered the bottle was stuck to bottom of drawer in the hard, dried pool of liquid. 5. On 8/21/24 at 2:12 PM, during inspection of the Oceanside Unit 100 hallway medication cart, LPN H removed an old, soiled, almost opaque plastic bag that contained a bottle of liquid iron supplement. There was dark brown, spilled medication on the sides of the bottle that partially covered the label, and dried residue in the bottom of the plastic bag. An old rubber band was stretched around the plastic bag to secure it to the bottle. LPN H explained the night nurse usually deep-cleaned the medication cart on a Sunday night. She acknowledged the bottle should have been cleaned and placed in a clean plastic bag. 6. On 8/22/24 at 11:45 AM, during inspection of the Riverside Unit 400 hallway medication cart, LPN G opened a drawer that contained five prescription inhalers, one COVID-19 test kit, and six syringes of normal saline flush. There was no divider in the drawer and the inhalers were adjacent to two large containers of germicidal wipes. LPN G confirmed cleaning supplies should not be stored in the same drawer as medication. Review of the facility's policy and procedure for Storage of Medications, revised in January 2018, revealed medications and biologicals were to be stored safely, securely, and properly. The document indicated medication supply should be accessible only to licensed nursing personnel and pharmacy personnel. The policy revealed medication rooms, carts, supplies would be locked when not attended. The document indicated potentially harmful substances including cleaning supplies and disinfectants should be clearly identified and stored separately from medication. The policy revealed deteriorated medications and soiled containers would be removed from the cart, disposed of, and re-ordered as indicated.

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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. 50401 Based on observation and interview, the facility failed to ensure food items were stored in a manner to prevent contamination by keeping them sealed, dated and discarded before their expiration date. This failure had the potential to negatively effect 158 of 158 residents who consumed food items by mouth. Findings: 1. On 8/19/24 at 10:20 AM, during the initial kitchen inspection with the Certified Dietary Manager (CDM), the walk-in freezer was observed to contain multiple cardboard shipping boxes in which the interior bag holding food items was unsealed, leaving the food items open to the air. These unsealed and undated items were beef patties, Rib type-meat, Plant-Based Chick-N-Strips, eggs, and pancakes. A box of popsicles was observed with a large build-up of ice encasing approximately half the popsicles in the box. In the walk-In refrigerator, there was a half-pan of cooked rice dated 8/14. The CDM confirmed the date on the half-pan of rice and stated their policy was to discard prepared food after three days, and discarded the rice. A package with approximately 8-10 sausage patties were also found open to the air, unsealed with no date to indicate when it was opened. In addition, previously opened containers of soup base and parmesan cheese were also found undated. The CDM acknowledged these findings and threw the food items away. In the dry storage area, a box with an unsealed, open plastic bag was found. The plastic bag contained thickening agent which was not sealed or dated. The CDM confirmed the open plastic bag and stated he would have a staff member repackage this dry food item properly. 2. On 8/21/24 at 1:43 PM, the walk-in freezer and refrigerator were re-inspected with the CDM. In the walk-in refrigerator, again a half-pan of cooked rice and an opened container of Parmesan cheese were found undated. Also a full pan of leftover ham was observed with the plastic wrap open/unsealed. Review of the facility's Dietary Services policy for Food Receiving and Storage dated 1/30/24 revealed dry foods stored in bins would be removed from original packaging, labeled and dated. The policy also indicated all food stored in the refrigerator and freezer would be covered, labeled, and dated, and other opened containers of food and beverages must be dated, sealed, or covered and held no longer than 72 hours.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 35086 Based on observation, interview, and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee developed and implemented timely and appropriate plans of action to prevent repeat deficient practices related to Activities of Daily Living (ADLs) for Dependent Residents and Activities to Meet Resident Interest or Needs. Findings: Review of the facility's survey history revealed repeat deficiency concerns for ADL care and activities during the past 5 years, and again during current survey. The concerns for ADL care specifically nail care and activities to meet the residents' interests and needs to attain their highest practicable well-being would reflect the third time in five years deficiencies were cited for these areas of concern. On 8/22/24 at 4:00 PM, the Administrator and Risk Manager spoke about the facility's QAPI program. The Administrator verified they completed a plan of correction for ADLs and activities last year and did not currently have any Performance Improvement Plans (PIPs), or other audits for the areas of concern regarding ADL care and activities to meet resident needs and interests. The Administrator was asked how the QAPI committee addressed and/or prevented repeat concerns and deficiencies. The Administrator said, the committee looked at the concerns monthly after receiving deficiencies until they felt the facility was in substantial compliance with the regulation. The Administrator acknowledged the facility had not considered looking at the repeated deficiencies again before the next survey cycle or any alternative measures to help ensure the facility did not continue to have repeated deficiencies with their annual surveys. Review of the facility Quality Assurance and Performance Improvement Plan date 1/1/24 read, The purpose of QAPI in our organization is to take a proactive approach to continually improve .Criteria for prioritizing and selecting PIPs are bases on prevalence .The key elements of the QAPI program will be reviewed to assure that they are occurring, that the program is efficient .Ongoing training needs will be identified and addressed .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during distribution of lunch trays and set up of lunch meals on 1 of 2 hallways, (400 hallway), on 1 of 4 units, (Riverside Unit). Findings: On 8/19/24 at 11:47 AM, Certified Nursing Assistant (CNA) J distributed lunch trays on the 400 hallway. Without performing hand hygiene, she removed a tray from the meal cart, entered room [ROOM NUMBER], and placed it on a table. CNA J touched the table, removed lids from containers, and then exited the room without using hand sanitizer. CNA J returned to the meal cart, retrieved another tray, and entered room [ROOM NUMBER]. She placed the tray on the table beside bed A, uncovered food items, and set up the meal. During the process, she touched the table and the back of the resident's chair. CNA J did not perform hand hygiene prior to exiting the room and she returned to the meal cart to continue distributing lunch trays. Next, she retrieved a tray and returned to room [ROOM NUMBER] where she placed it on the table beside bed B. CNA J removed the plate cover, opened a box of milk, and removed plastic lids from other containers on the tray to complete meal set up. As she exited the room, the resident in bed A reminded her he did not get a box of milk on his tray. CNA J acknowledged the request, and again left the room without performing hand hygiene. She then used both hands, one on each meal cart, to pull the carts further down the hallway. CNA J left the carts, walked to the nourishment room to retrieve a box a milk, and found there was no milk in the refrigerator. As she walked to the main kitchen to get a box of milk, CNA J commented on the warm temperature in the hallway and wiped sweat from her forehead by moving her left forearm to the back of her hand and her fingers across her forehead. On 8/19/24 at 11:53 AM, CNA J stood at the kitchen door and received a box of milk from dietary staff. She held the box in her left hand as she walked back towards the Riverside Unit. On the way back to the 400 hallway, CNA J raised her right arm and again wiped away sweat by dragging her right forearm to the back of her hand and fingers across her forehead. She entered room [ROOM NUMBER], placed the box of milk on the table beside bed A, and used both hands to open the box. She removed the wrapper from a straw and inserted the straw into the milk. On 8/19/24 at 11:56 AM, CNA J exited room [ROOM NUMBER] and did not perform hand hygiene before returning to the meal cart to continue distribution of residents' meal trays. She retrieved another tray, entered room [ROOM NUMBER], and placed it on the table beside bed A. CNA J uncovered the meal, removed the lid on the juice container, opened the box of milk, and poured the contents into a specialty cup. As she exited the room, CNA J raised her hand to touch her hair. Next, she retrieved another meal tray from the cart and returned to room [ROOM NUMBER] to place it on the table beside bed B. She adjusted the back of the resident's wheelchair, then touched the tray and picked up the packet of utensils without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 12:00 PM, when CNA J walked towards the meal cart to retrieve another tray, she was prompted to pause the distribution of lunch meal trays. She was informed of concerns regarding the omission of hand hygiene prior to touching items on residents' lunch meal trays, after touching surfaces in residents' rooms, and after touching her skin and hair. CNA J validated she did not perform hand hygiene before touching each resident's tray and items on the tray. On 8/19/24 at 12:02 PM, the Riverside Unit Manager (UM) stated her expectation was all staff would sanitize their hands frequently during meal distribution to reduce the spread of germs. The UM verified there were easily accessible hand sanitizer dispensers in the hallways and resident rooms. The facility's policy and procedure for Assistance with Meals, revised on 1/18/18, read, All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. Review of the facility's policy and procedure for Handwashing/Hand Hygiene, dated 1/30/24, revealed the facility considered hand hygiene to be the primary means to prevent the spread of infections. The policy noted hand hygiene products and supplies including soap and alcohol-based hand rub or hand sanitizer would be accessible and convenient for staff to promote compliance with proper infection control practices. The document indicated staff would perform hand hygiene after contact with objects in the resident's immediate vicinity, before handling food, and before and after assisting a resident with meals.