STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to: 1. Ensure call lights were positioned within reach for 11 of 58 residents (3, 23, 33, 85, 87, 140, 156, 189, 197, 221, 401) , during initial tour, reviewed for call lights; and 2. A bariatric bed (a specialized bed made to accommodate larger, heavier than usual residents) was not provided as ordered by the physician for one of one resident (401) reviewed for accommodation of needs. This failure had the potential to endanger the health, safety, and recovery of the residents. Findings: 1a. Resident 3 was admitted to the facility on [DATE], with diagnoses which include anxiety disorder and schizophrenia (a mental disorder resulting in a faulty perception with withdrawal from reality), per the facility's Admission Record. On 4/23/24 at 9:54 A.M., an observation was conducted in Resident 3's room. Resident 3 was asleep on her right lateral side. The call light button and attached cord was lying on the floor, near the right side of the bed, out of the resident's sight and reach. On 4/23/24 at 3:07 P.M., a second observation was conducted of Resident 3's room. Resident 3 was lying flat in bed and was awake. The call light button and attached cord was lying on the floor, beside the right side of the bed, out of the resident's sight and reach. On 4/24/24 at 7:56 A.M., an observation was conducted of Resident 3's room. Resident 3 was asleep in bed, with her breakfast tray covered on the right side of the bed. The call light button and attached cord was lying on the floor, at the right side of the bed. On 4/25/24, Resident 3's clinical record was reviewed: The quarterly MDS (clinical assessment tool), dated 11/16/23, listed a cognitive score of 99, indicating cognition assessment could not be completed. The mental status assessment indicated the resident was oriented to place, time, and staff, but was moderately impaired related to decision making. The Functional Abilities indicated Resident 3 could ambulate with no assistive devices. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, titled ADL (activities of daily living) Functional Status, dated 12/20/23, listed interventions such as, call light within reach and attend needs promptly. 1b. Resident 23 was readmitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record. On 4/23/24 at 8:56 A.M., an observation was conducted of Resident 23's room. Resident 23 was lying supine in bed. The call light cord was wrapped around the upper right bed rail and the button was hanging down vertically toward the floor. The call light was out of the resident's sight and reach. On 4/25/24, Resident 23's clinical record was reviewed: The Admission MDS, dated [DATE], listed a cognitive score of 10, indicating moderately impaired cognition. The Functional Status indicated Resident 23 required assistance with bathing, dressing and personal hygiene. The care plan, titled ADL Functional Status, dated 11/28/23, listed interventions such as, call light within reach and attend needs promptly. 1c. Resident 33 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke) affecting the left non-dominant side, per the facility's Admission Record. On 4/23/24 at 9:26 A.M., an observation was conducted of Resident 33's room. Resident 33 stated he could not find his call light and asked me to assist with locating it. The call light cord was traced from the wall socket to behind the head of the bed, hanging vertically towards the floor. The call light was out of sight and reach of the resident. On 4/24/24 at 8:09 A.M., a second observation was conducted inside Resident 33's room. The call light cord was wrapped around the left upper bed rail and the button was hanging down vertically towards the floor. The head of the bed was elevated, due to the resident eating breakfast and the call button was out of the resident's sight and reach. On 4/25/24, Resident 33's clinical record was reviewed: The quarterly MDS, dated [DATE], listed a cognitive score of 3, indicating cognition was severely impaired. The Functional Abilities indicated Resident 33 required assistance with, sitting, rolling from side to side, transferring from bed to chair and all other functions. The care plan, titled ADL Functional Status, dated 5/4/23, listed interventions such as, call light within reach and attend needs promptly. 1d. Resident 85 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder, (a mental health condition with symptoms of schizophrenia and a mood disorder), per the facility's Admission Record. On 4/23/24 at 10:15 A.M., an observation of Resident 85's room was conducted. Resident 85 was asleep in bed, lying in a left lateral position. The call button and attached cord was lying on the floor, near the right side of the bed. The call button was out of the resident's sight and reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at 3:09 P.M., a second observation was conducted. Resident 85 was sitting up in bed, watching television. The call light was lying on the floor, near the right side of the bed. On 4/24/24 at 7:52 A.M., a third observation was conducted. Resident 85 was asleep with her breakfast tray covered on the bedside table. The call light was on the floor, to the right side of the bed. On 4/25/24, Resident 85's clinical record was reviewed: The quarterly MDS, dated [DATE], listed a cognitive score of 12, indicating the resident was cognitively intact. The Functional Abilities indicated maximum assist was required from staff for transfers from bed to chair, rolling from side to side and incontinence care. The care plan, titled Self Care deficit related to decreased movement, dated 3/17/24, listed interventions such as, call light within reach and attend needs promptly. 1e. Resident 87 was admitted to the facility on [DATE], with diagnoses which included cerebral infarctions (strokes), per the facility's Admission Record. On 4/24/24 at 7:45 A.M., and at 11:18 A.M., an observation was conducted in Resident 87's room. Resident 87 was lying in bed watching television. The call light cord was wrapped around the upper right bed rail and the button was hanging vertically down towards the floor. The call light button was out of the resident's sight and reach. On 4/25/24 at 8:28 A.M., an observation and interview was conducted with Resident 87. The call light on lying on the bed near the resident's left hand. Resident 87 stated when she can't find her call light she begins to panic because she might need help, and no one would know it. On 4/15/24 Resident 87's clinical record was reviewed: The quarterly MDS, dated [DATE], listed a cognitive score of 13, indicating cognition was intact. The Functional Status indicated Resident 87 required partial assistance with rolling from side to side, transferring from bed to chair and with personal care. The care plan, titled ADL Functional Status, 7/13/23, listed interventions such as, call light within reach and attend needs promptly. 1f. Resident 140 was readmitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke), per the facility's Admission Record. On 4/23/24 at 9:34 A.M., and 3:04 P.M., an observation was conducted in Resident 140's room. A square touch pad with a cord attached was tied behind the head of the bed to a pull string, used for the overhead light. The touch pad was out of the resident's sight and reach. On 4/25/24, Resident 140's clinical record was reviewed: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual MDS, dated [DATE], listed a cognitive score of 99, indicating cognition assessment could not be completed. The Functional Abilities indicated Resident 140 required maximum staff assist with turning, moving, and personal care. The care plan, titled At Risk for self-care deficit, dated revised 2/2/24, listed interventions such as, call light within reach and attend needs promptly. 1g. Resident 156 was admitted to the facility on [DATE], with diagnoses which include metabolic encephalopathy (a chemical dysfunction in the brain), per the facility's Admission Record. On 4/23/24 at 9:25 A.M., and at 3:02 P.M., an observation was conducted in Resident 156's room. The resident was lying in bed and the call button with the cord attached was lying on the floor, next to the right side of the bed. On 4/25/24, Resident 156's clinical record was reviewed: The quarterly MDS, dated [DATE], listed a cognitive score of 99, indicating a cognition assessment could not be completed. The Functional Abilities indicated Resident 156 required maximum staff assist with turning, moving, and personal care. 1h. Resident 197 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a mental health condition with symptoms of schizophrenia and a mood disorder), per the facility's Admission Record. On 4/23/24 at 8:57 A.M., an observation was conducted in Resident 197's room, in bed. The call light cord was wrapped around the upper right bed rail. The call light button was hanging down towards the floor, which was out of the resident's sight and reach. On 4/25/24, Resident 197's clinical record was reviewed: The Admission MDS, dated [DATE], listed a cognitive score of 13, indicating cognition was intact. The Functional Abilities indicated Resident 197 required supervision with turning, moving, and transferring. The care plan, titled ADL Functional Status, dated 12/11/22, listed interventions such as, call light within reach and attend needs promptly. 1i. Resident 189 was readmitted to the facility on [DATE], with diagnoses which included encephalopathy (a chemical dysfunction in the brain), per the facility's Admission Record. On 04/23/24 at 10:31 A.M., an observation was conducted of Resident 189's room. The call light was clipped to the upper pillowcase on the right side, above the resident's head and the call button was hanging down towards the floor. The call light was out of the resident's sight and reach. On 4/25/24, Resident 189's clinical record was reviewed: The quarterly MDS, dated [DATE], listed a cognitive score of 2, indicating cognition was severely impaired. The Functional Abilities indicated the resident was dependent for all care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, titled ADL Functional Status, dated 3/28/23, listed interventions such as, call light within reach and attend needs promptly. 1j. Resident 221 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record. On 04/23/24 at 8:16 A.M., and at 2:37 P.M. an observation was conducted of Resident 221's room. Resident 221 was lying in bed, dressed, with soft music playing on the radio. The call light was clipped to the right upper pillowcase and the call button was hanging down towards the floor, out of the resident's sight and reach. On 4/25/24, Resident 221's clinical record was reviewed: The quarterly MDS, dated [DATE], listed a cognitive score of 00, indicating they were unable to assess the cognition status. The Functional Abilities indicated Resident 221 required supervision only for transferring, showers, and personal care. The care plan, titled ADL Functional Status, dated 12/11/23, listed interventions such as, call light within reach and attend needs promptly. 1k. Resident 401 was admitted to the facility on [DATE], with diagnoses which included acute (sudden) and chronic (long term) respiratory failure, per the facility's Admission Record. On 4/24/23 at 8:21 A.M., an observation was conducted of Resident 401's room. The call light was wrapped around the upper left bed rail and the call button was hanging down towards the floor, out of the resident's sight and reach for the resident. On 4/25/24, Resident 401's clinical record was reviewed: The Admission MDS, dated [DATE] listed a cognitive score of 13, indicated cognition was intact. The Functional Status indicated Resident 401 required maximum assistant with rolling side to side, moving from bed to chair, and personal care. The care plan, titled Self Care deficit related to decreased movement, dated 3/10/24, listed interventions such as, call light within reach and attend needs promptly. On 4/24/24 at 8:21 A.M., an interview was conducted with CNA 31. CNA 31 stated call lights should always be positioned on the bed and in reach of the resident's hand. CNA 31 stated if call lights were not within reach, residents could try to get out of bed without assistance and fall. CNA 31 stated the call lights were a way of resident's letting staff know they needed assistance and were important to give them a sense of control. On 4/24/24 at 3:32 P.M., an interview was conducted with LN 31. LN 31 stated at the beginning of every shift and throughout the day, she expected CNAs to inspect the resident's room, to ensure call lights were in place and their needs were met. LN 31 stated if resident did not have access to a call light, they could not communicate with staff that they needed something. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 4:12 P.M., an interview was conducted with the DSD. The DSD stated all staff were expected to check call light placement when entering a resident room, and to make sure the resident had access to call for assistance. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated she expected call lights to always be in reach of residents so they could call for help when needed. Per the facility's policy, titled Call System, Resident, dated September 2022, 1. Each resident is provided with a means to call staff directly for assistance from his/her bed . 2. Resident 401 was admitted to the facility on [DATE], with diagnoses which included morbid (severe) obesity, per the facility's Admission Record. On 4/23/24 at 2:22 P.M., an observation and interview was conducted within Resident 401's room. Resident 401 was in an extra-large electric wheelchair and had a regular mattress on her bed. Resident 401 stated she was just admitted three few weeks ago and was still getting use to the facility. On 4/24/24, Resident 401's clinical record was reviewed. The Admission MDS, dated [DATE] listed a cognitive score of 13, indicating cognition was intact. The Functional Status indicated Resident 401 required maximum assistant with rolling side to side, moving from bed to chair, and personal care. According to the physician orders dated 3/6/24, .Bariatric mattress . On 4/24/24 at 3:51 P.M., an observation, interview, and record review was conducted with LN 31. LN 31 reviewed Resident 401's admission orders and stated a bariatric mattress was ordered. LN 31 observed Resident 401's room and stated, That's not a bariatric mattress. LN 31 stated when a resident was admitted , it was the responsibility of the admission nurse to carry out all the orders. LN 31 stated the Director of Maintenance (DM) would have been notified, to order the special mattress. When the mattress arrived, the DM and his staff would set up the mattress in the room. LN 31 stated the mattress should have been ordered and set up and it was not. LN 31 stated this could have caused the resident to be uncomfortable and feel confined with the regular mattress. On 4/25/24 at 2:47 P.M. an interview was conducted with the DON. The DON stated she expected staff to follow the physician orders. If a bariatric bed was ordered by the physician then the resident should have had one. The DON stated by Resident 401 not having a bariatric bed, there was a possibility she was not as comfortable as she could have been. Per the facility's policy, title Accommodation of Needs, dated March 2021, .1. The resident's individual needs and preferences are accommodated to the extent possible .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interviews, and record review, the facility failed to report an injury of unknown origin to the California Department of Public Health for one of two allegation of abuse incidents. As a result, investigation into the injury was delayed and placed Resident 220 at risk for further injury. Findings: A review of Resident 220's Admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (an acute condition of brain dysfunction), violent behavior, dementia (a condition that effects cognitive function). A review of Resident 220's Minimum Data Set Assessment (MDS - assessment tool), dated 4/17/24, indicated the resident scored 0 on the brief interview of mental status (a score of 0-7 suggests severe cognitive impairment). On 4/23/24 at 3:29 P.M., an observation was conducted in the hallway of station 3B. Resident 220 was observed ambulating in the hallway, accompanied by a staff member. Resident 220 had greenish purple bruises to the whole face, extending to the neck area. On 4/24/24 at 3:36 P.M., CNA 23 was interviewed. CNA 23 stated she had cared for Resident 220 in the past. CNA 23 stated Resident 220 ambulated daily. CNA 23 stated Resident 220 had exhibited combative behavior towards staff and other residents for no reason. CNA 23 stated that if she sees an injury of unknown origin, she would .contact (name of the abuse coordinator) the abuse coordinator and tell the charge nurse .we don't want to neglect her. On 4/25/24 at 10:32 A.M., an interview was conducted with Resident 220's family member via telephone. The family member stated that the facility informed him of the bruises on Resident 220's face. The family member stated [the facility] assumed she had a fall .nobody saw [the fall]. The family member stated that the facility informed him that an investigation was conducted to determine how Resident 220 sustained the bruises. A record review of Resident 220's Change of Condition/Incident form, dated 4/24/24, indicated on 4/13/24, . resident noted with discoloration to face and both eyes with some swelling noted .Resident was unable to give details. Resident was confused which is her baseline level of consciousness On 4/25/24 at 1:14 P.M., an interview was conducted with licensed nurse (LN) 21. LN 21 stated that if a resident had an injury of unknown origin, she would inform the charge nurse and the abuse coordinator for their safety . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 3:31 P.M., an interview with the administrator (ADM) was conducted in the conference room with the DON present. The ADM stated the source of Resident 220's injury was still uncertain and the injuries of unknown origin had not been reported to CDPH. The DON and ADM both acknowledged, the facility's abuse investigation and reporting policies had not been implemented. A review of the facility's policy titled Abuse Investigation and Reporting revised July 2017, indicated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported The P&P further stated all alleged violations .including injuries of an unknown source .will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 The facility failed to develop and implement an individualized care plan related to: 1. The diagnosis of post-traumatic stress disorder (PTSD-an anxiety disorder that comes from a traumatic event), to identify the mental and psychological needs for three of three residents (10, 164, 176). and, 2. Resident's nail care (185). and, 3. A resident's care plan was not implemented related to smoking risk (35). As a result, there was not a consistent approach by staff to address residents' care needs. Findings: 1a. Resident 10 was admitted to the facility on [DATE], with diagnoses which include post-traumatic stress disorder (PTSD), per the facility's Admission Record. On 4/23/24 at 8:46 A.M., an observation was conducted of Resident 10 in her room. Resident 10 was sitting in a chair, dressed wearing no shoes or socks, rocking herself forward and back. Resident 10's breakfast tray was covered and untouched on her bedside table. When the lid of her breakfast tray was lifted, Resident 10 became agitated and waved both her hands sideways to stop. Resident 10's roommate saidnnot to touch Resident 10's things because she will go off on you. Resident 10 was non-verbal and grunted when asked questions. On 4/23/24 at 2:34 P.M., Resident 10 was observed sitting in a chair within her room. Resident 10 had a cup and water and was splashing the water on her upper and lower arms, then rubbing the water into her skin, as if it were lotion. On 4/24/24 Resident 10's clinical record was reviewed: The quarterly MDS (a clinical assessment tool), dated 2/12/24, listed a cognitive score of 3, indicating cognition was severely impaired. The active diagnoses listed post-traumatic stress disorder as one of her diagnoses. The Medication Section indicated she was taking no psychotropic or antianxiety medications. There was no documented evidence of her PTSD event or triggers within the clinical record. The care plan, titled PTSD, dated 3/3/24, indicated Resident 10 had severe cognitive deficit and does not recall incident causing PTSD or will not provide details but exhibits by refusing care, shouting, pacing, and hoarding food or items under her bed. No triggers were listed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/25/24 at 12:30 P.M., an interview was conducted with LN 35. LN 35 stated care plans were important to nursing to inform staff what potential issues could arise, how to approach the resident, what works as an intervention, and what things to be looking for. LN 35 stated care plans were a communication tool for staff, so care could be provided in a consistent manner. On 4/25/24 at 1:43 P.M., an interview and record review was conducted with LN 32. LN 32 stated she was unaware Resident 10 had a diagnosis for PTSD. LN 32 reviewed Resident 10's care plan for PTSD and stated, this care plan does not tell me anything such as triggers, how to handle episode of acting out from triggers, or how to resolve it. LN 32 stated if Resident 10 had PTSD, all staff should be aware and approach the resident in a consistent manner. On 4/25/24 at 2:36 P.M., and interview and record review was conducted with LN 36. LN 36 stated she was aware Resident 10 had PTSD, but she did not know the event that caused it or triggered it. LN 36 reviewed Resident 10's care plan and stated it would be important to know what the triggers were, but nothing was listed in the care plan, or what specific interventions worked. LN 36 stated she would have expected the IDT to revise the PTSD care plan and list more information, because it currently only told them (staff), what her response was when triggered, not what the triggers were. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated they were unsure what Resident 10's PTSD was caused from. The DON stated she knows Resident 10 was very protective of her property and environment, and if that was disturbed, she acted out. The DON stated Resident 10 has been unable to communicate with the them about the event or what the triggers were, but she thinks it has to do with her maintaining her property and space. The DON stated they did not have any means to get more information since there was no family available, but perhaps, property should be listed on the care plan as a possible trigger 36765 1b. Resident 164 was admitted to the facility on [DATE] with diagnoses which included PTSD according to the facility's Admission Record. Findings: An observation of Resident 164 was conducted on 4/23/24 at 2:30 P.M. Resident 164 was reclining in bed, on her right side, with her hand over her face and the room dark. Resident 164 requested the surveyor to leave. A review of Resident 164's medical record was conducted on 4/24/24 at 3:57 P.M. A care plan for PTSD indicated, .resident is trigged by emotional distress . The care plan did not state what the triggers are or what to do about them. A concurrent interview and record review was conducted with the unit manager (UM) on 4/25/24 at 8:02 A.M. The UM stated, This resident is triggered by a history with family especially her father. I haven't gone into it too much because it was sexual. The Resident sees a psychologist but not any therapy that I know of. In addition, the UM stated, The care plan makes us aware that she has triggers, but we don't know what the triggers are and we just walk on eggshells around her and we do not talk about it; we keep it light. Further, the UM stated, Do you think we should upset her by asking her what the triggers are? (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with certified nursing assistant (CNA)1 on 4/25/24 at 8:32 A.M. CNA 1 stated, This resident occasionally socializes, and is independent. I was not aware of a PTSD care plan and I don't know what specific triggers she has. Absolutely, it would be helpful to know what triggers her so we can provide her the best care. An interview was conducted with licensed nurse (LN)1 on 4/25/24 at 9:05 A.M. LN1 stated, I am aware she has PTSD and she doesn't talk about it; I don't know her specific triggers but if she is crying or withdrawn, I just let her be and tell her I am here for her. An interview was conducted with the social services director (SSD) on 4/25/24 at 2:32 P.M. The SSD stated, I do expect staff to know about the diagnosis of PTSD and triggers; the care plan should include triggers; it is essential for us to know how to treat her and avoid those triggers and what to do if she is triggered. An interview was conducted with the DON on 4/26/24 at 11:12 A.M. The DON stated, It is important to know a resident has PTSD and what the triggers were to provide care and also to avoid the triggers and what to do if a resident is currently triggered. 49330 1c. A review of Resident 176's clinical record titled Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included PTSD. A review of Resident 176's written care plan for PTSD dated 3/4/24 did not include Resident 176's triggers for PTSD. On 4/25/24 at 2:28 P.M., an interview was conducted with the Social Services Director (SSD). The SSD stated Resident 176's care plan for PTSD should have included the triggers. The SSD acknowledged staff should know what Resident 176's triggers were to prevent any behaviors that could cause him distress. A review of the facility's policy, dated, December 2016, titled, Care Plans Comprehensive Person-Centered, indicated, .1. Policy: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functionable needs is to be developed and implemented for each resident .and Policy Interpretation: 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 2. A review of the Admission Record indicated Resident 185 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, and reduced mobility. On 4/23/24 at a 8:58 A.M., an observation and interview was conducted with Resident 185. Resident 185 was laying in bed. Resident 185's fingernails were long, with a dark brown substance underneath his right fingernails. Resident 185 stated nobody had offered to cut his fingernails. Resident 185 stated he would like to get his fingernails trimmed. (continued on next page)

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	555076	A. Building B. Wing	04/26/2024

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Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 185's minimum data set (MDS - assessment tool) data, dated 3/20/24, indicated Resident 185's cognition score was 4 to indicate resident has severe cognitive impairment. The MDS data also indicated Resident 86 requires substantial/maximum assistance with activities of daily living (ADL- basic daily care with personal hygiene). A review of Resident 185's care plan dated 4/8/2024 indicated resident was at risk for ADL decline and listed .Assist with grooming and trimming of fingernails . as an intervention. On 4/26/24 at 1:20 P.M., an interview was conducted with the DON. The DON stated it was important for licensed nurses to implement Resident 185's care plan by assisting residents with nail care. A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated .A comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident 3. A review of Resident 35's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease (a disease of the central nervous system that affects motor function), dementia (loss of cognitive function), and nicotine dependence. A review of Resident 35's written care plan for smoking dated 3/13/24, indicated the resident was to have a non-flammable apron or cover/barrier during smoking activity. On 4/25/24 at 9 A.M., an observation was conducted in the smoking patio. Resident 35 was assisted to the smoking patio by a staff member. The activity assistant (ACT) handed a cigarette to Resident 35 and used a lighter to light the cigarette. Resident 35 was not wearing a smoking apron (an apron made from flame retardant material designed to protect the wearer from cigarette burns). Resident 35 put the lit cigarette in his mouth and began to propel his wheelchair approximately 2 feet, then stopped and applied the brakes using both hands. On 4/25/24 at 9:06 A.M., an observation and interview were conducted with the Activity Director in the smoking patio. The activity director (AD) was seen walking towards Resident 35 with a smoking apron in her hand. The smoking apron was in an unopened clear plastic container. The AD stated that Resident 35 had a care plan to wear the smoking apron. The AD acknowledged that Resident 35 should have been offered a smoking apron prior to smoking per Resident 35's plan of care. On 4/26/24, at 1:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated a smoking apron should have been placed on the resident to protect the resident and his clothing from cigarette burns. The DON acknowledged that Resident 35's care plan was not implemented. A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated .A comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident

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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 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** 49330 Based on observation, interview, and record review, the facility failed to ensure assistance with activities of daily living (ADL - basic and everyday skills that are essential to living independently) was provided to four of four residents (67, 86,185, 167) reviewed for ADL when: 1. Resident 67 and 86 were not provided incontinence (loss of bladder control) care in a timely manner. and, 2. Resident 86, 185 and 167 were not offered nail care. Findings: 1a A review of the Admission Record indicated Resident 67 was admitted to the facility on [DATE] with diagnoses that included paraplegia (the inability to move the legs and lower body due to spinal injury), anemia (low number of red blood cells). A review of Resident 67's Minimum Data Set (MDS - an assessment tool), dated 3/13/24, was conducted. The MDS assessment indicated Resident 67 required substantial/maximal assistance with toileting hygiene and personal hygiene. Resident 67's MDS data also indicated Resident 67's cognition (the understanding of thought processing with language, learning, attention, and memory) score was 10 to indicate resident had some moderate impairment in cognition. An observation and interview of Resident 67 was conducted on 4/23/24 at 9:17 A.M. Resident 67 was observed laying in bed with a flat sheet covering him. The flat sheet was visibly wet with urine. Resident 67 stated he was wearing briefs and needed to be changed. Resident 67 stated he asked for help quite a while ago but his CNA (Certified Nurse Assistant) was on a break. Resident 67 stated he used his call button for help, and staff answered, but turned the call light off and said they would return to help him. On 4/25/24 at 7:52 A.M., an interview was conducted with CNA 24. CNA 24 stated if an assigned CNA was on a break when Resident 67 needed his briefs changed, someone should cover . and [Resident 67] could get a bedsore if not changed timely. On 4/26/24 at 1:20 P.M., an interview was conducted with the DON. The DON stated staff should attend to the residents needs and keep him comfortable. The DON acknowledged that it was important for Resident 67 to have his briefs changed to avoid skin breakdown. 1b. A review of the Admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction (a stroke), depression (a constant feeling of sadness), and reduced mobility. A review of Resident 86's Minimum Data Set (MDS - assessment tool), dated 3/20/24, indicated Resident 86's cognition score was 10 to indicate resident has moderate cognitive impairment. The MDS data also indicated Resident 86 required substantial/maximum assistance with ADL's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview of Resident 86 was conducted on 4/23/24 at 8:41 A.M. in Resident 86's room. Resident 86's blanket was wet, and the room smelled of urine. Resident 86's fingernails was long. On 4/25/24 at 7:52 A.M., an interview was conducted with Certified Nurse Assistant (CNA) 25. CNA 25 stated it was important to provide incontinence care for a resident because [the resident] could get a bedsore . if not changed timely. CNA 25 stated that if the assigned CNA is on a break, the covering CNA should change the resident if the briefs and/or blankets are wet from urine. On 4/26/24 at 1:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff should attend to the residents needs and keep him comfortable. The DON acknowledged that it was important for Resident 86 to have his briefs changed to avoid skin breakdown. A review of the facility policy and procedure titled, Activities of Daily Living (ADL), Supporting, revised March 2018, indicated .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 2a. A review of the Admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction (a stroke), depression (a constant feeling of sadness) , and reduced mobility. A review of Resident 86's Minimum Data Set (MDS - assessment tool), dated 3/20/24, indicated Resident 86's cognition score was 10 to indicate resident has moderate cognitive impairment. The MDS data also indicated Resident 86 required substantial/maximum assistance with ADL's. An observation and interview of Resident 86 was conducted on 4/23/24 at 8:41 A.M. in Resident 86's room. Resident 86's fingernails was long. On 4/25/24 at 1:02 P.M., an interview was conducted with LN 22. LN 22 stated only licensed nurses could cut nails whether a resident was diabetic or not. LN 22 stated resident's nails were usually cut on Sundays. LN 22 stated staff checked resident's nails daily and would trim long nails as needed. LN 22 stated it was important to keep resident's nails trim because if a resident scratches themselves .bacteria can foster in them, they can randomly scratch themselves . and it is an .easy entrance for a pathogen On 4/26/24 at 1:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff should attend to the residents needs and keep him comfortable. The DON also stated it was important to keep residents' nails trim and clean to prevent injury from scratching self. 2b. A review of the Admission Record indicated Resident 185 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, and reduced mobility. A review of Resident 185's Minimum Data Set (MDS - assessment tool) , dated 3/20/24, indicated Resident 185's cognition score was 4 to indicate resident has severe cognitive impairment. The MDS data also indicated Resident 86 required substantial/maximum assistance with ADL's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at a 8:58 A.M., an observation and interview was conducted with Resident 185. Resident 185 was laying in bed. Resident 185's fingernails were long, with a dark brown substance underneath his right fingernails. Resident 185 stated nobody had offered to cut his fingernails. Resident 185 stated he would like to have his fingernails trimmed. On 4/24/2024 at 4:15 P.M., CNA 24 was interviewed. CNA 24 stated, I know about [Resident 185's] long nails. CNA 24 stated Resident 185 Doesn't tend to ask for certain care .people need to offer to do things for him. CNA 24 stated that CNAs were able to cut nails if they are not diabetic. On 4/25/24 at 1:02 P.M., an interview was conducted with Licensed Nurse (LN) 22. LN 22 stated only licensed nurses could cut nails whether a resident was diabetic or not. LN 22 stated resident's nails were usually cut on Sundays. LN 22 stated staff checked resident's nails daily and would trim long nails as needed. LN 22 stated it was important to keep resident's nails trim because if a resident scratches themselves .bacteria can foster in them, they can randomly scratch themselves . and it is an .easy entrance for a pathogen On 4/26/24 at 1:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important for licensed nurses to offer nail care. The DON stated it was important to keep residents' nails trim and clean to prevent injury from scratching self. 46235 2c. Resident 167 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a brain disorder that slowly destroys memory, thinking skills and eventually the ability to carry out simple tasks) according to the facility's Admission Record. During an observation and interview on 4/23/24, at 10:33 A.M., Resident 167 was in bed with his shirt halfway off his upper body. Resident 167 showed his fingernails which was observed to be long with black debris under the nails. When asked if Resident 167 preferred his nails long, Resident 167 stated no, he would like his fingernails trimmed. Resident 167 was observed on 4/24/24, at 3:17 P.M., Resident 167 was in bed with his eyes closed with fingernails still long with black debris under the nails. An interview and concurrent observation of Resident 167 was conducted on 4/24/24, at 4:22 P.M., with licensed nurse (LN) 11. LN 11 acknowledged that Resident 167 had long fingernails. During an interview on 4/25/24, at 9:21 A.M,. with certified nurse assistant (CNA) 11, CNA 11 stated the licensed nurses provided nail care for residents. CNA 11 stated he would report to the LN if a resident needed nail trimming. CNA 11 stated he had not reported to the LN that Resident 167's fingernails were long. During an interview with the DON on 4/26/24, at 1:46 P.M., the DON stated the licensed nurses trimmed residents' fingernails once a week. The DON stated the CNAs cleaned under the nails if dirty. The DON further stated long fingernails needed to be trimmed to prevent scratching of self and others. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures (P&P) titled, Activities of Daily Living (ADL), Supporting, dated March 2018 was reviewed. The P&P indicated, .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview and record review, the facility failed to follow up on one of five resident's broken eyeglasses who was reviewed for visual devices, Resident 124. The deficient practice resulted in the resident using broken eyeglasses and had the potential for decreased vision, and diminished self-worth. Findings: Resident 124 was admitted to the facility on [DATE] with the diagnoses including ectropion (eyelid open in an outward direction) of unspecified eye according to the facility's Admission Record. On 4/23/24, at 12:07 P.M., Resident 124 was observed having lunch in the dining room with scotch tape on the top rim of his eyeglasses. During a joint observation and interview on 4/24/24, at 4:20 P.M. with LN 11, Resident 124 was in bed coloring a book wearing eyeglasses with tape on the rim. Resident 124 stated the glass came off and nobody had checked his glasses for repair. LN 11 stated he had not reported the broken eyeglasses to social services. Certified nurse assistant (CNA) 11 was interviewed on 4/25/24, at 9:27 A.M., CNA 11 stated he was assigned to Resident 124 for the past two days and had not reported the broken eyeglasses. During an interview on 4/25/24, at 10 A.M., with the social service director (SSD), the SSD stated a referral was made to repair Resident 124's eyeglasses and there should have been a follow up. A review of Resident 124's progress notes dated 2/29/24 was conducted. The progress notes indicated referral was made to vision. No further progress notes as a follow up was made. During a review of the facility's policy and procedure (P&P) titled, . Visually Impaired Resident, Care of, dated February 2018, the P&P indicated, .Resident who have lost of damaged their devices will be assisted in obtaining services to replace the devices . During a review of the facility's P&P titled, Social Services, dated October 2010, the P&P indicated, .The social services department is responsible for .compiling and maintaining up to date information about health and service agencies available for resident referrals .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to ensure residents were safe when: 1. Staff did not identify and address a potential hazard in one of two resident rooms (Resident 221), reviewed for accidents and, 2. Safe smoking assessments were not completed for one of two residents reviewed for smoking (Resident 35). As a result, there was the potential for Resident 221 and 35 to become injured from the room hazard and from not being assessed by a licensed nurse for smoking safety. Findings: 1. Resident 221 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record. On 4/23/24 at 8:16 A.M., an observation was conducted inside Resident 221's room. Resident 221 was dressed, lying flat on his bed. The bed was pushed up against the wall on the right side, and the HOB was in contact with the adjacent wall. On the wall next to the right side of the bed, approximately 3 feet up, was peeling paint, exposed dry wall, and a plastic border strip the was peeled away from the wall. On 4/25/24, Resident 221's clinical record was reviewed: The quarterly MDS, dated [DATE], listed a cognitive score of 00, indicating they were unable to assess the cognitive status. The Functional Abilities indicated Resident 221 required supervision for transferring, showers, and personal care. On 4/25/24 at 12:58 P.M., an observation and interview was conducted with the Activities Director (AD) of Resident 221's room. The AD observed the wall next to Resident 221's bed and stated, I saw the wall yesterday and determined it did not look good. The AD stated the wall was a safety hazard and Resident 221 could be ingesting the paint and dry wall, or he could cut himself on the plastic trim. The AD stated she informed the Director of Maintenance (DM) and he said he would look at it. The AD stated she did not document the required repair in the maintenance log book, kept at the nursing station, and she should have. On 4/25/24 at 1:05 P.M., an observation and interview was conducted with LN 32 of Resident 221's room. LN 32 stated if she identified a potential hazard, she would want it fixed immediately so she would call maintenance, and then log the problem in the maintenance book kept at the nursing station. LN 32 viewed the wall next to Resident 221's bed. LN 32 stated, yes, that looks bad. LN 32 touched the plastic trim and stated, it's really sharp and he could have cut himself. LN 32 stated Resident 221 had dementia so he could be peeling the paint and ingesting it, which also could be hazardous. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 1:12 P.M., an observation and interview was conducted with the DM of Resident 221's room. The DM stated, the wall did not look safe or homelike. The DM stated the resident could have cut himself on the sharp plastic or ingested the drywall and paint. The DM stated he will fix this immediately to avoid harm. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated she expected staff to report and document potential hazards immediately so they could be fixed. The DON stated all staff should be observing for hazards daily and reporting them. Per the facility's policy, title Hazardous Area, Devices and Equipment, dated July 2017, Identification of Hazards: 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness .c. Sharp objects that are accessible to vulnerable residents; .g. Access to toxic chemicals . Interventions: Once identified, the safety committee will document recommendations for the area . 49330 2. A review of Resident 35's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease (a disease of the central nervous system that affects motor function), dementia (loss of cognitive function), schizophrenia (a mental disorder resulting in disordered thinking and behavior), and nicotine dependence. A record review of Resident 35's Minimum Data Set (MDS - assessment tool), dated 2/2/24, indicated Resident 35's cognition (the understanding of thought processing with language, learning, attention, and memory) score was 99 to indicate resident was unable to complete the interview. An interview was conducted with the Activity Assistant (ACT), on 4/24/24 at 9:02 AM. in the smoking patio. The ACT stated Resident 35 was a smoker. The ACT stated Resident 35 had been witnessed placing the cigarette butt in his pocket. An observation of Resident 35 was conducted on 4/25/24 at 8:35 AM. Resident 35 was observed self-propelling in his wheelchair and asking staff for cigarettes. Resident 35 was observed pounding on the glass door leading to the smoking area. A staff member was heard reminding the resident that the smoke break was in 20 minutes. On 4/25/24 at 9 AM., an observation was conducted in the smoking patio. Resident 35 was assisted to the smoking patio by a staff member. The ACT then handed a cigarette to Resident 35 and used a lighter to light the cigarette. Resident 35 was not wearing a smoking apron (an apron made from flame retardant material designed to protect the wearer from cigarette burns). Resident 35 put the lit cigarette in his mouth and began to propel his wheelchair approximately 2 feet, then stopped and applied the brakes using both hands. On 4/25/24 at 9:06 AM., an observation and interview with the Activity Director (AD) was conducted in the smoking patio. The AD was seen walking towards Resident 35 with a smoking apron in her hand. The smoking apron was in an unopened clear plastic container. The AD stated that Resident 35 had a care plan to wear the smoking apron. The AD acknowledged that Resident 35 should have been offered a smoking apron prior to smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 2:03 PM, a joint interview and record review was conducted with LN 22. When asked if Resident 35 refuses to wear his apron, LN 22 stated, Not that I am aware of. LN 22 stated that Resident 35 did not have good safety awareness and should be offered a smoking apron. LN 22 stated, We don't want him to burn himself or his clothes. On 4/26/24 at 1:20 PM, an interview was conducted with the DON. The DON stated a smoking apron should have been placed on the resident to protect the resident and his clothing from cigarette burns. According to a review of the facility's policy titled Smoking Policy revised July 2017, .This facility shall establish and maintain safe resident smoking practices

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on interview and record review, the facility failed to ensure the nutritional needs were met for a sampled resident (Resident 41) with an unintentional significant weight loss of 10.31% in six months when Resident 41's Glucerna supplement, was not consistently provided or monitored as ordered by the Nurse Practitioner (NP). This failure had the potential to result in undesirable and/or avoidable weight loss for one of two sampled residents with facility reported weight loss. Cross reference F685 Findings: Per the facility's face sheet, Resident 41 was admitted on [DATE] with diagnoses that included but not limited to dysphagia (difficulty swallowing), metabolic encephalopathy (disorder that affects brain function), and chronic kidney disease (kidneys are damaged and cannot filter blood well). A record review of Resident 41's document titled, History and Physical, dated 1/26/24, indicated resident was sent to the hospital on 1/22/24 for not eating and drinking for several days. Resident 41 returned from the hospital on 1/26/24 with diagnoses of a urinary tract infection (bladder infection) and dehydration (condition that occurs when the body loses too much water and other fluids that it needs to work normally). During a record review of facility document titled, RD Nutritional Observation, dated 1/26/24, completed by RD 1, the Nutritional Observation indicated Resident 41 had a nutrition diagnosis of .inadequate energy intake related to decreased appetite as evidence by refusing most food offered .hospitalized for severe dehydration. RD 1's recommended intervention was Glucerna TID (three times a day), and was ordered on 1/29/24. During a review of the Glucerna nutrition facts label, an 8-ounce Glucerna shake provides 220 calories, 9 grams of protein, 26 grams of carbohydrates and 4 grams of fiber. A review of Resident 41's weight history indicated on 10/03/2023, Resident 41 weighed 205.6 lbs. On 04/15/2024, Resident 41 weighed 184.4 pounds which indicated a 10.31% significant weight loss. October 2023= 205.6 pounds November 2023= 200.8 pounds December 2023= 202.2 pounds January 2024 = 187.6 pounds February 2024= 184.4 pounds (continued on next page)

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	555076	A. Building B. Wing	04/26/2024

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Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	March 2024 = 186.6 pounds April 2024 = 184.4 pounds During an interview on 04/25/24 at 10 AM with CNA 42, CNA 42 stated Resident 41 did not receive Glucerna for breakfast. During a record review of Resident 41's physician' progress notes dated 11/28/23, 12/20/23 and 3/31/24 did not mention Resident 41's weight loss. During a record review of the Resident 41's Nutrition assessment dated [DATE] completed by RDS, the nutrition assessment indicated .Usual body weight 202-203 pounds .Interventions: .Goal weight range 200-210 pounds .No significant weight changes for 6 months . During an observation and interview on 4/25/24 at 10:20 A.M., Resident 41 was sitting in his wheelchair in his room. Resident 41 stated that he does not like puree food, and he does not have teeth but has dentures that do not fit well, so he does not wear them. Resident 41 further stated it was hard to chew his food, but he still manages to eat. Resident 41 also stated he did not receive Glucerna in the morning. Resident 41 stated he would drink the Glucerna if it was served to him. On 4/25/24, at 12:25 P.M., an interview was conducted with LN 11. LN 11 stated if he sees the Glucerna on Resident 41's meal tray, he would give it to him. But he does not often see a Glucerna on Resident 41's meal trays. On 4/25/24, at 1:25 P.M., an interview was conducted with Resident 41. Resident 41 stated he didn't like the lunch meal and that he did not receive a Glucerna. On 4/25/42, at 1:35 P.M., an interview was conducted with CNA 43. CNA 43 stated that Resident 41 consumed 50% of lunch and did not receive a Glucerna at lunch. During a concurrent record review and interview on 4/25/24 at 3:13 P.M. with RD 1 and the RDS, regarding Resident 41's weight loss. Facility document titled Annual RD Assessment, dated March 18, 2024, indicated the recommendation was to continue Resident 41's current plan of care for weight maintenance that included receiving a Glucerna shake three times a day. The RDS stated she was unaware that Resident 41 was not receiving the Glucerna shake consistently at breakfast and lunch. The RDS stated she had not seen Resident 41 receive or drink the supplement. The RDS stated she does not speak to the MD or NP because nursing staff communicates with them regarding recommendations and/or significant weight changes. During an interview on 4/26/24 at 10:46 AM with the Director of Nursing (DON), the DON stated that weight loss is handled by the registered dietitians (RD). The DON stated the RD does a weight report, calculation percentage for weight loss in 1 month or 1 week and tracks insidious (occurs gradually over time) weight loss. The DON stated that nursing does an assessment of the resident for any conditions that may have contributed to the weight loss and reports it to the physician. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/26/24 at 1:46 PM with RDS, RDS stated Resident 41's unintentional weight loss may have been avoided and Resident 41 may have benefited from a Fortified diet which provides an additional 300-400 calories per meal, and consistent intake of food and supplements like the Glucerna. During a review of the facility policy and procedure (P&P) titled Weight Change Protocol, dated 11/14/2018, the P&P indicated The RD will assess .suggest interventions, monitor and evaluate the success of the interventions. 48270

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to administer oxygen and continuous positive airway pressure (CPAP-a machine that uses mild air pressure to keep breathing airways open while you sleep) as ordered by the physician for two of four residents (Resident 89 and 401), reviewed for oxygen therapy. As a result, residents were not given the care and service prescribed, which had the potential to hinder or worsen their recovery process. Findings: 1. Resident 89 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD-a lung disease causing restricted airflow and breathing problems), per the facility's Admission Record. On 4/23/24 at 9:10 A.M., an observation was conducted of Resident 89 in his room as he slept. Resident 89 was receiving oxygen via nasal cannula (a clear, flexible tube which delivers oxygen to the nostrils). The oxygen was supplied by a condenser (a machine that delivers concentrated oxygen), sitting on the floor, next to the right side of the bed. The oxygen rate read 3 liters (l) per minute (min). The humidifier bottle was empty (a clear bottle containing distilled water to moisten the oxygen being delivered for comfort). On 4/23/24 at 2:41 P.M., an observation and interview was conducted with Resident as he laid in bed. Resident 89 stated he was on 3 l of oxygen. On 4/23/24 89's clinical record was reviewed: The Admission MDS (a clinical assessment tool) dated 3/14/24, listed a cognitive score of 13, indicating cognition was intact. According to the physician's order, dated 4/15/24, .oxygen 3 l at night . The facility's flow sheet, titled Oxygen Saturations (a devise placed on the finger to measure the percentage of oxygen in the blood stream), was reviewed from 4/1/24 through 4/23/24. The oxygen saturation rate on room air (without oxygen) lowest was 90% on 4/18/24 and highest 99% on 4/21/24. According to the care plan, titled Altered cardiovascular status, dated 3/20/24, listed interventions such as, give oxygen as ordered. On 4/24/24 at 3:32 P.M., an interview and record review was conducted with LN 33, regarding Resident 89's oxygen therapy. LN 33 stated physician orders for oxygen therapy were at night time, not 24 hours a day, should always be followed. LN 33 stated if a resident required an increase in oxygen, she would expect there to be nursing assessment and the physician to be notified. LN 33 stated since Resident 89 had COPD, staff needed to limit his oxygen levels due to having poor gas exchange the lungs. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LN 33 continued, stating oxygen saturations should always be checked on room air to see what the true oxygen level in the blood was. LN 33 stated oxygen saturation levels with a COPD resident should always be kept above 90%. LN 33 reviewed Resident 89's physician order and stated the resident should only be receiving oxygen at night, and since his oxygen saturations were good, there was no need to have him on oxygen during the day. LN 33 stated the harm could be a build-up of Co 2 (carbon dioxide), making Resident 89 more dependent on oxygen and it would be harder to wean him off. 2. Resident 401 was admitted to the facility on [DATE] with diagnoses of COPD and sleep apnea, per the facility's Admission Record. On 4/23/24 2:22 P.M., an observation and interview was conducted with Resident 401 in her room. Resident 401 was sitting in a large electric wheelchair and receiving oxygen via a oxygen tank strapped to the back of her wheelchair. The oxygen rate indicated she was receiving 5 l/min. Sitting on a side table next to her bed, was a CPAP machine. Resident 401 stated she was supposed to have the CPAP machine on every night, but since she has been at the facility, staff have only put it on her three times. Resident 401 stated she cannot put the CPAP facial mask on herself, because she is unable to lift her right hand above her chest. Resident 401 stated when the CPAP machine is not applied at night, she does not sleep as well, and she is tired the next day. On 4/24/24 at 11:24 A.M., an observation was conducted of Resident 401 in her room. Resident 401 was receiving 5 l of oxygen per minute via nasal cannula. On 4/24/24, Resident 441's clinical record was reviewed: The Admission MDS, dated [DATE] listed a cognitive score of 13, indicating cognition was intact. The Functional Status indicated Resident 401 required maximum assistant with rolling side to side, moving from bed to chair, and personal care. According to the physician orders dated 3/8/24, .Oxygen at 2 liters/min or to keep O 2 (oxygen) sat (saturations) above 89% via nasal cannula .CPAP machine to be applied at night . The facility's flow sheet, titled Oxygen Saturations were viewed from 4/1/24 through 4/23/24. The oxygen saturation rate on room air (without oxygen) lowest was 93% on 4/5/24 and highest 98% on 4/21/24. According to the care plan, titled Alteration in Respiratory function, dated 3/7/24, listed interventions such as, notify MD (medical doctor) of any significant observations. Observe for signs and symptoms of respiratory distress. On 4/24/24 at 3:32 P.M., an interview and record review was conducted with LN 33, regarding Resident 401's oxygen therapy. LN 33 stated physician orders for oxygen therapy should always be followed. LN 33 stated if a resident required an increase in oxygen, she would expect there to be nursing assessment and the physician to be notified. LN 33 reviewed Resident 401's order for oxygen and reviewed oxygen saturations. LN 33 stated Resident 401 should be only receiving 2 l of oxygen and not 5 l. LN 33 stated based on Resident 401's oxygen saturations, there was no indication she required an increase in oxygen, and if she did, there should be a physician's order for the increase. LN 33 stated the harm could be a build-up of Co2, making Resident 401 more dependent on oxygen and it would be harder to wean her off. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LN 33 reviewed Resident 401's physician's order and Medication Administration Record (MAR) from 4/1/24 through 4/24/24. LN 33 stated there was a physician's order for the CPAP to be applied at night, but the order was not listed on the MAR, so staff were unaware and not applying it. LN 33 stated the order was put in as, a standard order, so it was not showing up on the MAR. LN 33 stated she would change the CPAP order immediately, so Resident 401 could start getting her CPAP being applied ever night. LN 33 stated the harm of not applying the CPAP at night was restless sleep, along with and her oxygen levels dropping while sleeping. On 4/24/24 at 4:12 P.M., an interview was conducted with the DSD. The DSD stated she expected physician's orders to be followed and treatments to be documented. The DSD stated with Resident 401's CPAP not being applied at night; the resident's breathing status could be compromised. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated she expected all physician's orders to be followed and if not, the physician needed to be contacted to explain. The DON stated by not applying oxygen as ordered, residents could become dependent on oxygen and harder to wean off. The DON stated by Resident 401 not having her CPAP applied for sleep she was at risk of respiratory distress and not having good, solid sleep. Per the facility's policy, titled Oxygen Administration, dated October 2010, .Preparation: 1. Review that there is a physician's order for this procedure. Review the physician's order .Documentation: .3. The rate of the oxygen flow, route, and rationale . Per the facility's policy, titled CPAP/BiPAP support, dated March 2015, Purpose .2. To improve arterial oxygenation .Preparation .3. Review the physician's order .: 46235 2. This failure had the potential to create excessive drying of Resident 138's airway. Resident 138 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA-a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. During an observation and interview on 4/23/24, at 9:25 A.M., Resident 138 was in bed with a BIPAP machine on top of the bedside drawer. Resident 138 stated she applied the BIPAP mask on herself but did not like using the BIPAP because it was uncomfortable. The BIPAP machine's humidifier chamber was observed to be empty. An interview and joint observation were conducted with licensed nurse (LN) 12 on 4/25/24, at 8:49 A.M. LN 12 stated Resident 138 had a diagnosis of OSA and used a BIPAP machine at night. LN 12 stated the respiratory therapist (RT) was responsible for the machine's set up, but licensed nurses were responsible for adding sterile water to the BIPAP machine's humidifier chamber. LN 12 checked the BIPAP's humidifier chamber, and it was empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/26/24, at 9:34 A.M., with the RT, the RT stated RT's set up BIPAP machines upon a resident's admission and the machines were frequently checked. The RT stated refill of BIPAP's water was done by the RT or the nurses. The RT was not able to show documentation in Resident 138's medical record that the water was refilled as needed. The RT stated the humidifier chamber should not be empty to help keep the air moist during resident's use. A review of the facility's policy and procedure (P&P) titled, CPAP/BiPAP Support, dated March 2015 was conducted. The P&P indicated, .To improve arterial oxygenation (PaO2) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease .To promote resident comfort and safety. The P&P did not provide guidance for staff regarding when to refill the BIPAP machine's humidifier chamber.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36765 Based on observation, interview and record review, the facility failed to identify, treat or manage a resident's (155) pain prior to wound care. This failure had the potential to cause unnecessary pain for Resident 155. Findings: Resident 155 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome (a medical condition involving pain, depression and anxiety that interfere with daily life) per the facility's Admission Record. An observation was conducted on 4/24/24 at 8:44 A.M. of Resident 155. Resident 155 was reclining in bed and had bilateral bandages on her feet. Resident 155 stated she had pain in her feet and the pain medication she received was not effective. An interview was conducted on 4/24/24 at 9 A.M. with the unit manager (UM). The UM stated, Resident 155 has no other orders for pain medication. An interview was conducted on 4/25/24 at 10:23 A.M. with Resident 155. Resident 155 stated, I just had another dressing change and my feet really hurt. I did not have pain medicine before they did it (the dressing change)and I did tell them that the dressing changes hurts me. An interview was conducted on 4/25/24 at 10:24 A.M. with the UM. The UM stated, We have not been medicating her prior to the dressing change. An interview was conducted on 4/25/24 at 10:40 A.M. with LN1. LN 1 stated, I don't give her pain meds before the dressing change, but it is a good idea. A review of Resident 155's Pain care plan, dated 4/5/24 did not indicate that pain medications should be administered prior to the dressing change of her feet. An interview was conducted on 4/26/24 at 11:13 A.M. with the DON. The DON stated, It is important to manage the resident's pain prior to the dressing change so she is not suffering and it can be tolerated. A review of the facility's policy, dated 3/2020, titled, Pain Assessment and Management, indicated: .Purpose: the purposes of this procedure are to help staff identify pain in the residents and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain . Identifying causes of pain: 2. review the residents clinical record to identify conditions or situations that may predispose the resident to pain .3. Review the residents treatment record to identify any situations or treatments where an increase in the resident's pain may be identified, for example .b. treatments such as wound care or dressing change .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review, the facility failed to ensure assessments were completed before a resident's dialysis (process of removing toxins from the kidneys and blood through a machine) treatment for one of three residents reviewed for dialysis. (Resident 219) This deficient practice had the potential to result in undetected complications such as infection and bleeding at the access site (part of the body where dialysis is received), and abnormal vital signs (temperature, breathing, heart rate) which can lead to a delay in necessary care. Findings: Resident 698 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD-the last stage of kidney disease which the kidneys can no longer support the body's needs) according to the facility's Admission Record. During an interview on 4/23/24, at 11:02 A.M., with Resident 219, Resident 219 stated she attended dialysis treatments three times per week. An interview and joint review was conducted on 4/24/24, at 4:15 P.M., with licensed nurse (LN) 11. LN 11 stated the night shift nurse completed the dialysis communication form for Resident 219 prior to leaving for dialysis. LN 11 reviewed the dialysis communication form dated 4/24/24 and stated the pre-dialysis portion of the form was incomplete. LN 11 stated the dialysis communication form should have been completed for the dialysis staff to know Resident 219's condition. A concurrent review of Resident 219's dialysis communication forms were reviewed with LN 12 on 4/25/24, at 8:24 A.M. LN 12 stated the pre-dialysis communication forms dated 2/14/24, 3/4/24, 3/6/24, 3/8/24, 3/22/24, 3/20/24, 3/27/24, 3/29/24, 4/1/24, 4/3/24, 4/8/24, 4/10/24, 4/15/24, 4/17/24 and 4/24/24 were not completed. LN 12 further stated she did not know the reason the forms were incomplete. During an interview on 4/26/24, at 1:46 P.M., with the DON, the DON stated it was the facility's policy to complete dialysis communication forms for the dialysis center to know any changes with the resident. A review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, dated September 2010 was conducted. The P&P indicated, .Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including .How information will be exchanged between the facilities . During a review of the facility's dialysis agreement, dated December 5, 2022, the agreement indicated, .the FACILITY will be responsible for .maintaining records involving the care and condition of the ESRD Patient .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility did not ensure residents with past traumas received trauma informed care in accordance with professional standards of practice in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for three of three resident (10,164,176) reviewed for trauma informed care. As a result, there was the potential for residents to not have a sense of emotional and physical safety. Findings: 1. Resident 10 was admitted to the facility on [DATE], with diagnoses which included post-traumatic stress disorder (PTSD- a mental health condition that's triggered by a terrifying event) , per the facility's Admission Record. On 4/23/24 at 8:46 A.M., an observation was conducted of Resident 10 in her room. Resident 10 was sitting in a chair, dressed wearing no shoe or socks, rocking herself forward and back. Resident 10's breakfast tray was covered and untouched on her bedside table. When the breakfast tray lid was lifted, Resident 10 became agitated and waved both her hands sideways for me to stop. Resident 10's roommate told me not to touch Resident 10's things because, she will go off on you. Resident 10 was on non-verbal and grunted when asked questions. On 4/23/24 at 2:34 P.M., Resident 10 was observed sitting in a chair within her room. Resident 10 had a cup with water and was splashing the water on her upper and lower arms, then rubbing the water into her skin, as if it were lotion. On 4/24/24 Resident 10's clinical record was reviewed: The quarterly MDS (a clinical assessment tool), dated 2/12/24, listed a cognitive score of 3, indicating cognition was severely impaired. The active diagnoses listed post-traumatic stress disorder as one of her diagnoses. The Medication Section indicated she was not taking any psychotropic or antianxiety medications. There was no documented evidence of her PTSD event or triggers within the clinical record. The facility's history and physical (H&P) exams were reviewed (2017, 2019, 2021, 2022, 2023) the only mention of PTSD was on the 2017 H&P as a diagnoses, and no further details were mentioned. The facility's last two interdisciplinary conference meetings (IDT-where department heads meet to discuss care, concerns, and any new issues), dated 11/27/23 and 2/22/24 were reviewed. There was no documented evidence PTSD was addressed or triggers were documented. Resident 10's care was guided by the bioethics committee (an assigned committee made up of department heads that make medical decisions on the resident's behalf, since no family or friends could be located). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, titled PTSD, dated 3/3/24, indicated Resident 10 had severe cognitive deficit and did not recall incident causing PTSD or would not provide details, but exhibits by refusing care, shouting, pacing, and hoarding food or items under her bed. No triggers were identified on the care plan. On 4/25/24 at 1:43 P.M., an interview and record review was conducted with LN 32. LN 32 stated she was unaware Resident 10 had a diagnosis of PTSD. LN 32 reviewed Resident 10's care plan for PTSD and stated, this care plan does not tell me anything such as triggers, how to handle episode of acting out from triggers, or how to resolve it. LN 32 stated if Resident 10 had PTSD, all staff should be aware and approach the resident in a consistent manner. On 4/25/24 at 2:36 P.M., an interview and record review was conducted with LN 36. LN 36 stated she was aware Resident 10 had PTSD, but she did not know the event that caused it or what triggered it. LN 36 reviewed Resident 10's care plan and stated it would be important to know what the triggers were, but nothing was listed in the care plan, or what specific interventions worked. LN 36 stated she would have expected the IDT to revise the PTSD care plan and list more information, because it currently only told them what her response was when triggered, not what the triggers were. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated they were unsure what Resident 10's PTSD was caused from. The DON stated she knows Resident 10 was very protective of her property and her environment, and if that was disturbed, the resident acted out. The DON stated Resident 10 has been unable to communicate with the them about the event or what her triggers were, but she thinks it has to do with her maintaining her property and space. The DON stated they did not have any means to get any more information, since there was no family available, but perhaps, property should be listed on the care plan as a possible trigger. Per the facility's policy titled Trauma Informed Care, dated March 2019, .Resident Care Strategies: 1. As part of the comprehensive assessment, identify history or interpersonal violence when possible. Identifying past traumas or adverse experiences may involve record review or the use of screening tools . 36765 2. Resident 164 was admitted to the facility on [DATE] with diagnoses that included PTSD according to the facility's Admission Record. An observation of Resident 164 was conducted on 4/23/24 at 2:30 P.M. Resident 164 was reclining in bed, on her right side, with her hand over her face and the room dark. Resident 164 requested the surveyor to leave. A review of Resident 164's medical record was conducted on 4/24/24 at 3:57 P.M. A care plan for PTSD indicated, .resident is trigged by emotional distress . The care plan did not state what the triggers were or what to do about them. (continued on next page)

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	555076	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A concurrent interview and record review was conducted with the unit manager (UM) on 4/25/24 at 8:02 P.M. The UM stated, This resident is triggered by a history with family especially her father. I haven't gone into it too much because it was sexual. The Resident sees a psychologist but not any therapy that I know of. In addition, the UM stated, The care plan makes us aware that she has triggers, but we don't know what the triggers are and we just walk on eggshells around her and we do not talk about it; we keep it light. Further, the UM stated, Do you think we should upset her by asking her what the triggers are? An interview was conducted with CNA 1 on 4/25/24 at 8:32 A.M. CNA 1 stated, This resident occasionally socializes, and is independent. I was not aware of a PTSD care plan and I don't know what specific triggers she has. Absolutely it would be helpful to know what triggers her so we can provide her the best care. An interview was conducted with LN 1 on 4/25/24 at 9:05 A.M. LN 1 stated, I am aware she has PTSD and she doesn't talk about it; I don't know her specific triggers but if she is crying or withdrawn, I just let her be and tell her I am here for her. An interview was conducted with the social services director (SSD) on 4/25/24 at 2:32 P.M. The SSD stated, I do expect staff to know about the diagnosis of PTSD and triggers; the care plan should include triggers; it is essential for us to know how to treat her and avoid those triggers and what to do if she is triggered. An interview was conducted with the DON on 4/26/24 at 11:12 A.M. The DON stated, It is important to know a resident has PTSD and what the triggers are to provide care and also to avoid the triggers and what to do if a resident is currently triggered. A review of the facility's policy, dated 2019, titled, Trauma Informed Care, indicated .Purpose: to guide staff in appropriate and compassion care specific to individuals who have experienced trauma .Preparation: 1. Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization . 49330 3. A review of Resident 176's clinical record titled Admission Record, indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included PTSD. A review of Resident 176's Minimum Data Set (MDS - an assessment tool), dated 2/9/24, indicated that Resident 176 had a BIMS (Brief Interview for Mental Status - a tool used to screen and identify the mental status of residents) of 4. According to the Resident Assessment Instrument/Minimum Data Set (RAI/MDS - a comprehensive assessment and care planning process) manual, a score of 4 indicated that Resident 176 had severely impaired cognition. An observation and interview of Resident 176 was conducted with Resident on 4/23/24 at 3:31 P.M., in the resident's room. Resident 176 stated he was in the military. Resident 176 was not able to verbalize his PTSD triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with CNA 21 was conducted on 4/23/24 at 3:55 P.M. CNA 21 stated she had provided care for Resident 176 in the past, and that Resident 176 was alert and is able to communicate his needs to staff. CNA 21 stated she did not know about Resident 176's PTSD diagnosis, his triggers, or his care needs related to PTSD. An interview with CNA 22 was conducted on 4/25/24 at 8:05 A.M. CNA 22 stated he was assigned to Resident 176 for the first time. CNA 22 stated he did not know if Resident 176 had PTSD. CNA 22 stated he has had PTSD training and that it was important to know the resident's triggers to prevent the behaviors . associated with the triggers. A joint interview and record review was conducted with the Social Services Director, on 4/25/24 at 2:28 P.M. The SSD stated that the plan of care for a resident with PTSD is individualized for each resident. The SSD stated Resident 176's PTSD triggers were flashes and noises . The SSD acknowledged that staff should know what Resident 176's PTSD triggers were so staff could support the resident and prevent any behaviors. SSD stated the resident's PTSD triggers should be included in the care plan. SSD stated Resident 176's care plan was updated on 4/25/24, but should've been updated when Resident 176 was admitted . SSD stated that it is essential to know triggers to know how to treat [Resident 176]. We should minimize triggers and if he is triggered, we can help him through that. An interview with the DON, with the Administrator present, was conducted on 4/26/24 at 1:20 P.M. The DON stated her expectation was for staff to know the residents with PTSD, and their triggers, to effectively care for the residents and prevent re-traumatization. A review of the facility policy and procedure titled, Trauma-Informed and Culturally Competent Care, revised August 2022, indicated trauma-informed care was provided to residents with PTSD .To address the needs of trauma survivors by minimizing triggers and/or re-traumatization .Identify and decrease exposure to triggers that may re-traumatize the resident .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 48270 Based on observation, interview, and record review the facility failed to ensure the kitchen staff competently performed and carried out the functions of the food and nutrition services department when: 1. Two Diet Aides (DAs) did not correctly test the sanitizer in the low temperature dish machine, and 2. One Diet Aide (DA) could not properly calibrate a food thermometer. These failures had the potential for food contamination, resulting in food borne illnesses for all residents who consume food from the kitchen. Cross reference F804 Findings: 1. During an observation and interview on 4/23/24 at 9 AM with Diet Aide (DA) DA 1, DA 1 was clearing clean dishes from the clean side of the dish machine. DA 1 stated the dish machine was a low temperature machine with a minimum wash temperature of 120 degrees. DA 1 also stated 100 ppm (parts per million) was the minimum level for sanitizer testing. DA 1 then tested the dish machine sanitizer by dipping a test strip in the dish solution on the counter at the end of the machine. The test strip was dark gray, and DA 1 held it to the test strip container and stated it's 100 ppm, so it's good. During an observation and interview on 4/25/24 at 9:05 AM with DA 5, DA 5 stated the minimum wash temperature for the dishwasher should be 140 F and above, and the sanitizer should be between 200 F to 400 F. A review of the dish machine manufacturer's data plate indicated the minimum wash temperature was 120 degrees F, and minimum chlorine sanitizer level was 50 ppm, and range 50-100 ppm. Review of the 2022 Federal Food and Drug Administration (FDA) Food Code, section 4-501.116, titled Warewashing Equipment, Determining Chemical Sanitizer Concentration indicated, .Concentration of the sanitizing solution shall be accurately determined . Review of facility policy and procedure (P&P) titled DishWashing dated 2018, the P&P indicated . Low-temperature machine: If you do not have the manufacturer's recommendations, use the machine at a range of 120 to l 40 F. The chlorine should read 50-100 ppm on dish surface in final rinse. The proper chlorine level is crucial in sanitizing the dishes. If you do not achieve the proper temperature or chlorine level, resort to the MANUAL METHOD OF DISH WASHING . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent observation and interview on 4/23/24 at 01:00 PM, Diet Aide (DA) 4 was setting up the lunch tray line foods. DA 4 used a thermometer and took the temperature of standing water in one section of the steamtable. DA 4 then took the temperature of the roasted turkey and indicated it was 120 degrees F (Fahrenheit). The surveyor's thermometer was used to check the temperature of the prepared roasted turkey and the temperature indicated it was 164 degrees F. DA 4 stated she did not calibrate the thermometer and stated she needed to calibrate her thermometer now. When DA 4 attempted to calibrate her thermometer, DA 4 took a cup from the clean dish rack, filled it with ice, then placed the thermometer in the cup. DA 4 then asked, how many degrees should it be? to CK 2. DA 4 then stated she did not really know how to calibrate the thermometer. CK 2 then stated, It should be 32 degrees. Review of the 2022 Federal Food and Drug Administration (FDA) Food Code, section 4-204.112 titled Temperature Measuring Devices indicated The importance of maintaining time/temperature control for safety foods at the specified temperatures requires that temperature measuring devices be easily readable. The inability to accurately read a thermometer could result in food being held at unsafe temperatures. Temperature measuring devices must be appropriately scaled per Code requirements to ensure accurate readings. Review of the facility policy titled Thermometer Use and Calibration, dated 2018, indicated the Food thermometers are to be calibrated each week .1. Fill a large glass with crushed ice and add clean tap water until slush is formed. Stir the mixture well. 2. Put the thermometer's stem into the ice water so that the sensing area is completely submerged (a dimple marks the end of the sensing area). Do not let the stem touch the bottom or sides of the glass. The thermometer stem or probe must remain in the ice water one minute and during calibration process. 3. If the thermometer does not read 32 F, then the thermometer must be calibrated or discarded . Review of the facility Job Description for Dietary Aide indicated the Essential responsibilities and job functions include performs food service and preparation duties in accordance with .established policies and procedures .Operates and maintains dietary equipment as needed. During a review of the Dietary Department Kitchen Staff In-Services Binder from May 2023-April 2024, the in-services binder did not have in-services reviewing proper thermometer calibration or dish machine sanitizer testing for kitchen staff. During an interview on 4/25/24 at 3 PM with the RDS and RD 1, RDS stated she expected the kitchen staff to perform their duties correctly. RDS stated DA 1 and DA 5 should know how to correctly test the dish machine sanitizer level, and what the correct dish machine sanitizer level is. The RDS further stated DA 4 was nervous but should know how to correctly demonstrate how to calibrate a thermometer.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 38924 Based on observations, interviews and record review, the facility failed to ensure the approved menus by the Registered Dietitian (RD) were followed as printed. This failure had the potential to alter the palatability and nutritional value of the food, which could decrease food intake and compromise the resident's nutritional status. Cross reference F804 Findings: Review of the facility document titled RD Approval of Menus, signed by the facility RD on 3/1/24, indicated The Registered Dietitian for the facility has reviewed the menus and spreadsheets and has agreed that the menus meet the therapeutic needs of and reflect, based on reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups . During a review of the facility's Week 4 Spring Menu April 22-28th 2024, did not have a soup listed for breakfast, lunch, or dinner. During a review of the facility's Spring Cycle Menus, Week 4 -Tuesday 4/23/24, the Lunch meal for Regular diets included Roast Turkey, Cranberry-Ginger-Citrus sauce, Bread Dressing, Seasoned peas, Three-bean salad, and Vanilla mousse chocolate chip dessert. During an observation and interview on 4/23/24 at 12:02 PM, there was a pan with soup on the trayline. The Registered Dietitian Supervisor (RDS) stated the Cooks make a different soup everyday using a vegetable. The RDS further stated the Cooks add thickener and butter to the soup the serves it to residents on fortified diets. The RDS stated the soups are provided to residents who request soup. On 4/23/24 at 12:38 PM, an interviewed was conducted with CK 2 about the soup preparation. CK 2 stated she made the soup for the day was made with powdered fortified milk, butter, green peas, green beans. During an interview on 4/25/24 at 3:49 PM with the RDS, the RDS stated nearly twenty residents receive the regular or fortified soup. The RDS acknowledged the regular soup was not on the printed menu but stated it should be listed on there because it was part of the daily nutritional analysis. Review of the facility's policy and procedure (P&P) titled Menu Planning, dated 2020, indicated .4. The menus are planned to meet nutritional needs for residents in accordance with established national guidelines, Physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus are to be approved by the facility Registered Dietitian prior to the beginning of each quarterly menu cycle .5. The menus are written as a four-week cycle, providing three meals per day .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48270 Based on observation, interview and record review, the facility failed to ensure the food was served at an acceptable temperature and palatability taste to the residents, according to the facility policy and the facility's resident council. This failure had the potential to affect meal and food intake which could impair the nutrition status of the residents. Cross reference F803 Findings: During a review of the facility's Spring Cycle Menus, Week 4 -Tuesday 4/23/24, the Lunch meal for the Regular diet included Roast Turkey, Cranberry-Ginger-Citrus sauce, Bread Dressing, Seasoned peas, Three-bean salad, and Vanilla mousse chocolate chip dessert. The Pureed meal included pureed Roast Turkey, pureed Cranberry-Ginger-Citrus sauce, pureed Bread Dressing, pureed Seasoned peas, pureed vegetable, and Vanilla mousse without chocolate chips. During an observation and interview on 4/23/24 at 9:32 AM with CK 1 was conducted. CK 1 was preparing food for the lunch menu. CK 1 stated he made the pureed turkey with ground turkey that he cooked. CK 1 then stated CK 2 added salt and pepper seasoning, and thickener to the cooked ground turkey for the Pureed diets. CK 1 stated he warmed up and sliced three pre-cooked turkey breasts for the Regular diets. During a review of the facility's Spring Cycle Menus, Week 4 -Wednesday 4/24/24, the Lunch meal for the Regular diet included Oven BBQ Beef Roast, Mashed sweet potatoes, Fresh Zucchini and carrots, Parsley garnish, Cheddar biscuit, Ice cream dessert, and milk. The Pureed meal included pureed Oven BBQ beef roast, pureed mashed sweet potatoes, pureed zucchini and carrots, pureed peas, pureed cheddar biscuit, and ice cream. During an observation and interview on 4/24/24 at 9:40 AM with CK 1 was conducted. CK 1 stated he used ground beef to make the pureed beef roast. CK 1 stated after he cooked the ground beef, CK 2 added salt and pepper seasoning, then thickener to make the pureed beef for Pureed diets. CK 1 stated he warmed up and sliced three pre-cooked beef roasts for the Regular diets. CK 1 stated both the Regular Roast Beef and Pureed ground beef would get an ounce of BBQ poured on top. On 4/24/24, at 10 AM, a Resident Council meeting was conducted. During the meeting, multiple residents anonymously stated the food does not taste good and has been served cold. The residents stated the food has to be reheated by the nursing staff on a regular basis. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a test tray concurrent observation and interview on 4/24/24 at 12:50 PM with the RDS, the RDS's thermometer did not correctly obtain the food temperatures on the test tray. The RDS stated she thought the thermometer was calibrated but it was not. The facility thermometer read 80 degrees Fahrenheit (F) for the puree ground beef and was 123.6 degrees F on the Surveyor's thermometer. The RDS acknowledged that using a calibrated thermometer is important for food to be served at a palatable temperature so residents will eat and enjoy the food. The pureed BBQ ground beef tasted grimy and did not have the same flavor as the regular oven BBQ beef roast. The RDS stated there was a different taste between the pureed and regular meat entrees. Review of the facility policy titled Pureed Food Preparation, dated 2018, indicated for pureed foods, to Start with regular recipe . A review of the facility policy titled Meal Service, dated 2018, indicated that temperature measuring devices shall be calibrated .to assure their accuracy .Resident preferences for .food temperatures shall be honored. During a concurrent kitchen observation and interview on 4/23/24 at 12:37 PM with Diet Aide (DA) 3 about the egg salad preparation, DA 3 stated she used hard boiled eggs, mustard powder, and mayonnaise and doesn't measure the ingredients. DA 3 stated there was a recipe but she's been working here so long she just eyeballs the amounts. DA 3 also stated once she finished combining all the ingredients, she scoops out the portion amount and place it on sliced bread. DA 3 then stated she wraps them in plastic wrap, then places them in the refrigerator for the Residents' nourishments. During an interview with the RDS on 4/25/26 at 4:15 PM, the RDS stated she expected all kitchen employees to follow the approved menus as printed. Review of the facility's undated document titled RECIPE: EGG SALAD SANDWICH, indicated .Ingredients: Large pasteurized eggs .hard cooked, Mayonnaise, chilled, Pickle relish, Mustard powder, Wheat bread . Directions: 1.Combine eggs, mayonnaise, pickle relish and mustard powder. 2. Scoop #12 per sandwich .3. Temp. sandwiches and if higher than 41 degrees F, start the cool down log. (Must come down from 70 degrees to 41 degrees within 4 hours). 4. Keep sandwiches in refrigerator, covered, at less than 41 degrees F until service . According to the 2022 Federal Food and Drug Administration (FDA) Food Code, Section 3-501.14 titled Cooling, .(B) Time/Temperature control for Safety Food (TCS) shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as reconstituted foods, tuna, etc . Review of the facility policy titled Food Preparation, dated 2018, indicated that The facility will use approved recipes .Recipes are specific as to portion yield, method of preparation, amounts of ingredients, and time and temperature guide.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on observation, interview, and record review, the facility failed to ensure that a Vegetarian Diet (no consumption of animal meat) meal preference was honored for an unsampled resident, Resident 48. This failure had the potential for decreased food intake which could increase the risk of unintended weight loss due to the facility not meeting the resident's nutritional needs. Findings: Resident 48 was readmitted to the facility on [DATE] with diagnoses that included but not limited to diabetes (high levels of sugar in the blood) and hypertension (high blood pressure)per the facility's Admission record. During an observation and interview with Resident 48 on 4/23/24 at 8:15 A.M., Resident 48 was observed in her room with a breakfast tray on the bedside table. The breakfast tray included a bowl of cottage cheese and a plate of sliced tomatoes. Resident 48 stated she did not like at the food at the facility because they do not give her foods she can eat as a vegetarian, including eggs. Resident 48 consumed about 50% of the cottage cheese and 70% of the tomato slices. Resident 48 stated she ordered a large green smoothie shake from an outside vendor with bananas for breakfast. A review of Resident 48's diet meal ticket indicated .disliked beef, chicken, pork, fish, ham, turkey, gravy, and tomato soup . During a review of Resident 48's labs dated 3/18/24, the lab report indicated CRP (C-Reactive Protein)=3.4 mg/dL (High), Vitamin D 25OH- 7 mg/dL (Low) (normal vitamin D = 30-100 mg/dL). During an observation and interview on 4/24/24 at 3:17 PM, Resident 48 stated she spends $100s of dollars on her food. The resident stated she was unaware the facility had a Vegetarian Diet with foods appropriate for vegetarians. During an interview on 4/25/24 at 12:52 PM, Resident 48 stated if I just had cooked brown rice and steamed vegetables consistently for dinner, I would be happy. During an observation and interview on 4/26/24 at 12:15 P.M. Resident 48's was eating her lunch meal in her room. The resident's meal tray she had pudding, spinach, bread, mash potatoes, all pureed consistency. She had a couple bites of the spinach. Overall, Resident 48 ate 25% of her meal, and no alternatives were offered to her. During an interview on 4/25/24 at 1:11 PM, CNA 41 stated she has warmed up a lot of food from the outside for Resident 48. CNA 41 also stated she was unaware resident 48 was a Vegetarian but noticed her eating a lot of food from the outside. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/24 at 3:49 PM with RDS and RD1, RD1 stated she had been working with Resident 48 to provide her with vegetarian foods. RD 1 stated she offered Resident 48 Peanut Butter and Jelly (PB&J) sandwiches, and PB&J crackers for lunch because the resident didn't like grilled cheese sandwiches at lunch. RD1 also stated Resident 48 didn't like wet and soggy food or bread. RD 1 stated she was unaware the facility had a Vegetarian Diet in the facility's Diet Manual. RDS stated Resident 48 indicated she wanted a veggie burger and side salad (chef salad) for lunch but stated the chef salad lettuce was not fresh and the veggie burger was hard, so she did not want it. The RDS stated she was unaware of the Vegetarian Diet in the Diet Manual, but stated it was the facility's responsibility to provide vegetarian appropriate foods to meet the resident's food preferences and meet her dietary needs. During an interview with the director of nursing (DON) on 4/26/24 at 1:35 P.M., the DON stated she expected residents' food preferences to be honored by the facility. The DON was not aware Resident 48 did not receive vegetarian appropriate foods from the vegetarian diet. During a review of the facility's policy titled Resident Preference Interview, dated 4/1/14, indicated .II form A - Dietary Questionnaire will be completed upon admission, readmission and no less than annually to capture the resident's dietary preferences .V. The Dietary Manager will update the copy of the Dietary Questionnaire as necessary. Review of the facility's Vegetarian Diet dated __, the vegetarian diet indicated, .A careful diet history is needed to ensure healthy food practices and the correct type of vegetarian diet. Diet orders need to clarify the correct category. NUTRITIONAL BREAKDOWN: Calories 2000-2250, Protein 78-85 grams, Fat 100-105 grams, and Carbohydrates 245-265 grams.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation methods in the kitchen were followed according to standards of practice and facility policy when: 1. The ice machine had dark black and dark gray debris around the chute opening and inside the ice making evaporator, and was not cleaned according to manufacturer's guidelines. 2. The ice machine did not have an air gap. 3. Two bags of hoagie rolls were found to be outdated and expired. 4. A walk-in and reach-in refrigerator did not have internal working thermometers for temperature monitoring. 5. Four food scoopers were found with brown, crusted debris and 12 scoops were found with water in them and seven sharp butcher cutting knives were found with greasy grime and food particles crusted on them. These failures had the potential to expose residents to contaminants that could cause foodborne illness. Findings: 1. During a kitchen observation and interview on [DATE] at 2:40 PM of the ice machine with the Maintenance Director (MDR), the MDR stated he completes the ice bin cleaning every month but does not clean the inside ice-making parts. The MDR stated he turns off the ice machine, clears all the ice out, then wipes it with a microfiber rag that was soaked into a sanitizer warm water solution. He stated he also wipes the outside of the machine. The MDR stated an outside vendor cleans the internal ice-making parts monthly. During an observation of the ice machine and interview on [DATE] at 4:43 PM with the Ice machine vendor technician, MDR, Registered Dietitian Supervisor (RDS), and the Regional Facility Administrator (RFA), the technician stated he last cleaned the ice machine a week ago and cleaned it monthly. The technician also stated when he cleaned the ice machine, he turned it off, then pours the cleaner solution into the shaft and wipes the ice machine trough (grid), tray, and chute. The technician then stated he poured the sanitizer solution through the same areas and wiped them down also. The Surveyor checked the inside of the ice machine chute and there was black and dark gray debris around the opening and the evaporator areas. The technician stated he didn't clean the side walls around the ice chute or evaporator area but stated he could have used a small brush to clean and wipe them. The MDR and RFA stated the ice machine should have been cleaned correctly according to manufacturer's instructions. (continued on next page)

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	555076	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's undated Ice machine manufacturer's guidelines document titled Ice Machine Operation, Section 3, indicated .an extremely dirty ice machine must be taken apart to be cleaned and sanitized . Review of the ice machine manufacturer's instructions titled Cleaning and Sanitizing indicated .Step 9 .use , d+[DATE] the cleaner water solution to clean all food surfaces of the ice machine bin/dispenser. Use a nylon brush .to thoroughly clean the following ice machine area: side walls, base (area above water trough), evaporator plastic parts (top, bottom, and sides), bin or dispenser. Review of the 2022 Federal FDA Food Code section ,d+[DATE].11 indicated Equipment Food-Contact Surfaces and Utensils. Ice bins and components of ice makers need to be cleaned: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold .Ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms . Review of the facility's policy and procedure (P&P) titled Ice Machine Cleaning, dated 2020, indicated .3. Clean the inside of ice machine with a sanitizing agent per manufacturer's instructions .use manufacturer's procedures to clean and sanitize the machine . Review of the facility's P&P titled Section 8 Sanitation, dated 2018, indicated .12. Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner . 2. During a kitchen observation on [DATE] at 9:40 AM, the ice machine air gap was observed with pvc (polyvinyl chloride) white rubber piping that extended from the machine into a floor drain. During a kitchen observation and interview on [DATE] at 2:45 PM of the ice machine air gap with the RDS and MDR, the RDS stated the ice machine air gap was installed several years ago but she did not know if the air gap was appropriate. The MDR stated he was unaware of the incorrect use of the pvc piping from the ice machine air gap. Review of the 2022 Federal FDA Food Code, section ,d+[DATE].11(A), indicated .A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment .are placed . Review of the HEALTH AND SAFETY CODE - HSC, DIVISION 104. ENVIRONMENTAL HEALTH [106500 - 119406], PART 7. CALIFORNIA RETAIL FOOD CODE [113700 - 114437], CHAPTER 7. Water, Plumbing, and Waste [114189 - 114245.7], ARTICLE 1. Water [114189 - 114195], section 114193. (a) All steam tables, ice machines and bins, food preparation sinks, warewashing sinks, display cases, walk-in refrigeration units, and other similar equipment that discharge liquid waste shall be drained by means of indirect waste pipes, and all wastes drained by them shall discharge through an airgap into a floor sink or other approved type of receptor. Review of California Code of Regulations S536. Piping Standards, Subchapter 1. Unfired Pressure Vessel Safety Orders, Article 7. Compressed and Liquefied Natural Gas System (a) General .(5) Use of the following is prohibited: .(D) Plastic pipe, tubing, hose . https://www.dir.ca.gov/title,d+[DATE].html (continued on next page)

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Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During the initial kitchen tour on [DATE], at 7:55 AM, an observation of the dry storage room was conducted. Two bags of hoagie rolls (6 rolls per bag) were found on large bread racks dated [DATE] and expired in the dry food storage room. During an interview with DA 1 and RD 1 on [DATE] at 8:08 AM, both DA 1 and RD 1 stated the hoagie rolls were expired and should have been thrown away. During a kitchen observation on [DATE] at 8:27 AM, there were three large white plastic bins with the following labels and use by dates, bread crumbs use by date- [DATE], thicner use by date- [DATE], brown sugar use by date- [DATE] and powdered sugar used by date- [DATE]. Inside the walk-in refrigerator, there were twelve plastic cups filled with a milk looking liquid, with lids labeled HS with ,d+[DATE] and four dated , d+[DATE]. During an interview on [DATE] at 8:56 AM with DA 2, DA 2 stated food should have an opened date written on the label. DA 2 stated she does not write a use by date on the label, but some kitchen staff do this. During an interview on [DATE] at 4:08 PM with the RDS, the RDS stated she expected staff to label foods with an opened date and use by date according to a dating sheet posted near the walk-in refrigerator. According to the 2022 Federal FDA Food Code, section ,d+[DATE].17 (A) (B) (C) (D) indicate .the day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises . Review of facility policy titled Labeling and Dating of Foods, dated 2020, indicated .Newly opened food items will need to be closed and labeled with an open date and used by the date that follows guidelines . 4. During an observation of the kitchen on [DATE] at 8:36 AM of the walk-in refrigerator, an internal thermometer was found inside the walk-in refrigerator with the red dye not working and it was hard to determine what the degrees were. During an observation and interview of the reach-in refrigerator on [DATE] at 8:55 AM, the internal thermometer was on a top shelf that read 58 degrees Fahrenheit (F). The Surveyor poured milk from a gallon jug stored inside the refrigerator and took the temperature of the milk. The Surveyor's thermometer read 48 degrees F. The RDS stated the thermometer should be replaced, and the walk-in refrigerator thermometer should be replaced. Review of facility document titled PROCEDURE FOR REFRIGERATED STORAGE, dated 2018, indicated I. Refrigerator - 41 F or lower .To keep food at a specific temperature, the air temperature in the refrigerator usually must be about 2 F lower .2.Two thermometers, placed to be easily visible for checking, should be inside all walk- in, reach-in refrigerators. The second thermometer is a check against the first thermometer for accuracy . (continued on next page)

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Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During the initial kitchen tour on [DATE] at 8:45 AM, an observation and interview was conducted with the RDS and CK 1. There were four food scoopers found with brown, crusted debris and 12 scoopers with water in them stored on a dish rack with clean dry utensils and scoopers. There were also seven sharp butcher cutting knives found stuck to a knife board on the wall with greasy grime black and red food particles crusted and stained on the blades. CK 1 stated he was about to use the knives to start cutting the turkey for lunch. The RDS stated the knives should be cleaned. The RDS also stated the scoopers should not be stored dirty or wet with clean dry scoopers. According to the 2022 Federal FDA Food Code, section ,d+[DATE].11, titled Equipment Food-Contact Surfaces and Utensils, Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. Food-contact .should be cleaned as needed throughout the day but must be cleaned no less than every 4 hours to prevent the growth of microorganisms on those surfaces. Review of the facility document titled Sanitation, dated 2018, indicated All utensils, counters, shelves and equipment shall be kept clean .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview and record review, the facility failed to ensure a clinical record was completed for one of one resident (Resident 219) reviewed for accurate medical record. This failure did not provide an accurate representation of the care provided to Resident 219 and had the potential to cause confusion amongst care providers. Findings: Resident 219 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (cancerous tumor) of prostate (a male organ below the bladder) according to the facility's Admission Record. During an observation on 4/23/24, at 11:55 A.M., Resident 219 was in bed with an indwelling urinary catheter (soft, plastic or rubber tube that is inserted into the bladder to drain the urine) hanging at the side of the bed, draining tea colored urine. An interview and concurrent observation was conducted with LN 13 on 4/24/24, at 11:50 A.M. LN 13 stated Resident 219 had an indwelling urinary catheter for prostate cancer. LN 13 stated licensed nurses provided indwelling urinary catheter care daily as ordered by the physician. LN 13 stated the catheter was changed as needed and monthly. Resident 219 stated his urine was darker than normal. During an interview and concurrent record review on 4/25/24, at 8:38 A.M., with LN 12, LN 12 reviewed the treatment administration record (TAR) for Resident 219. LN 12 stated the TAR indicated a physician's order for urinary catheter care daily. LN 12 stated a check mark on the TAR indicated the care was provided. LN 12 stated there were no check marks for 3/9/24, 3/16/24, 3/17/24, 3/19/24, 3/20/24 and 3/21/24. LN 12 further stated the TAR indicated to monitor urinary drainage bag for color, consistency, odor, hematuria (blood in urine), bladder distention (the pouch that holds the urine stretches), burning sensation every shift. LN 12 stated there were no check marks for day shift on 4/1/24 through 4/4/24, 4/5/24, 4/6/24, 4/10/24, 4/16/24, 4/18/24, 4/19/24, 4/20/24, 4/22/24 and 4/24/24. LN 12 reviewed afternoon shift's documentation and stated there were no check marks for 4/1/24, 4/6/24, 4/7/24, 4/12/24 and 4/18/24 through 4/22/24. LN 12 reviewed night shift documentation and stated there were no check mark for 4/12/24. An interview was conducted on 4/26/24, at 1:46 P.M. with the director of nurses (DON). The DON stated the TAR should be completed to reflect the care provided to the resident. A review of the facility policy and procedure (P&P) titled, Charting and Documentation, dated July 2017 was conducted. The P&P indicated, .All services provided to the resident .shall be documented in the resident's medical record .The following information is to be documented in the medical record .c. Treatments or services performed .Documentation of the procedure and treatments will include care-specific details, including .b. the name and title of the individual (s) who provided the care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to demonstrate infection control practices when: 1. A continuous positive airway pressure machine (CPAP- a machine worn on the face at night for the treatment of sleep apnea), mouthpiece was not stored properly for one of four residents (401) reviewed for infection control. 2. An oxygen humidifier (a clear plastic bottle which contains distilled water, that infuses oxygen with water droplets for moisture and comfort during use) was not dated when it was initiated for one of four residents (187), reviewed for oxygen therapy. 3. A urinary catheter bag (a clear flexible tube placed inside the body to drain urine into an external bag) was on the floor for one of two residents (216), reviewed for urinary catheter care. 4. A bilevel positive airway pressure (BIPAP) machine (machine used as breathing support and administered through a face mask or nasal mask) was not cleaned according to the facility's policy and procedure for one of two residents (138) reviewed for the use of BIPAP/CPAP. As a result, residents were at risk for exposure to unwanted pathogens (microorganisms that cause disease). Findings: 1. Resident 401 was admitted to the facility on [DATE] with diagnoses of COPD (ineffective gas exchange in the lungs) and sleep apnea, per the facility's Admission Record. On 4/23/24 at 2:22 P.M., an observation and interview was conducted with Resident 401 in her room. Resident 401 was sitting in a large electric wheelchair and receiving oxygen via an oxygen tank strapped to the back of her wheelchair. On the tabletop, to the left of the bed was a CPAP machine. The mouthpiece was uncovered and resting in an opened top drawer. The top drawer contained personal items, such as a hairbrush, toothbrush, etc. Resident 402 stated they were going to move her to a different room soon and all her personal items on the wall had been removed. On 4/24/24 at 11:24 A.M., an observation was conducted of Resident 401 in her newly assigned room. Resident 401's CPAP was resting on top of a bedside table to the left of her bed. The mouthpiece was uncovered and resting on the tabletop, exposed to the environment. On 4/24/24, Resident 401's clinical record was reviewed: The Admission MDS, dated [DATE], listed a cognitive score of 13, indicating cognition was intact. The Functional Status indicated Resident 401 required maximum assistant with rolling side to side, moving from bed to chair, and personal care. According to the physician orders dated 3/8/24, .CPAP machine to be applied at night . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the care plan, titled Alteration in Respiratory function, dated 3/7/24, listed interventions such as, notify MD (medical doctor) of any significant observations. Observe for signs and symptoms of respiratory distress. There was not a care plan related to the CPAP machine, cleaning, or storage. On 4/24/24 at 3:32 P.M., an observation and interview was conducted with LN 33, regarding Resident 401's CPAP machine. LN 33 observed Resident 401's CPAP machine on her bedside table after the room change. LN 33 stated, the mouthpiece should not be left out like that, because it could get contaminated and cause an infection to the lungs. LN 33 stated the mouthpiece should be stored in a clear plastic bag to protect it, and it was not. LN 33 stated by not containing the mask inside a bag, it was at risk for cross contamination of pathogens (viruses, bacteria, and other types of germs that can cause disease). On 4/24/24 at 4:12 P.M., an interview was conducted with the DSD. The DSD stated she expected all CPAP/BiPAP masks to be covered and contained when not in use, to prevent infections. On 4/25/24 at 10:14 A.M., an interview was conducted with the ICN. The ICN stated she expected staff to bag CPAP/BiPAP mouth pieces after use and to clean them regularly, in order to protect the residents from cross contamination. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated she expected all CPAP/BiPAP machines to be maintained for cleanliness and protected from contamination, between use. An interview and concurrent medical record review was conducted on 4/26/24, at 9:34 A.M., with the respiratory therapist (RT). The RT stated cleaning of BIPAP mask, tubing and humidifier chamber was done by RT and it was documented in Resident 138's medical record. The RT reviewed Resident 138's treatment administration record (TAR) for April 2024. The RT stated there was no documentation in the TAR regarding cleaning of the BIPAP machine. During an interview on 4/26/24, at 1:46 P.M., with the DON, the DON stated the BIPAP machine should be cleaned for resident not to breathe in bacteria. A review of the facility's policy and procedure titled, CPAP/BiPAP Support, dated March 2015 indicated, . General Guidelines for Cleaning .7. Mask, nasal pillows, and tubing: Clean daily .mild dish detergent is recommended . The policy did not give guidance related to storage of facemask. 2. Resident 187 was admitted to the facility on [DATE], with diagnoses which included acute (sudden onset) and chronic (long term) respiratory failure with hypoxia (when insufficient amounts of oxygen are delivered to the tissues), per the facility's Admission Record. On 4/23/24 at 9:12 A.M., and at 3:53 P.M., an observation was conducted of Resident 187 as she laid in bed. Resident 187 was receiving oxygen at 2 liters (l) a minute (min), via nasal cannula (a clear, plastic tube that delivers oxygen to the nostrils) via an oxygen condenser (a machine that delivers concentrated oxygen). Attached to the back of the condenser was a humidifier. The humidifier was not dated with the time it was opened or initiated for use. On 4/24/24 at 8:14 A.M., and at 3:16 P.M., an observation was conducted of Resident 187's humidifier. The humidifier remained undated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 3:32 P.M., an interview was conducted with LN 33, regarding Resident 187's oxygen therapy. LN 33 stated a humidifier was important to provide comfort and moisture to the nares (opening of the nose), because oxygen can dry out the nasal passages. LN 33 stated humidifiers were changed out every Sunday by the night shift and needed to be dated. LN 33 stated it was important to change and date the humidifiers weekly to prevent the spread of infection, because pathogens can develop rapidly in the distilled water and it could travel to the lungs. On 4/24/24 at 4:12 P.M., an interview was conducted with the DSD. The DSD stated all oxygen tubing and humidifiers were required to be changed weekly and dated, so staff knew when they were last changed. On 4/25/24 at 10:14 A.M., an interview was conducted with the ICN. The ICN stated all oxygen tubing and humidifiers should be changed weekly or sooner if needed. The ICN stated pathogens could grow within the moist tubing and humidifiers, which could infect the residents. The ICN stated it was a standard of practice to date all oxygen equipment used, so staff knew when it was last changed out. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated it was important for staff to date all oxygen equipment and to ensure it was changed out every week. The DON stated the purpose of dating and changing out was to prevent infections from occurring. According to the facility's policy, titled Oxygen Administration, dated October 2010, there was no guidance related to infection prevention practices or the labeling and dating of oxygen equipment. 3. Resident 216 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record. On 4/24/24 at 8:19 A.M., an observation was conducted Resident 216 as he laid in bed. A urinary catheter bag covered with a blue dignity bag, was lying on the floor next to the right side of the bed. On 4/24/24 at 8:21 A.M., an observation and interview was conducted with CAN 31, who was assigned to Resident 216. CAN 31 observed the urinary catheter bag resting on the floor and stated, The bag should not be in contact with the floor, because it's considered an infection control issue. On 4/24/24 at 8:23 A.M., an interview was conducted with LN 34, who was preparing Resident 216's medication outside the room. LN 34 stated urinary tubing and collection bags should never be in contact with the floor. LN 34 stated the floor contains germs, which could travel up the catheter into the resident, resulting in an infection. On 4/25/24 at 10:13 A.M., an interview was conducted with the ICN. The ICN stated she expected all staff to ensure urinary catheter bags and the tubing never touched the floor, which could cause cross contamination. On 4/25/24 at 2:47 P.M., an interview was conducted with the DON. The DON stated she expected staff to demonstrated infection control practices at all times, when caring for urinary catheters, which should never touch the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's policy, titled Catheter Care, Urinary, dated September 2014, .Infection Control: .b. Be sure the catheter tubing and drainage bag are kept off the floor . 46235 4. Resident 138 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. During an observation and interview on 4/23/24, at 9:25 A.M., Resident 138 was in bed with a BIPAP machine on top of the bedside drawer and the mask on top of the machine. Resident 138 stated she applied the BIPAP mask on herself but did not like using the BIPAP because it was uncomfortable. An interview and concurrent medical record review was conducted on 4/26/24, at 9:34 A.M., with the respiratory therapist (RT). The RT stated cleaning of BIPAP mask, tubing and humidifier chamber was done by RT and it was documented in Resident 138's medical record. The RT reviewed Resident 138's treatment administration record (TAR) for April 2024. The RT stated there was no documentation in the TAR regarding cleaning of the BIPAP machine. During an interview on 4/26/24, at 1:46 P.M., with the DON, the DON stated the BIPAP machine should be cleaned for residents in order for them not to breathe in bacteria. A review of the facility's policy and procedure titled, CPAP/BiPAP Support, dated March 2015 indicated, . General Guidelines for Cleaning .7. Mask, nasal pillows, and tubing: Clean daily .mild dish detergent is recommended