STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555016	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John Kronstadt Convalescent Center	4432 James Avenue Castro Valley, CA 94546

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50474 Based on observation, interview, and record review, the facility failed to provide gender specific bathrooms to five of five sampled residents (Residents 1, 30, 32, 33 and 41). A female resident (Resident 32) shared a [NAME] and [NAME] bathroom (a bathroom that has two doors and is accessible from two bedrooms) with two male residents (Resident 30 and Resident 33) in the adjacent room. A female resident (Resident 1) shared [NAME] and [NAME] bathroom set up with a male resident (Resident 41). This failure placed Residents 1, 30, 32, 33 and 41 at risk for humiliation and discomfort. Findings: 1. During a concurrent observation and interview on 6/3/24 at 11:00 a.m., in Resident 41's room, Resident 41 was sitting in wheelchair. Resident 41 stated he shared the bathroom with a female resident (Resident 1) residing in the adjacent room. Resident 41 stated sharing the bathroom with a female resident was unacceptable. Resident 41 stated it was concerning for him as he would look bad if he happened to enter the bathroom if Resident 1 was already in the bathroom. During a record review of Resident 41's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/10/24, Section H - Bladder and Bowel of the assessment indicated Resident 41 was always continent (able to always control bladder voluntarily and/or bowels) with bowel and bladder. During an interview on 6/4/24 at 11:48 a.m. with Certified Nursing Assistant (CNA) 2, Resident 1 was observed sitting in a wheelchair in the hallway. CNA 2 stated Resident 1 was able to use the bathroom with assistance. CNA 2 stated she was aware Resident 1 shared a bathroom with a male resident (Resident 41) and that's why she preferred to take Resident 1 to the common bathroom by the dining room instead. CNA 2 stated female and male residents were not supposed to share one bathroom and she was concerned because it could cause discomfort to the residents especially the female residents. During a record review of Resident 1's Bowel and Bladder Record, dated April and May 2024, the record showed Resident 1 had multiple episodes of bowel continence. (continued on next page)

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 - Some	2. During an interview on 6/4/24 at 9:28 a.m. with Resident 30, in Resident 30 and Resident 33's shared bedroom, Resident 30 stated their bathroom was shared with a female resident (Resident 32) in the adjacent room. Resident 30 stated he felt it was inappropriate for men and women to share the bathroom together. Resident 30 stated there was an incident when another resident from the adjacent room exited the bathroom and entered their room. Resident 30 stated the facility did not inform him that he would be sharing the bathroom with female residents before he was moved to this room. During a record review of Resident 30's MDS assessment, dated 4/25/24, the MDS assessment Section H - Bladder and Bowel indicated Resident 30 was frequently incontinent (able to have at least one episode of continent voiding and bowel movement) with bowel and bladder. During an interview on 6/4/24 at 09:30 a.m. with Resident 33, Resident 33 stated he did not feel good about having to share their bathroom with female residents. Resident 33 stated it was not right to have two genders share the bathroom and the facility also did not inform him about it. During an observation and interview on 6/5/25, at 9:03 a.m., Resident 32 was observed inside the bathroom with Certified Nurse Assistant (CNA 1). Resident 32 stated she did not think it was right to share the bathroom with male residents. Resident 32 stated it made her uncomfortable sharing the bathroom with male residents from the adjacent room. She also stated there were incidents when other residents or staff did not knock the before opening the bathroom door. Resident 32 stated she did not feel good about it because her privacy was compromised. Resident 32 also stated she was not informed that the bathroom will be shared between male and female residents. During a record review of Resident 32's Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 3/21/24, the MDS assessment Section H - Bladder and Bowel indicated Resident 32 was occasionally incontinent with bladder (able to have less than 7 episodes of involuntary voiding) and frequently incontinent (able to have at least one episode of continent bowel movement) with bowel. During an interview on 6/4/24 at 12:25 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was the nurse caring for Residents 1, 30, 32, 33 and 41. LVN 2 stated she was aware of the shared bathrooms between male and females and that it was not appropriate because it could compromise the resident's privacy and dignity. During an interview on 6/4/24 at 12:33 p.m. with Director of Nursing (DON), DON stated the shared bathrooms had locks and signage posted on the bathroom doors to knock before entering. During an observation on 6/4/24 at 12:35 p.m. with DON, the shared bathroom between Residents 30, 33 and 32 did not have locks. The signage stating Knock before entering was only on the door for Residents 30 and Resident 33's side and not on Resident 32's side of the door. During a concurrent observation and interview on 6/4/24 at 12:40 p.m., the DON stated both the bathroom doors to the bathroom shared between Resident 41 and Resident 1 did not have a lock or signage stating Knock before entering. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/24, at 9:04 a.m. with Director of Nursing (DON), she stated she was unable to locate any records that Residents 1, 30, 32, 33 and 41 and/or their families were informed about the shared bathrooms between male and female residents when the residents were moved to their respective rooms. During a record review of the facility's Policy and Procedure (P&P) titled Dignity and Respect, last revised 5/1/22, the P&P showed the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45875 Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 16, Resident 23, and Resident 11) received proper grooming including nailcare when: 1) Resident 16 had long sharp fingernails. 2) Resident 23 had long sharp fingernails. 3) Resident 16 had long, thick fingernails. This failure placed residents at risk for getting infections from lack of proper hygiene and injuring themselves with long fingernails and compromise physical and psychosocial wellbeing. Findings: 1. During a review of Resident 16's Resident Face Sheet, printed on 6/5/24, the Face Sheet showed Resident 16 was admitted to the facility in November 2023 and had multiple medical diagnoses including glaucoma (a group of eye diseases that damage the optic nerve and can cause blindness) and Parkinson's disease (a progressive disease of the nervous system that affects movement). During a record review of Resident 16's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/17/24, Resident 16's Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) was 9 out of 15, which indicates moderately impaired mental status. Review of Section GG Functional Abilities and Goals indicated Resident 16 was dependent on staff for self-care including shower and personal hygiene. During an observation and interview on 6/3/24, at 10:10 a.m., Resident 16 was lying in his bed and was scratching his arm with long sharp nails causing redness to skin. Resident 16 stated he cannot trim his nails by himself because he cannot see and has asked the facility staff to trim his nails for him, but no one has helped him so far. Resident 16 stated he would like to have his nails trimmed and short. During a concurrent observation and interview on 6/3/24 at 10:22 a.m. with Licensed Vocational Nurse (LVN)1, Resident 16's fingernails were observed. LVN 1 stated Resident 16 has long fingernails. LVN 1 stated Resident 16 is diabetic and Licensed Nurses should be trimming the fingernails. LVN 1 also stated if nails are not trimmed there is risk, that resident can scratch himself and get skin tear. During a review of Resident 16's Care Plan-Self-care deficit, dated 5/22/24, the care plan indicated to assist resident 16 in ADL (Activities of daily living, things needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 23's Resident Face Sheet, printed on 6/5/24, the Face Sheet showed Resident 23 was admitted to the facility in February 2024 and had multiple medical diagnoses including cerebral infarction (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain). During a record review of Resident 23's MDS, dated [DATE], Resident 23's BIMS was 14 out of 15, which indicates intact mental status. Review of Section GG indicated Resident 23 was dependent on staff for self-care including shower and personal hygiene. During a concurrent observation and interview on 6/3/24 at 10:46 a.m., Resident 23 was lying in his bed and was noted with long sharp fingernails. Resident 23 stated he has requested the facility staff to trim his nails for him many times, but no one has helped yet. Stated he like to have short nails and cannot trim his nails by himself. During a concurrent observation and interview on 6/3/24 at 10:50 a.m. with LVN 4, Resident 23's fingernails were observed. LVN 4 stated Resident 23 has long fingernails. LVN 4 also stated licensed Nurse or Certified Nursing assistant can help resident with nails care. LVN 4 stated the risk of not trimming the nails, is that Resident 23 can scratch himself and cause bleeding and wound and dirt can settle underneath nails which can cause infection. During a review of Resident 16's Care Plan-Self-care deficit, dated 5/22/24, the care plan indicated to assist resident 16 in ADLs, including personal hygiene /showering. 50474 3. During a review of Resident 11's Face Sheet, printed on 6/4/24, the Face Sheet indicated Resident 1 was admitted to the facility in October 2019. During a record review of Resident 11's MDS, dated [DATE], the MDS assessment Section GG indicated Resident 1 was totally dependent on staff for showers and needed staff's maximum assist to maintain personal hygiene and grooming. During a record review of Resident 11's Activities of Daily Living Care Plan, dated 10/17/19, the care plan showed Resident 11 had a self-care deficit due to blindness and needed limited assistance with personal hygiene. During an observation and interview on 6/4/24, at 11:56 a.m. with Certified Nursing Assistant (CNA) 2, Resident 11 was lying in the bed. Resident 11 had about two inch long and thick fingernails on his left hand. Resident 11 stated he preferred his fingernails shorter. CNA 2 stated she only filed Resident 11's fingernails because they were already too long and thick, and a regular nail clipper did not work. CNA 2 stated the nurse has been informed about Resident 11's long and thick fingernails. CNA 2 stated the risk of having long and thick fingernails could provide discomfort to Resident 11. During an interview on 06/4/24, at 12:25 a.m. with LVN 2, LVN 2 stated she was aware that Resident 11 had long and thick fingernails. She stated Resident 11's fingernails have been long and thick since last year, but they could not use a regular nail clipper. LVN 2 stated they would need a special tool to trim Resident 11's fingernails. LVN 2 stated the risk of having long and thick fingernails could lead to a skin breakdown and infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/24, at 12:42 p.m. with Director of Nursing (DON), DON stated she was aware that Resident 11's fingernails were long and thick. DON stated Resident 11's fingernails were approximately between 1-2 inches long. DON stated the social worker was already informed about it, but no one had come to the facility yet to trim Resident 11's fingernails. During an interview on 6/4/24, at 12:44 p.m., Social Services Designee (SSD), stated she had not set up the appointment yet for Resident 11's fingernails. During a review of facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails, revised on 2/1/2017, the P &P indicated, Nail care is given to clean the nail bed and keep the nails trimmed .Policy. I. Fingernails are trimmed by Certified Nursing Assistants (CNA's), except for residents with diabetes or circulatory impairments, this includes all toenails except for high - risk residents. Note: A licensed nurse will trim high-risk resident's nails.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49983 Based on observation, interview, and record review the facility failed to ensure effective medication administration and accurate accountability of a controlled substance (medications that can be easily abused and are under strict government control) when: 1. Nursing staff did not correctly prime the pen needle during the administration of insulin (medication to lower blood sugar) for one of two sampled residents (Resident 27) receiving an insulin injection. This had the potential to result in Resident 27 to not receive a full dose of insulin. 2. One of 31 sampled residents (Resident 19) received calcium and iron at the same time. This had the potential for an interaction leading to the decreased absorption of iron, and the resident not receiving the full therapeutic effect of the medication. 3. During a random controlled medication use audit, one of two randomly sampled residents (Resident 7) did not have all administered medications correctly documented on the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medication) and on the Medication Administration Record (MAR) to indicate they were administered to the resident. This failure had the potential to result in misuse or diversion of controlled medications and had the potential to make it more difficult to monitor if medication dosages need to be adjusted. Findings: 1. During an observation on 06/03/24 at 11:59 a.m., Licensed Vocational Nurse (LVN) 4 primed the insulin pen (a device used to administer medication to lower blood sugar), named Fiasp (a rapid-acting insulin) Flexitouch pen, by holding it horizontally while having the needle cap on, prior to administering insulin to Resident 27. During an observation and interview on 6/3/24 at 12:40 p.m., LVN 4 explained the insulin pen priming process by holding the pen horizontally while keeping the needle cap on and turned the pen dial to 2 units and pressed the bottom of the pen (the dose button) to prime the needle. During an interview on 06/05/24 at 01:11 p.m., the Pharmacy Consultant (PC) stated that the correct way to prime an insulin pen is to hold the pen upright, and if pen is not primed correctly, the dose could be incorrect. A review of the manufacturer's Instructions for Use, for Fiasp Flextouch, revised 6/2023, retrieved from: https://www.novo-pi.com/fiasp.pdf indicated: Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top . Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. During a review of facility's policy and procedure (P&P), titled Medication Administration Subcutaneous Insulin, dated 05/2016, the P&P indicated the pen should be held with the needle pointing upwards. 2. During a medication administration observation on 06/04/24 at 04:25 p.m., LVN 6 was observed giving Resident 19 seven medications, including a tablet of Oyster Shell Calcium (a supplement) 500 mg and a tablet of iron sulfate (to treat iron deficiency) 325 mg. A record review of Resident 19's MAR, dated May 2024, indicated the facility scheduled both the calcium and iron sulfate to be given daily at 5 p.m. During an interview with the Director of Nursing (DON) on 06/05/2024 at 11:21 a.m., DON stated her quick online research showed iron sulfate's absorption may be affected by the co-administration with calcium carbonate, and their administration should be spaced out two (2) hours apart. During an interview on 06/05/24 at 01:11 p.m. with Facility's Pharmacy Consultant (PC), PC stated Resident 19 was receiving calcium and iron at the same time. PC stated she was aware of the interaction between the two medications, made herself a note in her computer, but did not communicate with the facility because it was a minor interaction. A record review, Lexicomp, a nationally recognized drug information resource, indicated the concurrent use of calcium carbonate and ferrous sulfate would lead to Risk Rating D (meaning consider therapy modification) drug-drug interaction. Specifically, Lexicomp indicated calcium carbonate may decrease the absorption of Iron Preparations . The absorption of ferrous sulfate has been shown to be reduced by 15% to 24% with calcium carbonate. It further indicated to consider separating the doses of the two medications as much time as possible in patients who require chronic use of both agents and monitor for decreased therapeutic effects of oral iron preparations. 3: During a concurrent interview and record review with DON on 6/4/2024 at 1:46 p.m., the CDR and MAR for Resident 7 were reviewed. DON stated the records indicate that the CDR was signed when oxycodone HCL 5 mg (a pain medication with potential for abuse) was removed for Resident 7 three times: on 1/10/24, on 2/[date unclear]/24, and 2/21/24, and the medication administration was not entered on the MAR. DON stated the nurse should sign the CDR and document in the MAR when controlled medications are given. DON stated LVN 3 signed the CDR for Resident 7 on 2/21/24, but did not enter the administration on the MAR. During an interview with LVN 3 on 6/4/2024 at 4:08 p.m., LVN 3 stated she signed the Controlled Drug Record for Resident 7 on 2/21/24, and the correct procedure is to always document in the CDR and in the MAR after giving a controlled substance. During an interview with DON on 06/05/24 at 11:21 a.m., DON stated the risk to not entering controlled doses on the MAR is that it makes it more difficult to monitor if the medication is effective and to monitor if medication dosages need to be adjusted. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's P&P titled Medication Administration Controlled Substances, dated 11/2017, the P&P indicated when a controlled medication is administered, the licensed nurse administering the medication should document the administration on the MAR.

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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** 49983 Based on observation, interview, and record review, the facility failed to store and label mediations in accordance with manufacturer specifications and currently accepted professional principles when: 1. The medication refrigerator temperature was below recommended temperature range for storage of refrigerated medications. 2. The medication refrigerator temperature was not consistently monitored and recorded twice daily for seven out of seven months, from [DATE] to [DATE]. 3. The temperature log had an incorrect temperature range for monitoring. 4. Nursing staff failed to notify the Maintenance Supervisor (MS) when the medication refrigerator temperature was out of range. 5. Six (6) bottles of eyedrops and one (1) insulin pen were not correctly labeled. These failures had the potential to result in 44 residents receiving medications or vaccines of unknown effectiveness and seven (7) residents potentially receiving an incorrect or expired medication. Findings: 1. During a concurrent observation and interview on [DATE] at 10:34 a.m. with the Director of Nursing (DON), the medication refrigerator was 29 degrees ( ) Fahrenheit (F). DON stated that the thermometer read 29 F and the appropriate temperature range was between 36 F and 46 F. The medication refrigerator contents included one (1) pneumovax vial (vaccine for pneumonia), one (1) Fiasp pen (a type of insulin pen), one (1) box containing five (5) Humalog Kwik pens (a type of insulin pen), one (1) Basaglar Kwikpen (a type of insulin pen), two (2) vials of TB test (used to test for tuberculosis), six (6) vials of open insulin, one (1) unopened emergency box containing one (1) vial of insulin (a medication to lower blood sugar) and one (1) vial of Lorazepam (a medication given for anxiety), one (1) vial of NPH (a type of long acting insulin), two (2) boxes of influenza vaccine (a vaccine for the flu) containing a total of 13 vials, and one (1) container of lantoprost eye drops (a medication to treat high pressure in the eye). During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated ,d+[DATE], the policy indicated that medications requiring refrigeration or temperatures between 36 F and 46 F should be kept in a refrigerator with a thermometer to allow temperature monitoring. A temperature log is maintained to verify that temperature has remained within accepted limits. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent interview and record review on [DATE] at 10:40 a.m. with the DON, the refrigerator temperature logs, titled Record of Refrigeration Temperatures, dated [DATE], the document indicated the last recorded temperature of the refrigerator was 34 F on [DATE] during the night shift, and the appropriate temperature should be between 36 F and 46 F. DON stated the temperature log was supposed to be monitored twice daily. The log was not filled out [DATE], and there were four (4) missing entries from [DATE], and three (3) missing entries in [DATE]. DON was requested to provide temperature logs for four (4) additional months, from [DATE] to [DATE]. During a review of the refrigerator temperature logs, titled Record of Refrigeration Temperatures, dated [DATE] to [DATE], the [DATE] log contained eight (8) missing entries and five (5) entries that were below 36 F. The [DATE] temperature log contained 12 missing entries and 44 that were below 36 F. The February 2024 temperature log had six (6) missing entries and 12 that were below 36 F. The [DATE] temperature log had eight (8) missing entries. The [DATE] temperature log had three (3) missing entries. The [DATE] temperature log had four (4) missing entries. The [DATE] temperature log (as of [DATE]) had three (3) missing entries and one (1) entry that was below 36 F. During a review of the refrigerator temperature logs, titled Record of Refrigeration Temperatures, dated [DATE], the document indicated the temperature of the refrigerator should be monitored twice daily during NOC (night) and P.M. (evening) shifts. 3. During a concurrent interview and record review on [DATE] at 01:14 p.m. with DON, DON stated that the correct range for the refrigerator was 36 F to 46 F and the facility's refrigerator temperature log, titled Record of Refrigeration Temperatures, dated [DATE], indicated that the acceptable temperature range for the medication refrigerator is between 36 F and not greater than 41 F. DON stated the temperature range of between 36 F and not greater than 41 F is incorrect and needs to be changed. 4. During a concurrent interview and record review on [DATE] at 10:40 a.m. with DON, the refrigerator temperature logs, titled Record of Refrigeration Temperatures, dated [DATE], DON stated the document indicates that if the recorded temperatures are below 36 F, MS should be notified. During an interview on [DATE] at 12:11 p.m., the MS stated he learned about the medication refrigerator being too cold today, and there had been no issues previously reported. The MS stated the temperature was 32 F when he checked it today, which is colder than the acceptable range of 36 F to 46 F. During a concurrent interview and record review on [DATE] at 3:50 p.m., Licensed Vocation Nurse (LVN) 5 stated that she entered 29 F on the temperature log on [DATE] and she does not remember if she entered it on the maintenance log. LVN 5 stated that the reason refrigerator temperatures are checked is to make sure that all the medications are in good standing and regulated well. LVN 5 stated that all issues with the medication refrigerator should be entered into the maintenance log. During a concurrent interview and record review on [DATE] at 11:21 a.m. with the DON, DON reviewed the Maintenance Request Log and stated there were no entries in the Maintenance Request Log for the dates in January and December when the medication refrigerator was recorded as being outside of range. DON stated that the expectation is that the nurses will notify maintenance and enter temperatures that are outside range in the maintenance log. DON stated that the potential consequences for the refrigerator being too cold is that the insulin and vaccines stored in the refrigerator are not supposed to be frozen, which could cause decreased effectiveness of the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555016	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John Kronstadt Convalescent Center	4432 James Avenue Castro Valley, CA 94546

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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	In a concurrent record review and interview on [DATE] at 4:08 p.m., LVN 3 stated that she signed the Record of Refrigeration Temperatures twice in January ([DATE] and [DATE]) indicating that the temperature of the medication refrigerator was 32 F. LVN 3 stated that she did not notify maintenance because she was not aware that 32 F was too cold. LVN 3 stated that the form Record of Refrigerator Temperature indicates that temperatures below 36 F should be reported to Maintenance Supervisor. During a telephone interview on [DATE] at 1:11 p.m., the Pharmacy Consultant (PC) stated that she recommended that the medication kept in the medication refrigerator be replaced because there are no studies on what happens to medications when kept in that temperature range, so it is unknown what the effects would be. The PC stated that the correct temperature range for the medication refrigerator is between 36 F to 46 F. During a review of the refrigerator temperature logs, titled Record of Refrigeration Temperatures, dated [DATE], the document indicated that adequate temperature was Refrigeration: 36 F and not greater than 41 F and indicated report to Maintenance Supervisor when recorded temperatures are not adequate. 5. During a concurrent observation and interview on [DATE] at 2:25 p.m. with LVN 4 at Medication Cart #1, there were five (5) bottles of artificial tears (an over the counter product that lubricates dry eyes) with the only patient identifier as the resident room number for Residents 14, 10, 35, 17, and 13. LVN 4 stated that the risk of not having the resident name on the bottle is that there's a risk to giving the product to the wrong resident if they change rooms. LVN 4 stated that a bottle of latanoprost (a medication given to treat high pressure in the eye) eye drops, prescribed for Resident 16, does not have an open date. During a review of Lexicomp, a nationally recognized drug information resource, Lexicomp indicated the following for the storage of latanoprost: Once opened, the container may be stored at room temperature . for 6 weeks. During an interview on [DATE] at 11:21 a.m., DON stated that eyedrops should be labeled with the resident's name, room number, and date that they were opened. DON stated that a potential consequence of not correctly labeling eye drops is that the wrong eyedrop could be given to the wrong resident and a consequence of not writing open dates is that expired eyedrops could be given. In a concurrent observation and interview on [DATE] at 12:12 p.m. with LVN 2, at Medication Cart #2, LVN 2 stated there was no open date for the Basaglar Kwikpen (a type of insulin administration pen) for Resident 37. LVN 2 stated that medications should be labeled with an open date and if there is no open date there is a risk that residents could receive expired medication. A review of Lexicomp indicated the following for storage of Basaglar Kwikpen: Store in-use prefilled pens at room temperature . and use within 28 days. During a review of facility policy titled Medication Administration: Subcutaneous Insulin, dated ,d+[DATE], the document indicated that the device should be dated after the first use.

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	555016	A. Building B. Wing	06/07/2024

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50474 Based on observation and interview, the facility had one resident room (room [ROOM NUMBER]) with multiple beds that provided less than 80 square feet (sq.ft) per resident who occupied the room. This deficient practice had the potential to result in inadequate space to provide necessary and safe nursing care and privacy for the residents. Findings: During an interview on 6/3/24 at 9:35 a.m. with Administrator (ADM), ADM stated the facility had a room waiver for room [ROOM NUMBER]. ADM stated room [ROOM NUMBER] had less than 80 sq ft per resident and had four resident beds. During an interview on 6/5/24 at 12:35 p.m. with the Maintenance Supervisor (MS), MS stated room [ROOM NUMBER] was the only room that had four residents. The following rooms and corresponding square footage (sq. ft) per bed were identified: Room Activity Room Size Floor Area 16 Resident room [ROOM NUMBER] sq. ft 77 sq.ft/bed During an observation on 6/3/24 at 9:40 a.m., Residents 2, 6, 7 and 42 were observed in their bed. The privacy of residents in room [ROOM NUMBER] was not impacted by shortage of space. Storage spaces were sufficient to accommodate the needs of residents. The ADM requested a continuous room waiver for the above residents' room.