STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555053	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	729 Browning Road Delano, CA 93215

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to ensure physicians provide the informed consent (process that a healthcare provider fully informs patient and/or family) for the use of antipsychotic (drugs that treat psychosis [mental distress, mental disorder]) medications for three of three sampled residents (Resident 1, Resident 40, and Resident 149) and verified by two licensed personnel when verbal or telephone consents were obtained. This failure had the potential for the residents to not receive accurate information about the drugs and not fully understand the risks, benefits, and alternative of the medications. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was readmitted on [DATE] with diagnosis including visual hallucination (involves seeing things that aren't real), schizoaffective disorder (chronic mental illness that combines symptoms of schizophrenia [disruptions in thought processes, perceptions, emotions, and social interactions] and a mood disorder), bipolar (a serious mental illness that causes unusual shifts in mood, psychosis, major depressive disorder (MDD-persistently low or depressed mood, low energy, and poor concentration) and anxiety disorder (excessive worry and feelings of fear, dread, and uneasiness). During a concurrent interview and record review on 12/4/24 at 9:20 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 1's Physician's Orders (PO) dated 12/20/23, was reviewed. The PO indicated, Lorazepam (used to treat anxiety disorders) 0.5 milligram (mg) three times a day for anxiety. A review of Resident 1's Psychoactive Medication Evaluation and Consent (PMEC) Form dated 12/20/23, indicated, Licensed Vocational Nurse (LVN) 5 completed the form with the indications for use, expected benefits, and possible side effects/risk. MDSC stated LVN 5 completed and signed the PMEC form and obtained the informed consent. MDSC stated the form did not have the physician statement of the risks, benefits, and alternatives for the use of the antipsychotic medication. MDSC stated there was no physician signature indicating the physician provided the informed consent for the prescribed antipsychotic medication. MDSC stated the consent was obtained from Resident 1's sister. MDSC stated Resident 1's sister does not come to the facility; the consent was obtained via telephone. MDSC stated the verbal consent required two licensed personnel to witness the verbal/phone consent, but it was only [LVN] 5 who validated the verbal consent. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/4/24 at 9:22 a.m. with MDSC, Resident 1's PO dated 1/10/24 indicated, Trazodone (medication to treat depression and anxiety) 50 mg at HS (bedtime) routinely for insomnia. A review of Resident 1's PMEC Form dated 1/10/24 indicated, LVN 4 completed the form with indications for use, expected benefits, and possible side effects. MDSC stated LVN 4 completed and signed the PMEC form and obtained the informed consent. MDSC stated the form did not have the physician statement of the risks, benefits, and alternatives for the use of the antipsychotic medication. MDSC stated there was no physician signature indicating the physician provided the informed consent for the prescribed antipsychotic medication. MDSC stated verbal/phone consent was obtained from Resident 1's sister. MDSC stated the verbal consent required two licensed personnel to witness the verbal/phone consent, but it was only [LVN] 4 who validated the verbal consent. During a concurrent interview and record review on 12/4/24 at 9:25 a.m. with MDSC, Resident 1's PO, dated 11/27/24, was reviewed. The PO indicated, Abilify (medication to treat manic or mixed episodes related to bipolar disorder) 15 mg daily. A review of Resident 1's PMEC Form dated 11/27/24 indicated, LVN 1 completed the form with indications for use, expected benefits, and possible side effects/risk. MDSC stated LVN 1 completed and signed the PMEC form and obtained the informed consent. MDSC stated the form did not have the physician statement of the risks, benefits, and alternatives for use of the antipsychotic medication. MDSC stated there was no physician signature indicating the physician provided the informed consent for the prescribed antipsychotic medication. During a review of Resident 40's Admission Record (AR), the AR indicated Resident 40 was admitted on [DATE] with diagnosis including, MDD and Insomnia (sleep disorder). During a concurrent interview and record review on 12/4/24 at 3:26 p.m. with MDSC, Resident 40's PO, dated 11/3/24, was reviewed. The PO indicated, Zolpidem 5 milligrams (mg) one tablet at bedtime. A review of Resident 40's PMEC Form dated 11/3/24 indicated, LVN 4 completed the form with indications for use, expected benefits, and possible side effects/risk. MDSC stated LVN 4 signed the completed PMEC form and obtained the informed consent. MDSC stated the form did not have the physician statement of the risks, benefits, and alternatives for the use of the antipsychotic medication. MDSC stated there was no physician signature indicating the physician provided the informed consent for the prescribed antipsychotic medication. During a review of Resident 149's PO, dated 11/27/24, the PO indicated, Trazodone tablet 50 mg give one tablet at bedtime for depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities for long periods of time) manifested by sleep disturbance. During a concurrent interview and record review on 12/4/24 at 4 p.m. with MDSC, the PMEC, dated 11/27/24, was reviewed. The PMEC form indicated LVN 6 completed the form with indications for use, expected benefits, and possible side effects/risk. MDSC stated LVN 6 completed and signed the PMEC form and obtained the informed consent. MDSC stated the form did not have the physician statement of the risks, benefits, and alternatives for the use of the antipsychotic medication. MDSC stated there was no physician signature indicating the physician provided the informed consent for the prescribed antipsychotic medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Informed Consent-Psychotherapeutic Medications and Restraint Devices, dated 12/14/17, the P&P indicated, POLICY 2. The healthcare practitioner ordering psychotherapeutic medication (physician ordering psychotropic or any medication that is identified/used as a chemical restraint) or prolonged use of devices is responsible for a. Obtaining informed consent, providing risk/benefits and other related information from the resident and/or resident's representative for use of such medication/devices. b. Providing documentation that informed consent was obtained, including the diagnosis/clinical indications for the medication and physical restraint. VERIFICATION PROCESS FOR INFORMED CONSENT: 1. The physician or other health professional will verify that the resident/surrogate decision-maker was given the information that supports the need and risk/benefit provided for the physical/chemical restraint/psychotherapeutic drug .using the following method: Telephone verification of informed consent with two witnesses.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 32946 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 101) was trained in self-administration of suction. This failure had the potential to place Resident 101 at risk for respiratory infection and/or respiratory complications. Findings: During a concurrent observation and interview on 12/2/24 at 9:24 a.m., inside Resident 101's room, Resident 101 appeared alert and was able to verbalize his needs. On the bedside table next to Resident 101's bed, a suction machine with a plastic container attached with tan frothy liquid inside the plastic collection container was noted. During an observation on 12/2/24 at 9:31 a.m., in Resident 101's room, Licensed Vocational Nurse (LVN) 6 was seen replacing the plastic container on the suction machine at Resident 101's bedside. During a concurrent interview and record review on 12/4/24 at 10:45 a.m. with LVN 8, Resident 101's medical record (MR), dated 12/4/24, was reviewed. LVN 8 was unable to locate an Interdisciplinary Team (IDT- a collaborative team where a variety of professionals work together to plan and coordinate patient care) training for Resident 101's ability and assessment to suction himself. During an interview on 12/5/24 at 10:55 a.m. with Resident 101, Resident 101 stated he had been using the suction machine in the facility. Resident 101 stated he uses it up to five times a day. A facility policy and procedure had been requested for the use of the suction machine, and not provided.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 51320 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled Resident Rights for three of nine sampled residents (Resident 19, Resident 28, and Resident 43) when the residents were unaware of the Ombudsman (an independent advocate who helps protect the rights of residents in long-term care facilities, including nursing homes) contact information and how to contact the Office of the Ombudsman. This failure had the potential for Resident 19, Resident 28, and Resident 43 not to be able to report concerns/issues regarding their rights. Findings: During a group interview on 12/3/24 at 10:20 a.m. with Resident 19, Resident 28, and Resident 43, all three residents (Resident 19, Resident 28, and Resident 43) stated they did not know how to contact the Ombudsman office and did not know where Ombudsman posters were located or posted. During an interview on 12/3/24 at 10:21 a.m. with Resident 43, Resident 43 stated how to contact the Ombudsman was not discussed during their group meetings. During an interview on 12/03/24 at 11:37 a.m. with Activities Director (AD), AD stated she does not go over how to contact the Ombudsman during group meetings. AD stated she does not give any information to the residents. During a review of the facility's P&P titled, Resident Rights, dated 2024, the P&P indicated, The resident has the right to receive notice orally (meaning spoken): c. Information and contact information for state and local advocacy organizations, including but not limited to the State Survey Agency, the State Long Term Care Ombudsman program and the protection and advocacy system. 45654

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 32946 Based on interview and record review, the facility failed to ensure 12 of 32 sampled residents (Resident 1, Resident 3, Resident 7, Resident 8, Resident 13, Resident 21, Resident 22, Resident 24, Resident 31, Resident 199, Resident 201, and Resident 301) had an Advance Directive (AD- a legal document that provides instructions for medical care and only go into effect if the individual is unable to make decisions for themselves) in the medical record. This failure had the potential for responsible parties and/or medical professionals to not honor resident's healthcare wishes and to not provide appropriate treatment in the event of an emergency medical situation. Findings: During a concurrent interview and record review on 12/4/24 at 8:36 a.m. with Social Services Director (SSD) and Medical Record Director (MRD), Resident 31's medical record (MR) was reviewed. MRD stated, He (Resident 31) does not have one, referring to a copy of a Durable Power of Attorney for Health Care-advance directive [DPAHC] in Resident 31's MR. During a concurrent interview and record review on 12/4/24 at 8:39 a.m. with SSD, Resident 22's MR was reviewed. SSD stated, For him, he (Resident 22) does not have an Advance Directive acknowledgment. During a concurrent interview and record review on 12/4/24 at 8:42 a.m. with SSD, Resident 301's MR was reviewed. SSD stated, He's (Resident 301) brand new, and doesn't have any Advance Directive acknowledgment. During a concurrent interview and record review on 12/4/24 at 8:47 a.m. with SSD, Resident 24's MR was reviewed. SSD stated, So for him, he (Resident 24) does not have an Advance Directive acknowledgment. During a concurrent interview and record review on 12/4/24 at 8:50 a.m. with SSD, Resident 201's MR was reviewed. SSD stated, He (Resident 201) is also a new resident that came last week. Usually within 48 hours of admission the AD acknowledgment should be done. We give the resident the AD or offer them the AD. It should be done. During a concurrent interview and record review on 12/4/24 at 8:54 a.m. with SSD, Resident 8's MR was reviewed. SSD stated, I don't see any AD acknowledgment for him (Resident 8). During a concurrent interview and record review on 11/6/24 at 8:59 a.m. with SSD, Resident 7's MR was reviewed. SSD stated, He (Resident 7) doesn't have one, referring to the AD acknowledgment. During a concurrent interview and record review on 12/4/24 at 9:05 a.m. with SSD, Resident 13's MR was reviewed. SSD stated, He (Resident 13) does not have an AD acknowledgment. During a concurrent interview and record review on 12/4/24 at 9:08 a.m. with SSD, Resident 199's MR was reviewed. SSD stated, She (Resident 199) doesn't have an [AD] acknowledgment either. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/4/24 at 9:17 a.m. with SSD, Resident 3's MR was reviewed. SSD stated, He (Resident 3) does not have an AD acknowledgement. During a concurrent interview and record review on 12/4/24 at 9:22 a.m. with SSD, Resident 1's MR was reviewed. SSD stated, He does not have an AD acknowledgement. During a concurrent interview and record review on 12/4/24 at 9:27 a.m. with SSD, Resident 21's MR was reviewed. SSD stated, No AD acknowledgment was found in the MR. During a review of the facility's policy and procedure (P&P) titled, Residents' Right Regarding Treatment and Advance Directives, dated 11/29/2024, the P&P indicated, Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Definition: Advance directive is a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts if the State), relating to the provision of health care when the individual [Resident] is incapacitated. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 41035 51320

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to provide the Office of the State Long-Term Care (OSLTCO) Ombudsman (independent advocate who helps protect the rights of residents in long-term care facilities/nursing homes) a Notice of Transfer for one of one sampled resident (Resident 25) transferred to an acute care facility. This failure had the potential for Resident 25 to not receive the added protection from being transferred or discharged in and out of the facility. Findings: During a concurrent interview and record review, on 12/5/24 at 10:26 a.m. with Director of Nursing (DON) and Medical Records Director (MRD), Resident 25's Situation, Background, Assessment, and Recommendation (SBAR-a communication tool) on hospitalization , dated 10/4/24, 10/18/24, and 11/13/24, were reviewed. Resident 25's hospitalization on [DATE] indicated weakness and lethargy (a state of fatigue and low energy) due to low hemoglobin (few red blood cells carrying oxygen to the body. The normal range for hemoglobin levels is 12 grams per deciliter to 17.4 grams per deciliter of blood for adults) of 7.4 grams per deciliter (gm/dl). Resident 25's hospitalization on [DATE] indicated high potassium level (affects the heart and may cause irregular heartbeat or heart attack. Normal potassium level is between 3.5 and 5.0 millimoles per liter (mmol/L) of 6.3 mmol/L). Resident 25's hospitalization on [DATE] indicated low hemoglobin level of 7. 1 gm/dl. DON was unable to find documentation of a notice of transfer sent to the Ombudsman. MRD stated she had not sent a copy of the notification of transfer to OLTCO for the transfer/discharges for the months of October and November, 2024. During a review of Notice of Transfer to OLTCO, DON was unable to provide evidence OLTCO was notified of Resident 25's transfers/discharges in October and November of 2024. During a review of OSLTCO document titled, Sending Required Transfer /Discharge Notices to your Local LTCO Program, [undated], the document indicated, Facilities are required to send copies of all notices related to facility-initiated transfers and discharges. Facilities must give residents and their representatives a notice of discharge or transfer at least 30 days in advance unless a resident is temporarily transferred on an emergency basis to an acute care facility (42 CFR 483 15(c)(4)(ii)(D). The facility must send copies of these notices to the LTCOP at the same time. During a review of the facility's policy and procedure (P&P) titled, Transfer/Discharge (Including AMA -Against Medical Advice), dated 11/29/24, the P&P indicated, 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. 5. Generally, the notice will be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. Exceptions to the 30 -day requirement apply when the transfer or discharge is effected (sic) because: c an immediate transfer or discharge is required by the resident's urgent medical needs .6. In this exceptional case, the notice will be provided to the resident, resident's representative if appropriate, and LTCO as soon as practicable before the transfer or discharge. 7. The facility will maintain evidence that the notice was sent to the Ombudsman.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 149) had a completed Baseline Care Plan (BCP-an initial person-centered care plan within the first 48 hours of admission that provide instructions for care of the resident) and a summary provided to the resident within 48 hours of admission. This failure had the potential for Resident 149 to not receive the care and the safeguards necessary within the 48-hour of admission. Findings: During a review of Resident 149's Admission Record (AR), the AR indicated, Resident 149 was admitted on [DATE] with diagnosis including Chronic Obstructive Pulmonary Disease (COPD-a common lung disease causing restricted airflow and breathing problems), Diabetes Mellitus (high blood sugar in the body), and Congestive Heart Failure (heart can't pump blood well enough to supply one's body with blood) with difficulty walking and needed assistance with personal care. During a concurrent interview and record review on 12/4/24 at 3:58 p.m. with Minimum Data Set (MDS-resident assessment tool) Coordinator (MDSC), Resident 149's BCP dated 10/28/24, was reviewed. MDSC was unable to provide documentation of a completed BCP for Resident 149. MDSC stated Resident 149 was not provided a summary of the BCP. MDSC stated there was no signature of the resident signifying receipt of the summary of Resident 149's BCP. During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, dated 11/29/24, the P&P indicated, 1. The baseline care plan will be developed within 48 hours of resident's admission .3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed .5. A supervising nurse or MDS nurse/designee is responsible for providing a written summary of the baseline care plan to the resident and representative. 6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided.

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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. 35649 Based on interview and record review, the facility failed to update and develop a comprehensive person-centered care plan for three of 10 sampled residents (Resident 1, Resident 3, and Resident 31). This failure had the potential for unmet care needs. Findings: 1. During a concurrent observation and interview on 12/2/24 at 9:59 a.m. with Certified Nursing Assistant (CNA) 1, in Resident 3's room, Resident 3's feet were dangling from the wheelchair and were noted to have foot drop (neurological symptom characterized by difficulty lifting the front part of the foot due to muscular or nerve problem) on both feet. The skin on both feet was dry and scaly. The big toenail on the right foot was long, hard, and thick with ragged edges, yellowish in color and had fungus-like appearance. Resident 3's right big toe was swollen with purplish discoloration. The right second and third toes were reddish purple in color and swollen. In between the toes, the skin was black in color. The skin on the left foot was also dry and scaly, especially the skin close to the left toes. The left toes were swollen and reddish purple in color. The five toenails on the left foot were long, hard, and yellowish in color. CNA 1 attempted to reposition Resident 3's feet and noted he jerked his feet. CNA 1 stated he could be in pain. During a concurrent interview and record review on 12/4/24 at 1:33 p.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 3's care plan was reviewed. MDSC was unable to find documentation the nursing staff updated and developed a care plan addressing foot care. 2. During a concurrent observation and interview on 12/2/24 at 12:27 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, Resident 1 was having a hard time cutting the meat as demonstrated by Resident 1's effort in using the knife and cutting through the meat. LVN 1 attempted to assist Resident 1 in cutting the meat. Resident 1 stated she could not chew the meat and noticed Resident 1 ate at least 25 % of her lunch meal. Resident 1 did not touch the sweet potatoes and the butter cabbage. During a concurrent interview and record review on 12/4/24 at 10 a.m. with MDSC, Resident 1's Nursing Progress Notes (NPN) dated 12/2/24, was reviewed. MDSC was unable to find nursing documentation of an assessment regarding Resident 1's difficulty cutting meat and eating. MDSC stated the nurse did not update and develop a care plan regarding Resident 1's needs and identified problem when eating. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plan, dated 2024, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. 51320 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/02/24 at 9:36 a.m. in Resident 31's room, Resident 31 was lying in bed with a feeding tube (a tube that provides nutrition and medication to people who are unable to eat or swallow). During a review of Resident 31's Admission Records (AR), dated 7/10/24, the AR indicated Resident 31's diagnosis included Type 2 Diabetes Mellitus (DM-condition of high blood sugar) with other specified complication. During a review of Resident 31's Medication Administration Record (MAR), dated November 2024, the MAR indicated Diabetic Agent Monitoring: for s/s [signs and symptoms] of hypoglycemia [low blood sugar], monitor for s/s of hyperglycemia [high blood sugar] and inform MD [physician] for anything significant findings every shift. During a review of Resident 31's Lab (Laboratory) Results Report (LRR), dated 5/30/24, the LRR indicated Resident 31's A1C (a blood test that monitor blood sugar over 3 months) was 10.7 (A1C normal range is 4-6). During a concurrent interview and record review on 12/4/24 at 1:32 p.m. with LVN 6, Resident 31's care plan for DM was reviewed. LVN 6 stated there was no documentation of CP for Resident 31's diagnosis of DM. During an interview on 12/05/24 at 10:08 a.m. with Resident 31, Resident 31 stated nursing staff does not ask her specific questions to monitor her DM. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plan, dated 2024, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 35649 Based on observation, interview, and record review, the facility failed to notify the physician of a psychiatrist (physician whose specialty is mental health) recommendation for one of one sampled resident (Resident 149) state of depression (loss of pleasure or interest in activities for long periods). This failure resulted in Resident 149 's noncompliance and adherence with basic care needs and activities of daily living to meet his physical, mental, and psychosocial needs. Findings: During a concurrent observation and interview on 12/2/24 at 11:38 a.m. with Resident 149, in Resident 149's room, Resident 149 appeared unkempt. Resident 149's hair was oily, and wore a T-shirt and black pants that had a smell of urine. Resident 149's lower extremities were edematous, skin was dry and scaly with small blood tinged on the right foot, toenails on both feet were long and hard. There was a black substance inside the big toenails and in between the toes. Resident 149 had broken and missing teeth. Resident 149 stated he loved to sing but he did not feel like doing anything because of his depression. During a concurrent observation and interview on 12/3/24 at 12:12 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 149's room, Resident 149 was in the room wearing the same shirt and the long black pants he wore on 12/2/24. Resident 149 remained unkempt. Resident stated he refused his shower. LVN 2 stated Resident 149's feet were dry with flaky skin, and both feet were edematous. LVN 2 stated the toenails were long, thick, hard, yellowish in color, and with blackish substance inside the big toenails. LVN 2 measured the length, width, and thickness of all the toenails on both feet. During a concurrent interview and record review on 12/5/24 at 8:43 a.m. with Activities Assistant (AA), AA stated a room visit was made with Resident 149 on 12/2/24 at 11:45 a.m. AA stated she encouraged Resident 149 to play games but Resident 149 refused. AA stated Resident 149 asked for snacks. During a concurrent interview and record review on 12/5/24 at 8:39 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 149's Nursing Progress Notes (NPN) dated 12/2/24 and 12/3/24 were reviewed. The NPN dated 12/3/24 indicated Resident was offered shower but refused x 2 . The NPN dated 12/4/24 indicated, Offered shower to resident today, but refused shower and stated, I am depressed. Will take it tomorrow. MDSC stated the only documentation she could find was Resident 149's refusal to shower on Tuesday 12/3/24 and 12/4/24. During a concurrent interview and record review on 12/5/24 at 8:50 a.m. with MDSC, MDSC stated there was a psychiatric evaluation conducted on 12/4/24 at 8:30 a.m. The Psychiatric Evaluation, dated 12/4/24 indicated, Increase Trazodone to 100 milligrams (mg) from 50 mg PO (oral) qhs (every hour of sleep) to target depression as manifested by sleep disturbances. Resident will benefit from medication optimization. MDSC was unable to find documentation the attending physician was notified of the psychiatrist (physician whose specialty is mental health) recommendation. MDSC stated the nurses should have called the attending physician and notified him of the psychiatrist recommendation. MDSC stated there was no physician's order to increase Trazodone to 100 mg one tablet at bedtime. MDSC stated there was no nursing assessment/reassessment of the resident regarding Resident 149's change in condition of continued depression. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2/2021, the P&P indicated, 2. A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without interventions by staff or by implementing standard disease-related clinical interventions (is not self-limiting) .c. requires interdisciplinary review and revision of care plan. 3. Prior to notifying the physician, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (Situation, Background, Assessment, Recommendation) Communication Form 8. The nurse will record in the resident's medical record information relative to changes to the resident's medical/mental condition status. During a review of the facility's P&P titled, Informed Consent-Psychotherapeutic Medications and Restraint Devices, dated 12/14/17, the P&P indicated, The attending physician will be responsible for ordering psychotherapeutic . medications. During a review of the facility's P&P titled, Conducting an Accurate Resident Assessment, dated 11/29/24, the P&P indicated, The purpose of this policy is to assure that all residents receive an accurate assessment reflective of the resident's status at the time of the assessment by the staff qualified to assess relevant care areas. Explanation and Compliance Guidelines:3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 35649 Based on observation, interview and record review, the facility failed to: 1. Ensure licensed nurses assessed and notified the physician of foot problems identified for two of two sampled patients (Resident 3 and Resident 149). 2. Ensure the podiatry recommendation dated 6/18/24 to refer one of one sampled resident (Resident 3) to a vascular surgeon was acted upon. 3. Ensure the attending physician documented visit for one of one sampled resident (Resident 149) in the Progress Notes and addressed Resident 149's need for podiatry consult. These failures had the potential to result in adverse consequences when treatments were delayed. Findings: 1. During a concurrent observation and interview on 12/2/24 at 9:59 a.m. with Certified Nursing Assistant (CNA) 1, in Resident 3's room, Resident 3's feet were dangling from the wheelchair and were noted to have foot drop (neurological symptom characterized by difficulty lifting the front part of the foot due to muscular or nerve problem) on both feet. The skin on both feet was dry and scaly. The big toenail on the right foot was long, hard, and thick with ragged edges, yellowish in color and had fungus-like appearance. Resident 3's right big toe was swollen, with purplish discoloration. The right second and third toes were reddish purple in color and swollen. In between the toes were blackish in color. The skin on the left foot was also dry and scaly. The left toes were swollen and reddish purple in color. The five toenails on the left foot were long, hard, and yellowish in color. CNA 1 attempted to reposition Resident 3's feet and noted he jerked his feet. CNA 1 stated he could be in pain. During a concurrent observation and interview on 12/2/24 at 10:35 a.m. with Administrator in Resident 3's room, Administrator observed the condition of Resident 3's feet. Administrator stated, The skin on both feet is dry and scaly, purplish discoloration, and peeling off on the right side of the right foot. The right big toenail is long, hard and thickened. The second toe of the right foot was stuck to the right big toe. In between the there's dirt (blackish substance). The left toenails were long, hard, thick and yellowish in color. The skin on the left foot was also dry and scaly. During a concurrent observation and interview on 12/2/24 at 10:45 a.m. with CNA 1 and Administrator, CNA 1 measured Resident 3's right big toenail and left big toenail. CNA 1 stated the right big toenail measured two and one-half centimeters (cm) in length and the thickness was 1 cm. CNA 1 stated the left big toenail was 3 cm in length and 2 cm in thickness. Resident 3 moved and jerked his feet while CNA 1 was measuring the toenails and while the feet were being handled. Administrator stated that jerky motion and the movement of the feet away from CNA 1's hands indicated pain. Resident 3 was non-verbal. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/4/24 at 11:35 a.m. with MDSC, Resident 3's Nursing Progress Notes (NPN) dated 12/2/24 was reviewed. MDSC was unable to find documentation the licensed nurse (LVN 1) assessed the feet and notified the physician. Resident 3's Nursing Weekly Summary (NWS), dated 11/5/24, 11/12/24, and 11/19/24, were reviewed. The NWS indicated Skin Evaluation- no changes from previous assessment. There was no documented assessment. Resident 3's Shower Sheets, dated 10/17/24, 10/21/24, 10/28/24, and 11/4/24 were reviewed. The shower sheets indicated, Does the resident need his/her nails toenails cut? Yes. During a review of Resident 3's care plan on Activities of Daily Living (ADL), [undated], the care plan indicated, Bathing/Showering: Check nail length and trim and clean on bath days and as necessary. Report any changes to the nurse. During a concurrent interview and record review on 12/4/24 at 11:40 a.m. with MDSC, The Situation, Background, Assessment, and Recommendation (SBAR communication tool), dated 12/3/24, was reviewed. MDSC stated the SBAR was started but not completed. MDSC stated there was no documentation the nurse notified the physician about the foot. 2, During a concurrent interview and record review on 12/4/24 at 11:32 a.m. with MDSC, Resident 3's Podiatry consult dated 6/18/24 was reviewed. The podiatry consult indicated, long, thick painful toenails. bilateral, elongated, discolored, painful on palpation. Diagnosis: nail dystrophy (toenails that are deformed, thickened, or discolored), Diabetes Mellitus (DM- high blood sugar) with diabetic neuropathy (nerve damage caused by diabetes), pain right foot, pain left foot, edema. Plan: recommend consult with vascular surgeon. MDSC was unable to provide documentation of Resident 3's referral to a vascular surgeon as recommended by the physician on 6/18/24. 3. During a concurrent observation and interview on 12/2/24 at 11:25 a.m. with Medical Doctor (MD) 1, in Resident 149's room, MD 1 examined Resident 149's feet. MD 1 stated Resident 149 had edematous feet due to congestive heart failure (CHF-heart cannot pump enough blood to supply one's body), but edema was decreasing. MD 1 observed Resident 149's feet were dry, scaly, toenails were long, hard, and yellowish in color. MD 1 stated Resident 149 needs to be referred to podiatry. During a concurrent interview and record review on 12/3/24 at 12:23 p.m. with LVN 2, Resident 149's Physician's Progress Note, dated 12/2/24, was reviewed. LVN 2 was unable to find MD 1's progress notes regarding the visit and evaluation of Resident 149's feet. LVN 2 was unable to find MD 1's physician's order for a podiatry referral. During a review of the facility's policy and procedure (P&P) titled, Documentation in Medical Record, revised 11/29/24, the P&P indicated, 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical records in accordance with state and federal laws. 4. Principles of documentation include, but not limited to b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or response to care. During a review of the facility's policy and procedure (P&P) titled, Podiatry Services, dated 7/2021, the P&P indicated, It is the policy of this facility to ensure residents receive proper treatment and care .to maintain mobility and good foot health. Policy Explanation and Compliance Guidelines: 2. Residents requiring foot care who have complicating disease processes will be referred to qualified professionals such as Podiatrist, Doctor of Medicine, and/or Doctor of Osteopathy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35649 Based on observation, interview, and record review, the facility failed to ensure the physician ordered catheter care for one of one sampled resident (Resident 25) who had an indwelling urinary catheter (soft, plastic or rubber tube that is inserted into the bladder to drain the urine) due to neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems). This failure had the potential for Resident 25 to develop urinary tract infection or other bladder infections. Findings: During a review of Resident 25's Admission Record, (AR) dated 7/10/24, the AR indicated Resident 25's admitting diagnosis included Neuromuscular Dysfunction of Bladder. During a concurrent observation and interview on 12/2/24 at 9:37 a.m. with Resident 25 in Resident 25's room, Resident 25 had an indwelling urinary catheter, with the catheter tubing noted to be cloudy. Resident 25 stated she's had an indwelling Foley catheter for the last three years, and has frequent urinary tract infections due to prolonged use of an indwelling Foley catheter. During a concurrent interview and record review on 12/5/24 at 10:06 a.m. with Director of Nursing (DON), Resident 25's Physician's Order (PO), dated 12/2024, was reviewed. DON was unable to provide documentation of a PO for catheter care. DON stated the only physician's orders written was to measure the urine intake and output every shift and intake and output at night. DON was unable to find documentation of an order to change Foley catheter. DON stated the last time Resident 25's indwelling Foley catheter was replaced was on 8/8/24 when it got dislodged. During a review of the facility's policy and procedure (P&P) titled, Appropriate Use of Indwelling Catheter, dated 7/2021, the P&P indicated, 4. The use of an indwelling urinary catheter will be in accordance with physician's orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of change (if applicable). The interdisciplinary team with the support and guidance from the physician, will assure ongoing review, evaluation, and decision-making regarding the insertion, continuation, or removal of an indwelling catheter.

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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. 41035 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 199) had a full portable oxygen tank (cylinder used to store oxygen) for use. This failure had the potential to cause an adverse reaction to Resident 199 including hypoxia (decreased oxygen level). Findings: During an observation on 12/4/24 at 8:42 a.m. in the facility's outside patio, Resident 199 was sitting in her wheelchair. Resident 199 had a nasal cannula (a thin plastic tube that delivers oxygen directly into the nose through two small prongs). Resident 199 was pursed lip breathing (an exercise that helps slow your breathing and maximizes the amount of oxygen that goes in and out of your lungs). Resident 199's nasal cannula tubing was attached to an empty oxygen tank. During a concurrent observation and interview on 12/4/24 at 8:45 a.m. with Licensed Vocational Nurse (LVN) 8 in the facility's outside patio, Resident 199 was noticed with pursed lip breathing while wearing a nasal cannula attached to the oxygen tank. The gauge in the oxygen tank indicated the tank was empty. LVN 8 stated the tank was empty and stated he should have checked before taking her out. During a review of Resident 199's Physician Order (PO), dated 12/3/24, the PO indicated, Oxygen @ 2 to 4 L/Min (liters per minute) via nasal cannula continuously for shortness of breath. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration dated 2021, the P&P indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice.1. Oxygen is administered under orders of a physician.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 45654 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled Abuse [inappropriate treatment of an individual], Neglect [refusal to provide the needs of the resident], and Exploitation [taking improper advantage of an individual], for twenty-seven of forty two sampled Certified Nursing Assistants ([CNA] 1, CNA 6, CNA 7, CNA 8, CNA 9, CNA 10, CNA 11, CNA 12, CNA 13, CNA 14, CNA 15, CNA 16, CNA 17, CNA 18, CNA 19, CNA 20, CNA 21, CNA 22, CNA 23, CNA 24, CNA 25, CNA 26, CNA 27, CNA 28, CNA 29, CNA 30, and CNA 31), 17 of 22 sampled Licensed Vocational Nurses ([LVN] 1, LVN 6, LVN 7, LVN 9, LVN 10, LVN 11, LVN 12, LVN 13, LVN 14, LVN 15, LVN 16, LVN 17, LVN 18, LVN 19, LVN 20, LVN 21, and LVN 22), and seven of eight sampled Registered Nurses ([RN] 1, RN 2, RN 3, RN 4, RN 5, RN 6, and RN 7), annual training. This failure had the potential for abuse in residents to go unnoticed and unreported within the facility. Findings: During a concurrent interview and record review on 12/4/24 at 9:15 a.m. with Director of Staff Development (DSD), the facility's annual training record on Recognizing and Reporting Elder and Dependent Adult Abuse Acknowledgement of Training (RREDAA), dated 1/3/24 through 7/23/24, was reviewed. The RREDAA record indicated the following facility staff had not received the annual training: CNA 1, no documented training. CNA 6, no documented training. CNA 7, no documented training. CNA 8, no documented training. CNA 9, no documented training. CNA 10, no documented training. CNA 11, no documented training. CNA 12, no documented training. CNA 13, no documented training. CNA14, no documented training. CNA15, no documented training. CNA 16, no documented training. CNA 17, no documented training. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 18, no documented training. CNA 19, no documented training. CNA 20, no documented training. CNA 21, no documented training. CNA 22, no documented training. CNA 23, no documented training. CNA 24, no documented training. CNA 25, no documented training. CNA 26, no documented training. CNA 27, no documented training. CNA 28, no documented training. CNA 29, no documented training. CNA 30, no documented training. CNA 31, no documented training. LVN 1, no documented training. LVN 6, no documented training. LVN 7, no documented training. LVN 9, no documented training. LVN 10, no documented training. LVN 11, no documented training. LVN 12, no documented training. LVN 13, no documented training. LVN 14, no documented training. LVN 15, no documented training. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 16, no documented training. LVN 17, no documented training. LVN 18, no documented training. LVN 19, no documented training. LVN 20, no documented training. LVN 21, no documented training. LVN 22, no documented training. RN 1, no documented training. RN 2, no documented training. RN 3, no documented training. RN 4, no documented training. RN 5, no documented training. RN 6, no documented training. RN 7, no documented training. DSD stated they did not have any additional training. DSD did not provide any additional documentation. During a review of the facility's P&P titled, Abuse, Neglect, and Exploitation, dated 11/29/24, the P&P indicated, existing staff will receive annual education through planned in-services and as needed.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 35649 Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 25 and Resident 40) had social services follow-up for medically-related social services. This failure resulted in delay of medically-related social services for Resident's 40's vision and dental services and Resident 25's dental services. Findings: During a concurrent observation and interview on 12/2/24 at 9:17 a.m. with Resident 40, in Resident 40's room, Resident 40 had missing teeth and only had six teeth on the bottom. Resident 40 stated the dentist saw her three months ago and had not returned. During a concurrent interview and record review on 12/4/24 at 3:05 p.m. with Social Service Director (SSD) 2, Resident 40's Dental Consult Notes (DCN), dated 10/7/24 was reviewed. The DCN indicated, Resident 40 was seen and examined on 10/7/24. Resident 40 needed a full mouth dentures and impressions. DSS 2 stated impressions take 2-3 months for approval from the insurance company but Resident 40's dental recommendations should. have been followed-up in November. SSD 2 stated there was no social services follow up. During an interview on 12/2/24 at 9:19 a.m. with Resident 40, Resident 40 stated the eye doctor had examined her and had not returned. During a concurrent interview and record review on 12/4/24 at 2:55 p.m. with SSD 1 and SSD 2, Resident 40's Physician's Order (PO), dated 7/15/24, was reviewed. The PO indicated, Vision for eye health with follow up and treatment as indicated. SSD 2 stated there was no documentation of social services follow up to refer Resident 40 to see an ophthalmologist (eye doctor). SSD 1 was unable to find documentation of an ophthalmologist referral. During a concurrent observation and interview on 12/2/24 at 9:30 a.m. with Resident 25 in Resident 25's room, Resident 25's teeth were noted to be yellowish in color, decayed, with missing and broken teeth. Resident 25 stated the dentist came and took dental x-rays and had not heard from them. During a concurrent interview and record review on 12/5/24 at 10:44 a.m. with Director of Nursing (DON) and Medical Records Director (MRD), Resident's DCN, dated 9/6/24, was reviewed. The DCN indicated x-rays recommended. DON stated she could not find a documentation of social services follow-up. MRD stated there were no social services follow up since 9/6/24. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Social Services, dated 9/2021, the P&P indicated, 2. Medically-related social services are provided to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating, ambulation, etc.); and mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose). 4. The social worker/social services staff are responsible for: g. making referrals and obtaining needed services from outside entities .5. Not all medically-related social services are provided by a qualified social worker. However, the facility is responsible for ensuring that all residents are provided these services whether by a staff member or through referrals to an outside agency. During a review of the facility's P&P titled, Referrals, Social Services, dated 12/2008, the P&P indicated, 4. Social services will document the referral in the resident's medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 32946 Based on observation, interview, and record review, the facility failed to follow its policy and procedure on Medication Storage for one of one sampled resident (Resident 99) when a medication was left unattended at bedside. This failure had the potential for residents to inadvertently use medication without being monitored. Findings: During an observation on 12/2/24 at 8:42 a.m. in Resident 99's room, a 30 milliliter (ml) a plastic medication cup was 3/4 full of a blue gel-like substance sitting on the bedside table. During a concurrent observation and interview, on 12/2/24 at 8:47 a.m. with Licensed Vocational Nurse (LVN) 6, in Resident 99's room. LVN 6 lifted the 30 ml medication cup up to her nose and smelled the contents. LVN 6 stated, Its Bio-freeze gel (medication used to treat minor aches and pains of the muscles/joints). LVN 6 stated she did not know how long the medication cup had been sitting on Resident 99's bedside table. LVN 6 stated, It's something that is found on the medication treatment cart. During a concurrent observation and interview on 12/2/24 at 8:55 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 99's room, CNA 3 was seen looking at the medication cup containing the Bio-freeze. CNA 3 stated she did not know who placed the medication cup on the bedside table of Resident 99. During a concurrent observation and interview on 12/2/24 at 9:05 a.m. with Director of Nursing (DON), in Resident 99's room, DON was seen holding the medication cup containing the Bio-freeze gel. DON stated, it should not have been left in the room. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 11/29/2024, the P&P indicated, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35649 Based on observation, interview, and record review, the facility failed to: 1. Ensure one of one sampled resident (Resident 1) received the food as written on the meal ticket to meet the resident's nutritional requirement. 2. Assess Resident 1's ability to cut the meat in bite size and feed herself. These failures had the potential for Resident 1 to not be able to eat and receive the necessary nutritional value. Findings: 1. During meal observation on 12/2/24 at 12:13 p.m. in Resident 1's room, Resident 1's lunch tray was placed on the overbed table. The lunch tray included roasted pork loin, parmesan crusted sweet potatoes, butter cabbage, peach cobbler, house shake, a glass of milk, and a cup of coffee. During a concurrent interview and record review on 12/2/24 at 12:15 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's meal ticket was reviewed. The meal ticket indicated, Notes: Ice cream lunch and dinner; fortified (food has an extra nutrient added) soup for lunch; add sandwich with tray; add Nutri juice in a cup for lunch and dinner. LVN 1 stated Resident 1's meal tray did not include ice cream, fortified soup, sandwich, or a cup of Nutri juice. During an interview on 12/3/24 at 9:59 a.m. with Certified Dietary Manager (CDM), CDM stated the items missing on Resident 1's meal tray should have been included. During a review of Resident 1's Physician's Order dated 3/24/23, the PO indicated, Ice cream with syrup or whip cream two times a day (BID) with lunch and dinner. 2. During a concurrent observation and interview on 12/2/24 at 12:27 p.m. with LVN 1, in Resident 1's room, Resident 1 was having a hard time cutting the meat as demonstrated by Resident 1's effort in using the knife and cutting through the meat. Resident 1 stated, the meat was tough. LVN 1 attempted to assist Resident 1. During a concurrent interview and record review on 12/3/24 at 9:53 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 1's Nursing Progress Notes (NPN), dated 12/2/24, was reviewed. MDSC was unable to find nursing documentation regarding Resident 1's difficulty cutting the meat. MDSC stated there was no documentation the physician was notified about Resident 1's difficulty cutting the meat and eating. Resident 1's care plan, dated 12/2/24, was reviewed. MDSC was unable to find documentation the care plan was updated to ensure resident' needs were met. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Menus, dated 2/2020, the P&P indicated, The Nutrition Services Manager will develop menus in collaboration with the Registered Dietitian and review menus for nutritional adequacy. Menus are to be designed in consideration of resident preferences. Food served should adhere to the written menu.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 41035 Based on observation, interview, and record review, the facility failed to ensure an assistive feeding device was available for one of one sampled resident (Resident 13). This failure had the potential to negatively impact Resident 13's nutritional status. Findings: During a concurrent observation and interview on 12/2/24 at 12:43 p.m. with Certified Dietary Manager (CDM) in Resident 13's room, Resident 13's lunch tray was at his bedside. On the tray was a regular ceramic lunch plate. CDM stated Resident 13 has a regular plate and she thinks he needs a different type of plate. During a concurrent interview and record review on 12/2/24 at 12:44 p.m. with CDM, Resident 13's undated Meal Ticket (MT) was reviewed. The MT indicated Divided Plate. CDM stated Resident 13 should have been served on a divided plate and he was served on a regular plate. During a review of the facility's policy and procedure (P&P) titled, Adaptive Equipment-Feeding Devices, dated 2020, the P&P indicated, a. the facility will provide residents appropriate assistance to ensure that the resident can use the assistive device when consuming meals and snacks.Types of Adaptive Equipment are but not limited to B. Built-up dish with inner lip C. Special cups D. Special cups and glass holders E. Plate guards.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to ensure the Binding Arbitration Agreement (BAA - formed when two parties enter into a contract and agree in writing that any disputes arising between them out of that contract will have to be resolved without going to the courts and with the assistance of a neutral person) offered to six of six sampled residents (Resident 2, Resident 21, Resident 25, Resident 34, Resident 40, and Resident 149) were provided in a form and language that the residents and/or resident representatives understood. This failure had the potential for Residents 2, 21, 25, 34, 40, and 149 to not fully understand the terms and conditions stipulated in the arbitration agreement. Findings: During a concurrent interview and record review on 12/3/24 at 3:19 p.m. with Business Office Manager (BOM), BOM stated there were 30 residents who signed the BAA. BOM stated the residents and/or resident representatives did not request for the arbitration agreement, but she offered the arbitration agreement and discussed with them during the admission process. BOM stated, I presented them with the arbitration agreement, and they agreed to sign the agreement. I explained to the residents and their representatives that they will waive their rights to go to court if there was a malpractice. BOM stated she only explained what an arbitration was and did not discuss the Articles (actual contract of the agreement) included in the Arbitration Agreement. BOM stated not everyone spoke the English language. Resident 40 spoke Tagalog (Filipino language), Resident 21 spoke [NAME] (Indian language), and Resident 3 spoke Spanish (Hispanic language). BOM stated she spoke Spanish and could translate for the Spanish-speaking residents. BOM stated the facility did not have the agreement form in any other language that the resident or family could understand, except in English. BOM stated she could not explain every paragraph written in the agreement form. During a concurrent interview and record review on 12/3/24 at 3:30 p.m. with BOM, Resident 34's BAA, dated 1/19/23, was reviewed. The BAA was signed by Resident 34 herself. A review of Resident 34's Brief Interview of Mental Status (BIMS - a tool used to screen and identify the cognitive condition of the residents upon admission using a point system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment. 8 to 12 points suggests moderate cognitive impairment. 13 to 15 points suggests that cognition is intact) score indicated 5. BOM stated there was no other measure or manner to evaluate and determine whether the resident understood the terms and conditions of the binding agreement contract. BOM was unable to articulate how BAA would be handled in case a dispute arose. BOM was unable to state where the venue would be in the event of an arbitration. During a concurrent interview and record review on 12/3/24 at 3:45 p.m. with BOM, Resident 3's BAA, dated 6/27/24, was reviewed. Resident 3's BAA was signed by the niece. BOM stated Resident 3's niece did not have a legal power of attorney. BOM stated Resident 3's niece spoke English. BOM stated she provided the niece with a copy of the BAA in English form, not in the language spoken or understood by the resident or the resident's representative. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/5/24 at 3 p.m. with Resident 25, Resident 25's BAA, dated 7/11/24, was reviewed. Resident 25 has a BIMS of 15. Resident 25 stated she really did not understand what she signed for, but she signed the BAA on admission. Resident 25 stated, I don't remember what I signed. I did not fully understand, but I had to sign a bunch of papers on admission and that was one of them. During a concurrent interview and record review on 12/5/24 at 3:15 p.m. with Resident 149, Resident 149's BAA, dated 11/7/24, was reviewed. Resident 149 stated he did not remember what he signed but he signed a lot of papers on admission. Resident 149 stated, The lady on admission told me about not going to court when there was a dispute, I signed the paper. During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreement, dated 11/29/24, the P&P indicated, Policy Explanation and Compliance Guidance: 1. When explaining the arbitration agreement, the facility will: a. Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission, or as a requirement to continue to receive care at this facility. b. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure the resident or his or her representative acknowledge that he or she understands the agreement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on observation, interview, and record review, the facility failed to: 1. Ensure staff were provided education on Prevention and Recognition of signs and symptoms of Legionnaires' Disease (waterborne bacteria that cause serious lung disease) and/or other opportunistic waterborne pathogens. 2. Ensure surveillance for infection were properly conducted, data collected, analyzed, track and trended for 52 of 52 residents residing in the facility. 3. Follow infection prevention and control practices in accordance with the Centers for Disease Control and Prevention (CDC, national health organization) guidelines in the facility. 4. Ensure one of one suction machines was maintained in a clean and sanitary manner. These failures had the potential to transmit infectious diseases. Findings: 1. During a concurrent interview and record review on 12/3/24 at 9:15 a.m. with Infection Preventionist (IP) and Maintenance Supervisor (MS), Water Management Program (WMP) dated 10/31/24, was reviewed. The WMP indicated, The facility will educate nursing staff about Legionnaires' Disease to aid in early identification. IP was unable to provide documentation of Legionnaires' Disease education and stated, I don't have it. I have not given education on Legionnaires' Disease. During a review of the facility's policy and procedure (P&P) tiled, Legionella, dated 6/2020, the P&P indicated, II. Identification of Legionnaires' Disease: A. The facility will educate nursing staff about Legionnaires' Disease to aid in early identification. B. Clinical features of Legionnaires' Disease include cough, fever, and radiographic pneumonia. C. If any of the following are identified, the facility will notify the attending physician and the physician will determine the need for testing of Legionnaires' Disease. 2. During a concurrent interview and record review on 12/5/24 at 12 p.m. with IP, Infection Control Surveillance Activities were reviewed. IP stated the infection control surveillance activities were on hand hygiene and donning (putting on) and doffing (taking off) of Personal Protective Equipment (PPE- refers to gowns, gloves, masks, face shields worn to protect the individual from infection or injury). IP was unable to provide documentation of infection control surveillance activities. IP stated, I do not have those adherences. I have competencies on hand hygiene and donning and doffing of PPE. During a review of the facility's P&P titled, Surveillance for Infection, dated 9/2017, the P&P indicated, The infection preventionist will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventive interventions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3a. During a concurrent observation and interview on 12/2/24 at 10:23 a.m. with Housekeeper (HSK) in Shower room [ROOM NUMBER], there was a kidney basin with six razors and two shaving creams that were not identified. HSK stated she was not sure if the razors had been used. HSK stated she tried to clean and throw away the razors every morning, but they reappear every day. 3b. During a concurrent observation and interview on 12/2/24 at 10:30 a.m. with HSK in Shower room [ROOM NUMBER], there were three wheelchair footrests on top of the trash can. HSK stated the wheelchair footrests should not be there. HSK stated there's a bucket for footrests that don't work, and a separate bucket for footrests that work. HSK stated the footrests should not be left in the shower room. HSK stated every equipment shared by residents should be disinfected. 3c. During a concurrent observation and interview on 12/2/24 at 10:40 a.m. with Certified Nursing Assistant (CNA) 2, the Hoyer Lift (transfer equipment) that was used to transfer Resident 3 from wheelchair to bed was taken out of Resident 3's room and stored in Hallway 1 without being cleaned and disinfected. CNA 2 stated she did not disinfect the Hoyer Lift. CNA 2 stated the Hoyer Lift should be disinfected before and after resident use. 3d. During a concurrent observation and interview on 12/2/24 at 12:41 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 11's room, the nasal cannula tubing (a device that delivers extra oxygen through a tube and into one's nose) was not labeled with a date when the nasal cannula/oxygen tubing was changed. LVN 1 stated the respiratory therapist is responsible for changing and dating the respiratory care equipment and tubing. During an interview on 12/2/24 at 2:45 p.m. with Respiratory Therapist (RT), RT stated RT handles all the respiratory care 12 hours per shift starting from 6 a.m.- 6:30 p.m. everyday. RT stated nasal cannulas were changed every seven days, on Sundays. RT stated the tubing should have been changed and marked with the date when changed. During a review of the facility's P&P, titled, Cleaning and Disinfection of Resident-Care Equipment, dated 11/29/24, the P&P indicated, Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current Centers for Disease Control (CDC) recommendations to break the chain of infection . Single-use items are items that are designed to be used once, for only one person .These items are to be discarded after use, and therefore, cleaning is not required . 3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines: a .Discard single-use items after use. d. Multiple-resident use equipment shall be cleaned and disinfected after each use. 3e. During a concurrent observation and interview on 12/2/24 at 3 p.m. with RT in Resident 149's room, the Bilevel Positive Airway Pressure (BIPAP- a noninvasive mode of ventilation administered through a tight-fitting mask to assist with breathing) mask was left uncovered on top of the bedside table. RT stated the BIPAP mask should be placed in a covered container after each use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Oxygen Administration, dated 11/29/24, the P&P indicated, Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated . e. Keep delivery devices covered in plastic bag when not in use. 3f. During a concurrent observation and interview on 12/3/24 at 9:40 a.m. with Maintenance Supervisor (MS), in the clean area of the laundry room, approximately 10-12 boxes of laundry supplies in original boxes on a wood palette and approximately 8-10 three-tiered plastic containers were stored on the floor. MS stated the medical supplies included curtains, pillows, and sheets and the plastic containers were isolation carts brought in from the facility. MS stated the supplies had not been taken out of the original boxes and acknowledged the potential for infestation of pests that could be in the boxes and now stored in the clean area of the Laundry. 3g. During a concurrent observation and interview on 12/3/24 at 10 a.m. with MS, in the Laundry, the clean area and dirty area was separated with a red mark on the floor. The clean area and dirty area did not have a barrier to define the separation of the clean and dirty area in the Laundry. As one enters the laundry area, the right side was designated as dirty, and the left side was designated as clean. In the dirty area, there were barrels used for soiled clothing/linens and two washing machines. In the clean area, there were linen carts for clean clothing and washed linens, the hanging area for clean resident clothing, counter for folding clothes, and two clothes dryers. During an interview on 12/3/24 at 10:10 a.m. with Laundry Aide (LA), LA stated she sorts soiled clothes from the barrel in the dirty area. In the process of sorting clothes, LA uses some agitation of the soiled clothes, which had the potential to contaminate the clean clothing in the clean area through contaminants in the air blown from the dirty area to the clean area. The exhaust fan was on the wall in the clean area, which was closed during the inspection of the laundry area. There was no proper ventilation. During an interview on 12/3/24 at 10:15 a.m. with MS, MS stated the exhaust in the Laundry was closed and would only be open dependent on the workers. During a review of the facility's P&P titled, Laundry Services, dated 2024, the P&P indicated, 4. Soiled laundry shall be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons .b. Sorting of laundry shall occur after washing .6. If using fans in laundry processing areas, prevent cross-contamination of clean linens from air blowing from soiled processing areas (i.e., the ventilation should not flow from soiled processing areas to clean laundry areas. 3h. During a concurrent observation and interview on 12/2/24 at 10:18 a.m. with CNA 1 in Resident 3's room, CNA 1, with gloves on, provided direct care for Resident 3 and helped transfer Resident 3 from wheelchair to bed. CNA 1 removed her gloves but did not perform hand hygiene and proceeded to assist Resident 16. CNA 1 then took the shower chair and a bag filled with trash and entered Shower room [ROOM NUMBER]. CNA 1 stated she did not wash her hands. 41035 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/2/24 at 11:59 a.m. in the main dining room, CNA 6 placed wheeled Resident 199 to the dining table for lunch without providing Resident 199 with hand hygiene before lunch. During an interview on 12/2/24 at 12:16 p.m. with Activities Assistant (AA), AA stated the process is to wash the residents hands prior to eating. During a concurrent observation and interview on 12/2/24 at 12:33 p.m. with CNA 5 in Resident's 42's room. CNA 5 delivered Resident 42's food tray without providing Resident 42 with hand hygiene. CNA 5 stated resident 42 did not receive hand hygiene before receiving her meal and stated she should have offered it to her. During a review of the facility's policy and procedure (P&P) titled, Meal Service, dated 2018, the P&P indicated, 8. Residents'/patients' hands should be cleaned before each meal and after as needed. During a review of the facility's policies and procedures (P&P), the P&P titled, Hand Hygiene, dated 5/2024, the P&P indicated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . 6. Additional Considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . 32946 4. During a concurrent observation and interview on 12/2/24 at 9:24 a.m. with LVN 6, in Resident 101's room, a suction machine with a plastic container attached contained tan frothy liquid. LVN 6 stated, the plastic collection container contained 350 milliliters (unit of measurement) of the tan frothy liquid. Resident 101 stated the tan frothy liquid had been inside the plastic collection container for two days. LVN 6 stated the collection container was not marked with a time or date. During a review of the facility's P&P, titled, Cleaning and Disinfection of Resident-Care Equipment, dated 11/29/24, the P&P indicated, Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current Centers for Disease Control (CDC) recommendations to break the chain of infection. 3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 35649 Based on interview and record review, the facility failed to maintain an effective antibiotic stewardship program (efforts in hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate) when: 1. The Infection Preventionist (IP) failed to evaluate and follow up one of one resident (Resident 199) treated with antibiotic for fungal infection. 2. Antibiotic Stewardship Meeting under the leadership of the Pharmacist, the Medical Director, and Director of Nursing has not been conducted. 3. Antibiotic Stewardship education has not been provided to the nursing staff. These failures had the potential for residents to be inappropriately treated with antibiotics, which could be detrimental to the residents' medical care related to antibiotic use. Findings: 1. During a concurrent interview and record review on 12/5/24 at 11:34 a.m. with IP, Resident 199's Antibiotic Stewardship Log (ASL), dated 11/2024, was reviewed. The ASL indicated Resident 199 was started on Fluconazole (used to treat serious fungal or yeast infections) 200 milligrams (mg) four (4) tablets daily. IP stated Resident 199 was admitted to the facility with fungal infection. IP was unable to provide documentation of an X-ray or blood work ordered at the facility to validate Resident 199's diagnosis of fungal infection. IP was not aware why Resident 199 was on Fluconazole. IP stated she did not talk to the physician as to why Resident 199 was on Fluconazole. 2. During a concurrent interview and record review on 12/5/24 at 11:58 a.m. with IP, IP stated she did not have antibiotic stewardship meeting. IP stated the pharmacist has not been involved in the antibiotic stewardship program. IP stated. I do not consult with the pharmacist. 3. During a concurrent interview and record review on 12/5/24 at 12 p.m. with IP, IP was unable to provide evidence of Antibiotic Stewardship education provided to the nursing staff. IP stated she has not conducted education on antibiotic stewardship. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, dated 2023, the P&P indicated, 1. The Medical Director, Director of Nursing, and Consultant Pharmacist serve as the leaders of the Antibiotic Stewardship Program .b. Monitoring antibiotic use: ii. Antibiotic orders obtained upon admission, whether new admission or readmission to the facility, shall be reviewed for appropriateness . 9. Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families .11. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to e. Antibiotic stewardship meeting minutes .g. Records related to education of physicians, staff, residents, and families.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555053	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	729 Browning Road Delano, CA 93215

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 51320 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled Influenza (Flu contagious respiratory disease)Vaccine for five of 32 sampled residents (Resident 2, Resident 7, Resident 8, Resident 10, and Resident 100) when: 1. Resident 10, Resident 8, and Resident 7 were given influenza vaccine without informed consents obtained from the residents or their legal representatives (LR). 2. Resident 100 and Resident 2 did not receive explanation of risks and benefits for their refusal of the flu vaccines. 3. There was no documentation of date, lot number (essential for tracking the exact vaccine used especially in case of adverse reactions or recalls), expiration date, person administering, and site of injection of the flu vaccine vaccine administered to Resident 7. These failures had the potential for inaccurate documentation and spread of infectious diseases. Findings: 1. During a concurrent interview and record review on 12/5/24 at 8:38 a.m. with Infection Preventionist (IP), Resident 10's clinical record was reviewed. IP stated she could not find a signed consent for the administration of flu vaccine to Resident 10. IP stated Resident 10 should have a consent. During a concurrent interview and record review on 12/5/24 at 8:40 a.m. with IP, Resident 8's Consent for Flu Vaccine (CFV),[undated] was reviewed. Resident 8's CFV was not signed by Resident 8 or by Resident 8's LR. During a review of Resident 7's CFV, [undated], the CFV indicated there was no consent/signature of Resident 7 or Resident 7's LR to receive flu vaccine. 2. During a concurrent interview and record review on 12/5/24 at 8:56 a.m. with IP, Resident 100 and Resident 2 vaccine records were reviewed. There were no declination statements for refusal of vaccines. IP stated there needs to be risks and benefits. During a concurrent interview and record review on 12/5/24 at 9:16 a.m. with IP, Resident 100 and Resident 2's vaccination records were reviewed. IP stated she has an excel sheet to keep track of the vaccines, but I have not had time to update it (vaccination record). 3. During a review of Resident 7's Administration Note (AN), dated 10/18/24, Resident 's AN indicated Resident 7 flu vaccine was administered with no documentation of lot number, expiration date, person administering, and site of injection. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Influenza Vaccine, dated August 2016, the P&P indicated, The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives) .4 .Provision of such education shall be documented in the resident' .medical file. 5. For those who receive the vaccine, the date of vaccination .will be documented in the resident's medical record. 6. A resident refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 51320 Based on interview and record review the facility failed to complete the Covid-19 (Coronavirus disease (COVID- a highly contagious respiratory disease) consent form for four of 31 sampled residents (Resident 10, Resident 7, Resident 100, and Resident 2) when: 1. Resident 10 and Resident 7 received Covid-19 vaccine without consent from the residents or their legal representatives (LR). 2. Resident 100 and Resident 2 were not explained of risks and benefits for refusing the Covid-19 vaccines. These failures had the potential for inaccurate medical records and spread of infectious diseases. Finding: 1. During a concurrent interview and record review on 12/5/24 at 8:38 a.m. with Infection Preventionist (IP), Resident 10's Consent for COVID -19 Vaccination, [undated] was reviewed. IP stated she could not find a consent for Covid-19 vaccine for Resident 10. IP stated Resident 10 should have a consent. During a review of Resident 7's Consent, [undated], the Consent indicated there was no signature of Resident 7 or her LR. 2. During a concurrent interview and record review on 12/5/24 at 8:56 a.m. with IP, Resident 100 and Resident 2's vaccination records were reviewed. There were no documentation of risks and benefits for refusal of the Covid-19 vaccine. During a concurrent interview on 12/5/24 at 9:16 a.m. with IP, IP stated,I have not had time to update it [vaccination records]. During an interview on 12/5/24 at 3:55 p.m. with Nurse Consultant (NC), NC stated the facility has no policy on completion of vaccination consents.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 35649 Based on observation, interview, and record review, the facility failed to ensure one of one resident (Resident 11)'s oxygen tank with an attached gauge (a medical device designed to display the pressure level in an oxygen tank or cylinder) was secured when stored. This failure had the potential for health hazard and place residents at risk for harm. Findings: During a concurrent interview and record review on 12/2/24 at 12:41 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 11's room, an oxygen tank with an attached gauge meter and oxygen tubing wrapped around the tank, was found standing unsecured on the right side of Resident 11's bed. LVN 1 stated the oxygen tank should be in a rack. During an interview on 12/2/24 at 2:45 p.m. with Respiratory Therapist (RT), RT stated the director of respiratory care was aware, after the fact, that an oxygen tank was found standing unsecured, not in an oxygen rack. RT stated, That was absolutely not acceptable. RT stated it's dangerous and could hurt the resident and the staff. During a review of the facility's policy and procedure (P&P) titled Oxygen Safety, dated 11/29/24, the P&P indicated, 4. Oxygen Storage: c. Cylinders will be properly chained or supported in racks or other fastenings (i.e., sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty . j. Do not store oxygen cylinders with gauges attached to the cylinders .7. Liquid Oxygen: a. Liquid oxygen base reservoir containers shall be secured while in storage or in use to prevent tipping over.