STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Edna Subacute and Rehabilitation Center	1929 N. Fairview Street Santa Ana, CA 92706

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the informed consents were obtained prior to the use of the psychotropic medications (medications affecting brain activities associated with mental processes and behavior) for two of six final residents (Residents 32, and 540) reviewed for psychotropic medication use . * The facility failed to ensure an informed consent was obtained prior to administering the iloperidone medication (antipsychotic medication) for Resident 32. * The facility failed to ensure an informed consent was obtained prior to administering the lorazepam medication (antianxiety medication) for Resident 540. These failures had the potential for Residents 32 and 540 to not be informed of the psychotropic medications, and the potential side effects of the medications. Findings: Review of the facility's P&P titled Psychotropic Medication Management dated 12/2017 showed informed consent for psychoactive medications must be verified prior to use. 1. Medical record review for Resident 32 was initiated on 6/18/24. Resident 32 was readmitted to the facility on [DATE]. Review of Resident 32's H&P examination dated 4/27/24, showed Resident 32 had capacity to make medical decisions. Review of Resident 32's Order Review Report showed the following physician's orders dated 6/14/24: - to administer sertraline (antidepressant medication) 100 mg one tablet by mouth in the morning for depression manifested by verbalizing feeling sad; - to administer buspirone (antianxiety medication) 5 mg one tablet by mouth three times a day for anxiety manifested by inability to relax; and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- to administer iloperidone 1 mg one tablet by mouth two times a day for Schizophrenia (mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior) manifested by auditory hallucination. a. Review of Resident 32's medical record did not show an informed consent was obtained for the sertraline, buspirone, and iloperidone medications. On 6/20/24 at 1347 hours, an interview and concurrent medical record review for Resident 32 was conducted with the ADON. When asked for the informed consent form for the sertraline, buspirone, and iloperidone medications, the ADON could not find the informed consent form in Resident 32's medical record. The ADON stated maybe the new consents were in the medical records department office. On 6/20/24 at 1410 hours, an interview and concurrent medical record review for Resident 32 was conducted with the Medical Records Director. The Medical Records Director stated a copy of the informed consent form for the sertraline, buspirone, and iloperidone medications was in the medical records department office, to which she showed a copy of the informed consent form. The Medical Records Director stated the nurses would initially write the physician's name on the informed consent form, but the informed consent form had not been signed by the prescribing physician yet. The Medical Records Director stated she had the informed consent form in her office and had not uploaded to Resident 32's electronic health records because the prescribing physician had not signed the informed consent form. b. Review of Resident 32's Facility Verification/Informed Consent for Psychotherapeutic Drugs dated 6/14/24, showed the following medications: - sertraline 100 mg by mouth daily; - Buspar 5 mg by mouth three times a day; and - iloperidone 1 mg by mouth two time a day. Further review of Resident 32's Facility Verification/Informed Consent for Psychotherapeutic Drugs dated 6/14/24, showed the informed consent form for buspirone, sertraline, and iloperidone medications was signed by Resident 32 on 6/14/24, however the iloperidone medication was ordered on 6/17/24. On 6/20/24 at 1536 hours, an interview and concurrent medical record review was conducted with Resident 32. When asked about her medications, Resident 32 stated she had a concern about her antipsychotic medication. Resident 32 stated she only used to take antidepressant and antianxiety medications. Resident 32 verified she signed the consent form on 6/14/24, and stated she only signed for the Buspar and sertraline medications, but not the iloperidone medication. Resident 32 stated the iloperidone medication must have been added after she signed the informed consent form. On 6/20/24 at 1607 hours, an interview and concurrent medical record review for Resident 32 was conducted with RN 3. RN 3 verified the buspirone and sertraline medications were ordered on 6/14/24, while the iloperidone medication was ordered on 6/17/24. RN 3 verified the consent form for buspirone, sertraline, and iloperidone medications was signed on 6/14/24; however, the Iloperidone medication was ordered on 6/17/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 540 was initiated on 6/18/24. Resident 540 was admitted to the facility on [DATE]. Review of Resident 540's H&P examination dated 6/20/24, showed Resident 540 had the capacity to understand and make decisions. Review of Resident 540's Order Summary Report showed a physician's order dated 5/24/24, to administer lorazepam 0.5 mg one tablet by mouth every six hours as needed for anxiety for 30 days. Review of Resident 540's MARs for May and June 2024 showed Resident 540 was administered the lorazepam medication on 5/24 and 6/4/24. Review of Resident 540's medical record did not show an informed consent was obtained for the lorazepam medication. On 6/20/24 at 1356 hours, an interview and concurrent medical record review for Resident 540 was conducted with the ADON. The ADON verified the above findings. The ADON verified there was no informed consent for the lorazepam medication in Resident 540's medical record. On 6/20/24 at 1410 hours, an interview and concurrent medical record review for Resident 540 was conducted with the Medical Records Director. The Medical Records Director stated a copy of the informed consent for lorazepam medication was in the medical records department office, to which she showed a copy of the consent. The Medical Records Director stated the nurses only wrote the physician's name on the consent form, but the consent form has not been signed by the prescribing physician. The Medical Records Director stated she had the informed consent form in her office and had not uploaded to Resident 540's electronic health records because the prescribing physician had not signed the consent form. Cross reference to F758, example #1.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine if it was safe for one of 27 final sampled residents (Resident 95) to self-administer the medications. * Resident 95 was observed with the medications at bedside. Resident 95 did not have a physician's order, assessment, and care plan for the self-administration of medications. This failure had the potential for Resident 95 to administer the medications inaccurately. Findings: Review of the facility's P&P titled Self-Administration of Medication dated 2008 showed it is the policy of the facility to allow resident who request self-administration of medication to do so if the facility IDT has determined the resident is capable of doing so in a safe manner that does not present a risk to other residents of the facility. If a resident expresses a desire to self-administer their medications, or a physician orders self-administration, the facility will not allow the resident to self-administer meds until the following procedures are done: -A licensed nurse will complete the Self-Administration Assessment Review which includes the resident's physical and cognitive ability to safely administer and store their medication(s); -The assessment will then be routed to the DON/designee to review with the IDT for approval; and -The IDT will re-assess the resident to verify they are still able to self-administrate medications quarterly. The resident will do a return demonstration to the IDT to show they are able to perform this task. On 6/18/24 at 0951 hours, during the initial tour of the facility, Resident 95 was observed lying in bed, and a medication cup containing three tablets was observed on the bedside table in Resident 95's room. There was no licensed staff inside the room. Resident 95 stated the nurse gave the medications to her so she could eat her breakfast first, then she would take the medications. Resident 95 stated the nurses usually would just leave the medications at the bedside and she would take the medications later. On 6/18/24 at 1030 hours, an observation for Resident 95 and concurrent interview was conducted with LVN 3. Resident 95 was observed sitting in bed and stated she had already taken her medications, and a medication cup was on her breakfast tray. Resident 95 stated the medications were for itching, cholesterol, and a Tylenol (analgesic medication). LVN 3 verified the above findings. LVN 3 stated she had not given medications to Resident 95 because the resident wanted to take her medications later. LVN 3 stated the licensed staff were not supposed to leave the medications at bedside. Medical record review for Resident 95 was initiated on 6/18/24. Resident 95 was readmitted to the facility on [DATE]. Review of Resident 95's MDS dated [DATE], showed Resident 95 had a moderate cognitive impairment. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 95's Order Summary Report did not show a physician's order for Resident 95 to self-administer medications. Review of Resident 95's plan of care did not show a care plan problem to address Resident 95's self-administration of medications. Further review of Resident 95's medical record failed to show a physician's order to self-administer medications, nor an assessment was completed for Resident 95 to safely self-administer medications. On 6/19/24 at 1234 hours, an interview and concurrent medical record review for Resident 95 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the residents were assessed upon admission whether they could self-administer medications. RN 1 verified Resident 95 did not have a physician's order, assessment, and care plan for the self-administration of medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to promote the dignity and respect for two of 27 final sampled residents (Residents 81 and 540) and one nonsampled resident (Resident 96). * The call light was not within reach for Residents 81, 96, and 540. This failure created the potential to result in a delay to provide care and negatively impact the resident's psychosocial well-being. Findings: 1. Review of the facility's P&P titled Call light : Accessibility and Timely response dated 10/22 showed the staff will ensure the call light is within reach of the resident and secured as needed. Medical record review for Resident 81 was initiated on 2/4/22. Resident 81 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 81's Plan of Care dated 6/17/24, showed a care plan problem addressing Resident 81 had self-care deficit as evidenced by needs assistance with ADL care. The interventions included one-person physical assistance required for transfers; supervision required for toilet use; and one-person physical assist required for personal hygiene . On 6/19/24 at 0900 and 1000 hours, Resident 81 was observed laying in bed. Resident 81's call light was on the floor. On 6/19/24 at 1055 hours, CNA 2 was summoned to Resident 81's room. Resident 81 was observed laying in her bed and her call light was on the floor. CNA 2 verified the finding and stated it should not be in the floor. 2. Medical record review for Resident 96 was initiated on 6/19/24. Resident 96 was admitted to the facility on [DATE]. Review of Resident 96's H&P examination dated 10/31/23, showed Resident 96 had capacity to understand and make medical decisions. On 6/19/24 at 0930 and 1030 hours, Resident 96 was observed awake, sitiing on her bed, and watching the television. Resident 96's call light was observed hanging on the wall. Resident 96 was asked if he could reach the call light on the wall. Resident 96 stated no. On 6/19/24 at 1100 hours, LVN 3 was summoned to Resident 96's room. Resident 96 was observed sitting upright in the bed and watching the television. Resident 96's call light was observed on the floor. LVN 3 stated it should be within resident reach. LVN 3 verified the findings. 39453 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 10/2022 showed the staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light, and staff will ensure the call light is within reach of resident and secured, as needed. Medical record review for Resident 540 was initiated on 6/18/24. Resident 540 was admitted to the facility on [DATE]. Review of Resident 540's H&P examination dated 6/20/24, showed Resident 540 had the capacity to understand and make decisions. Review of Resident 540's MDS dated [DATE], showed Resident 540 had no impairment to the upper extremities, and required partial/moderate assistance for personal hygiene. On 6/18/24 at 1006 and 1010 hours, Resident 540 was observed lying in bed. Resident 540 was asking for her call light. Resident 540's call light button was observed underneath her pillow, which Resident 540 could not reach the call light cord. On 6/18/24 at 1016 hours, an observation for Resident 540 and concurrent interview was conducted with LVN 13. Resident 540 was observed lying in bed. Resident 540's call light button was observed underneath the pillows and not within the resident's reach. LVN 13 verified the above findings.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to clearly identify the current code status for one of seven final sampled residents (Resident 32) reviewed for advance directives. * The facility failed to clarify and honor Resident 32's desire to have a full code status. In addition, the facility failed to ensure the correct individual signed Resident 32's POLST. Resident 32's POLST showed Resident 32 was a DNR and another individual (not Resident 32) signed Resident 32's POLST. These failures had the potential to not provide care in accordance with the resident's treatment wishes. Findings: Review of the facility's P&P titled Advance Directives dated ,d+[DATE] showed the following: - POLST (Physician Order for Life Sustaining Treatment), this form is often mistaken as an advanced directive, it is actually a physician order that travels from location to location with the resident; and - DNR (Do Not Resuscitate) order is a written order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. On [DATE] at 1002 hours, an interview was conducted with Resident 32. Resident 32 stated there was an incident when she was told that her code status was DNR, but she was a full code. When asked to elaborate, Resident 32 stated she was transferred to the acute care hospital on [DATE], and she heard the RN telling the ambulance transport personnel that she was a DNR. Resident 32 stated she told the RN that she was not a DNR, but a full code. Resident 32 stated she felt scared when the facility staff thought she was DNR, but she was not. Resident 32 also questioned why the facility allowed another person she did not even know to sign her POLST form, indicating she was DNR. Medical record review for Resident 32 was initiated on [DATE]. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 32's H&P examination dated [DATE], showed Resident 32 had the capacity to make medical decisions. Review of Resident 32's POLST dated [DATE], showed to attempt CPR and to provide full treatment, and long-term artificial nutrition, including feeding tubes for Resident 32. Review of Resident 32's Order Review Report showed the following physician's orders: - On [DATE], for full cardiopulmonary resuscitation (CPR). This order was discontinued on [DATE]. - An order dated [DATE], for full cardiopulmonary resuscitation (CPR). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 32's plan of care showed a care plan problem initiated by the SSD dated [DATE], addressing Resident 32 desired no life-prolonging measures in the event of cardiac or respiratory arrest as evidenced by advance directives. The interventions/tasks included no CPR, ensure the resident had a signed DNR order in the clinical record and skilled nursing facility would not initiate CPR in the event if cardiac or respiratory arrest. Review of Resident 32's Progress Note showed a General Note by RN 3 dated [DATE] at 1832 hours, showing at 1829 hours, the ambulance service was in the facility for a scheduled transfer of Resident 32 to the acute care hospital emergency department for further evaluation of the abdominal pain. The note also showed a copy of Resident 32's POLST was provided to the ambulance transport personnel indicating DNR status. On [DATE] at 1559 hours, an interview and concurrent medical record review for Resident 32 was conducted with RN 3. RN 3 verified the above findings. When asked about the incident on [DATE], RN 3 stated Resident 32 was transferred to the acute care hospital emergency department for an abdominal evaluation, and RN 3 gave a report to the admitting nurse, and also to the ambulance transport personnel. RN 3 verified she reported Resident 32 was DNR, and also gave a copy of Resident 32's POLST to the ambulance transport personnel. RN 3 stated the POLST was part of the document packet to be delivered to the acute care hospital with the arrival of the resident at the acute care hospital emergency department. When asked where the POLST indicating Resident 32 was DNR located, RN 3 showed a black binder showing the original copies of the residents' POLST form. RN 3 showed Resident 32's POLST dated [DATE], showing Resident 32 was a full code. RN 3 could not find the POLST showing Resident 32 was DNR. On [DATE] at 1620 hours, an interview and concurrent medical record review for Resident 32 was conducted with the SSD. The SSD verified the above findings. When asked about the plan of care showing a care plan problem initiated on [DATE], addressing Resident 32 desired no life-prolonging measures in the event of cardiac or respiratory arrest as evidenced by advance directives, the SSD verified she initiated the care plan problem and interventions but did not know why Resident 32 was DNR, when her code status was a full code. On [DATE] at 0732 hours, an interview and concurrent medical record review for Resident 32 was conducted with the Medical Records Director. The Medical Records Director verified the above findings. When asked for copies of Resident 32's POLST forms on file, the following were given by the Medical Records Director: -POLST dated [DATE], showed to attempt CPR, and to provide full treatment, and long-term artificial nutrition, including feeding tubes, and no advance directive for Resident 32; and -POLST dated [DATE], showed DNR, and to provide comfort-focused treatment, and trial period of artificial nutrition, including feeding tubes, and advance directive dated [DATE], for Resident 32. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked why the POLST dated [DATE], was not in Resident 32's medical records, the Medical Records Director stated she kept this POLST form in the medical records office because it was part of Resident 32's old chart. The Medical Records Director stated this was the POLST she showed the facility when she came from the acute care hospital, or her initial admission. The Medical Records Director verified Resident 32 was admitted to the facility on [DATE], transferred to the acute care hospital on [DATE], and was readmitted to the facility on [DATE]. The Medical Records Director verified Resident 32 was not readmitted to the facility on [DATE]. On [DATE] at 0859 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified the above findings. When asked about the POLST, the SSD stated upon the resident's admission, the admitting nurse asked the resident or a representative if a POLST has been completed. If a POLST has been completed, the medical records department uploaded the POLST form in the electronic health record, and the licensed nursing staff would put the physician's order in. The SSD stated the social services department was responsible in ensuring the POLST from was completed and accurate. The SSD stated the IDT composed of the DON, ADON, Administrator and SSD went over the resident's POLST to verify the resident's code status. When asked about Resident 32's POLST form, the SSD stated Resident 32 signed a new POLST form to which she showed a copy of the POLST form dated [DATE]. When asked why the POLST form dated [DATE], was not uploaded in Resident 32's electronic health record, the SSD stated she kept it in her office because the physician had not signed the form yet. The SSD was informed of the following POLST forms for Resident 32: -POLST dated [DATE], showed to attempt CPR, and to provide full treatment, and long-term artificial nutrition, including feeding tubes, and no advance directive for Resident 32. The POLST form was signed by Resident 32; -POLST dated [DATE], showed DNR, and to provide comfort-focused treatment, and trial period of artificial nutrition, including feeding tubes, and advance directive dated [DATE], for Resident 32. The POLST form showed it was signed by another individual (other than Resident 32); -POLST dated [DATE], showed to attempt CPR, and to provide full treatment, and long-term artificial nutrition, including feeding tubes, and no advance directive for Resident 32. The POLST form was signed by Resident 32. When asked about the POLST dated [DATE], the SSD verified the POLST showed Resident 32's name on the top portion of the form, but it was not Resident 32 who signed the form. The SSD stated she was not sure how a different person, not the resident herself could have signed the POLST form for Resident 32. The SSD verified the individual who signed Resident 32's POLST form was the daughter of another resident residing in the facility who was not in any way related to Resident 32. Cross reference to F657, example #1.

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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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to ensure the comprehensive plans of care for two of 27 final sampled residents (Residents 30 and 32) reviewed for care plans were revised to reflect the residents' current care needs and interventions. * Resident 32's plan of care was not accurately updated to reflect the resident's full code status. * Resident 30's plan of care was not revised to reflect Resident 30's wound care interventions. These failures posed the risk of not providing the residents with individualized and person-centered care. Findings: 1. Medical record review for Resident 32 was initiated on [DATE]. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 32's POLST dated [DATE], showed to attempt CPR, and to provide full treatment, and long-term artificial nutrition, including feeding tubes for Resident 32. Review of Resident 32's Order Review Report showed the following physician's orders dated: - [DATE], for full cardiopulmonary resuscitation (CPR). This order was discontinued on [DATE]; and - [DATE], for full cardiopulmonary resuscitation (CPR). Review of Resident 32's plan of care showed a care plan problem initiated by the SSD dated [DATE], addressing Resident 32 desired no life-prolonging measures in the event of a cardiac or respiratory arrest as evidenced by advance directives. The interventions/tasks included no CPR, ensure the resident had a signed DNR order in the medical records and skilled nursing facility would not initiate CPR in the event if cardiac or respiratory arrest. On [DATE] at 1620 hours, an interview and concurrent medical record review for Resident 32 was conducted with the SSD. The SSD verified the above findings. When asked about the plan of care showing a care plan problem initiated by the SSD on [DATE], addressing Resident 32 desired no life-prolonging measures in the event of a cardiac or respiratory arrest as evidenced by an advance directives, the SSD verified she initiated the care plan problem and interventions but did not know why Resident 32 was DNR when her code status was a full code. The SSD verified Resident 32's plan of care did not reflect the resident's correct code status which was full code. Cross reference to F578. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Medical record review for Resident 30 was initiated on [DATE]. Resident 30 was readmitted to the facility on [DATE]. Review of Resident 30's Order Summary Report showed the following physician's orders dated [DATE]: -To apply collagenase powder (a topical medication used for removing the damaged or burned skin to allow for wound healing) to sacrum topically every day for pressure injury for 30 days; -To apply Dakin's external solution 0.25% (a dilute solution of sodium hypochlorite used to treat or prevent infection) to sacrum topically, soaked for 10 minutes and rinse with normal saline every day for pressure injury for 30 days; -To apply Silvadene external cream (a topical antibiotic medication used to treat of prevent infection) 1% to sacrum topically, then apply calcium alginate dressing (a highly absorbent dressing made of calcium-alginate, ideally used for superficial and cavity wounds) and seal with bordered gauze every day for pressure injury for 30 days. Review of Resident 30's plan of care showed a care plan problem dated [DATE], addressing Resident 30's coccyx pressure injury. The interventions/tasks included the following: - Daily wound care as ordered: collagenase powder and Silvadene external cream 1%, to apply to sacrum topically every day for pressure injury for 30 days after cleansing with Dakin's solution, irrigate with normal saline. Dry well. Apply Silvadene, then apply collagen powder and calcium alginate, and seal with a bordered gauze daily for 30 days; and; - Use one vial via irrigation every day shift for wound care for 30 days. Soak wound with gauze saturated with acetic acid for five minutes, pat dry, apply Bactroban (antibiotic) ointment, and cover with a dry dressing daily for 30 days. On [DATE] at 1020 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 30's plan of care showed two wound care interventions. LVN 3 verified Resident 30's plan of care was not revised to only show the current wound care treatment for Resident 30.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of 27 final sampled residents (Residents 8) and one nonsampled resident (Resident 107). * The facility failed to follow the physician's order for Resident 8 to administer the antibiotic as ordered intravenously. This failure created the risk of not providing the appropriate care for Resident 8. * The facility failed to follow the physician's order for Resident 107 to receive a health shake (nutritional suppplement)with meals. This failure posed the risk for Resident 107 to not receive adequate calories which could lead to weight loss. Findings: 1. Review of the facility's P&P titled General Infusion undated showed a pump shall be provided (unless the facility had their own supply) on all medications pharmacy services recommends be administered by electronic infusion pump: Vancomycin (antibiotic). Medical record review for Resident 8 was initiated on 6/19/24. Resident 8 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 8's physician's order dated 6/18/24, showed an order for Vancomycin hydrochloride solution reconstituted 750 mg intravenously every 12 hours for sepsis for 10 days. On 6/18/24 at 0950 hours, Resident 8 was administered Vancomycin intravenously with the infusion rate of 150 ml per hour. The Vancomycin IV bag was labeled showing 750 mg in 250 ml normal saline to infuse over 90 minutes with the infusion rate of 177 ml per hours. On 6/18/24 at 1120 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked what the infusion rate was for the Vancomycin administration. RN 1 stated the rate was 155 ml per hour so she set up the flow regulator at 150 ml per hours. RN 1 was asked again regarding the label for rate administration on the IV bag. RN 1 stated it should be in 177 ml per hours. RN 1 was observed adjusting the regulator to be between 150 and 200 ml per hours. RN 1 stated the Vancomycin should be administered with the pump and they had not received the IV pump at the time. RN 1 verified the above findings. 39856 2. Medical record review for Resident 107 was initiated on 6/19/24. Resident 107 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Order Summary Report dated 6 /20/24, showed a physician order dated 5/7/24, for a healthshake with meals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the lunch meal observation on 6/18/24 at 1219 hours, in the dining room, Resident 107's lunch meal tray ticket showed a pureed diet with one healthshake. The lunch meal for Resident 107 did not include a healthshake. RNA 1 confirmed the healthshake was missing and she would get one from the kitchen.

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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** 39683 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the post fall assessments were appropriately completed for two of three residents (Residents 42 and 124) reviewed for falls. * Resident 42's post fall neuro checks were incomplete for two falls. * The facility failed to continue to monitor and document assessment every shift for 72 hours post fall incident for Resident 124. These failures had the potential to delay identifying and responding to post fall changes. Findings: Review of the facility's P&P titled Fall Prevention and Response revised 8/20/23, showed when a resident has a fall, to neurological check for known, reasonably suspected, or verbalized head injury. 1. Medical record review for Resident 42 was initiated on 6/18/24. Resident 42 was readmitted to the facility on [DATE]. Review of Resident 42's MDS dated [DATE], showed the resident was rarely understood and short-term and long-term memory problems. The MDS also showed the resident's cognitive skills were moderately impaired. a. Review of Resident 42's SBAR-Fall Report of Incident 8hr-V 3 dated 12/22/23, showed at 2000 hours, the resident was found on the floor. Review of Resident 42's Neurocheck assessment dated [DATE], showed the neurochecks to be completed Q15 (every 15 minutes) times four, Q30 (every 30 minutes) times four, and Q60 (every 60 minutes) times two. However, the neurocheck assessments were incomplete. Review of Resident 42's Neurochecks Q15 x 4, Q30 x 4, and Q60 x 2 assessments dated 12/23/23, showed the incomplete neurocheck assessments. On 6/20/24 at 1003 hours, an interview and concurrent medical record review were conducted with the ADON. The ADON stated the post fall neurological checks were to be completed per the HER (health electronic record)scheduled at every 15 minutes for four assessments, then every 30 minutes for two assessments, and then every hour for two hours. The ADON reviewed the post fall neurological assessments and verified they were incomplete. b. Review of Resident 42's SBAR-Fall Report of Incident 8 hr-V 3 dated 5/17/24, showed at 2000 hours, the resident was found on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 42's Neurocheck-Q15 x 4, Q30 x 4, Q60 x 2 assessments dated 5/17/24, showed the following: - The 1st Q60 assessment was completed on 5/17/24 at 2345 hours - The 2nd Q60 assessment was completed on 5/18/24 at 2143 hours, more than 21 hours after the previous assessment, not at the scheduled 60 minutes. On 6/20/24 at 1003 hours, an interview and concurrent medical record review were conducted with the ADON. The ADON stated the post fall neurological checks were to be completed per the HER schedule at every 15 minutes for four assessment, then every 30 minutes for two assessments, and then every hour for two hours. The ADON reviewed the post fall assessments and verified the finding. 49258 2. Review of the facility's P&P titled Fall Prevention and Response revised 8/2023 showed when any resident experienced a fall, the licensed nurse should monitor resident's condition for at least 72 hours for any post-fall complications. Closed medical record review for Resident 124 was initiated on 6/19/24. Resident 124 was admitted to the facility on [DATE]. Resident 124 was discharged from the facility on 6/13/24. Review of Resident 124's H&P examination dated 5/5/25, showed Resident 124 had the capacity to make medical decisions. Review of Fall Risk assessment dated [DATE], showed Resident 124 had fallen the last three months, with impaired gait, and a score of 75.0 indicating Resident 124 was a high risk for falling. Review of the Change of Condition-Fall dated 6/6/24, showed Resident 124 had an assisted fall while at a therapy session and to continue to monitor per protocol of witnessed fall. Further record review of Resident 124's SBAR-Fall Report of Incident 8hr - V 3 dated 6/6/24 to 6/9/24, failed to show documented evidence of continued monitoring to assess for negative impact from the fall incident. On 6/19/24 at 1323 hours, an interview and concurrent medical record review were conducted with RN 1. RN 1 stated the Change in Condition assessment for any post-fall complications should be initiated and the licensed nurse should document the assessment every shift for 72 hours. RN 1 verified there were no documented evidence of the monitoring and assessment by the nurse for the evening shifts on 6/7 and 6/8/24, for Resident 124.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to accurately monitor the hydrations status for one of 27 sampled residents (Resident 539). * The facility failed to ensure accurate monitoring of Resident 539's fluid intake which included from meals, medication administration, free water, liquid supplements, IV (intravenous) hydration, IV therapy intake, and IV flushes. In addition, the facility failed to ensure the monitoring of Resident 539's fluid output showed the actual number of urine output from the resident's indwelling catheter, and not just the frequency of voiding. These failures had the potential to compromise Resident 539's hydration status and posed the risk for negative health outcomes. Findings: Review of the facility's P&P titled Intake and Output (I&O) dated 8/2014 showed it is the policy of the facility to monitor intake and output and accurately document when it is determined that monitoring is necessary to evaluate hydration status, compliance with fluid restrictions, or to assist in the assessing and managing fluid needs. The P&P, under procedures section also showed the following: -The nursing personnel are responsible for recording the intake and output when indicated for assigned residents; -The licensed nurse/CNA is responsible for completing the subtotal of oral fluids consumed during the shift, to include any fluids consumed during meals, between meals, and during recreational activities; -The licensed nurse is responsible for completing the subtotal of any fluids consumed during the shift for medication passes (includes physician-ordered liquid supplements), enteral fluids and flushes, and/or IV therapy intake as indicated. Output for the shift will also be monitored and documented by nursing personnel; and -The licensed nurse totals the intake and output for all three shifts (every 24 hours) and records the amounts under the total section of the intake and output record. Medical record review for Resident 539 was initiated on 6/18/24. Resident 539 was admitted to the facility on [DATE]. Review of Resident 539's Order Summary Report showed the following physician's orders: - On 6/11/24, to monitor intake and output every shift, and to notify physician for signs and symptoms of dehydration or fluid volume overload; - On 6/11/24, to monitor total intake and output for the day; - On 6/12/24, for Foley catheter (indwelling urinary catherter) 16 French to gravity drainage every shift; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 6/12/24, to give healthshake 4 ounces three times a day with meals; - On 6/13/24, to give free water 150 ml every four hours for dehydration; and - On 6/12/24, to flush IV non-valved central line with 10 ml normal saline before medication and 20 ml after. Review of Resident 539's Intravenous Administration Record showed Resident 539 was administered the following: - Dextrose 5% and 0.9 % Sodium Chloride (type of IV fluids) at 75 ml/hour intravenously every shift for hydration from 6/12 to 6/18/24; - IV flush with 10 ml normal saline before medication and 20 ml after on 6/12 to 6/18/24; - Vancomycin solution 750 mg intravenously on 6/12 to 6/15/24 at 1400 hours; and - Vancomycin solution 900 mg intravenously on 6/16 to 6/18/24 at 1400 hours. Review of Resident 539's MAR for June 2024 showed the following: - Healthshake 4 ounces was given on 6/12/24 at 1400 hours; 6/13 to 6/18/24 at 0900, 1300, and 1700 hours; and 6/19/24 at 0900 and 1300 hours. - Free water at 150 ml was given on 6/13/24 at 1200, 1600, and 2000 hours; 6/14 to 6/18/24 at 2400, 0400, 0800, 1200, 1600, and 2000 hours; and 6/19/24 at 2400, 0400, 0800, and 1200 hours. Further review of Resident 539's MAR for June 2024 showed the following daily totals for Resident 539's fluid intake and output: -On 6/12/24, 100 ml fluid intake and one-time output; -On 6/13/24, 300 ml fluid intake and one-time output; -On 6/14/24, 900 ml fluid intake and five-time output; -On 6/15/24, 900 ml fluid intake and five-time output; -On 6/16/24, 720 ml fluid intake and five-time output; -On 6/17/24, 900 ml fluid intake and five-time output; and -On 6/18/24, 320 ml fluid intake and three-time output. Review of Resident 539's medical record did not show an accurate documentation of Resident 539's daily fluid intake and output. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 1106 hours, an interview was conducted with CNA 6. When asked about Resident 539's fluid intake, CNA 6 stated Resident 539 usually consumed 240 ml water and 240 ml from her meal tray each meal. When asked about Resident 539's output, CNA 6 stated she emptied the urinary catheter bag. CNA 6 stated she reported the actual fluid intake and output from the urinary catheter bag to the LVN. CNA 6 stated she did not document the actual fluid intake of the resident, but only documented the meal percentage under the Tasks section on the resident's electronic health record. On 6/19/24 at 1214 hours, an interview and concurrent medical record review was conducted with LVN 13. When asked about Resident 539's fluid intake and output, LVN 13 stated the CNAs reported to the LVNs about the resident's daily fluid intake and output. LVN 13 stated the licensed nurses documented in the resident's MAR. LVN 13 verified Resident 539's MAR did not show an accurate monitoring of the resident's daily fluid intake and actual urine output. On 6/19/24 at 1242 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 verified Resident 539 was administered the IV hydration fluid at 75 ml/hour and IV antibiotic 250 ml each bag. When asked about Resident 539's fluid intake and output, RN 1 stated the fluid intake should include Resident 539's fluid intake from meals, and medication administration, free water, liquid supplements, IV hydration, IV antibiotic, and IV flushes. RN 1 verified Resident 539's MAR did not show an accurate monitoring of the resident's daily fluid intake and actual urine output.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for one nonsampled resident (Resident 12) and one of one final sampled resident (Resident 539) reviewed for IV devices. * The facility failed to ensure the PICC line external catheter and arm circumference measurements were performed and documented in the medical record for Residents 12. * The facility failed to ensure the external catheter length and arm circumference measurements were performed as per the resident's plan of care. In addition, the facility failed to ensure Resident 539's midline catheter (an eight to twelve cm catheter inserted in the upper arm with the tip located just below the axilla) dressing was not soiled and dated. These failures had the potential to delay identification of catheter related complications for the resident. Findings: Review of the facility's P&P titled Central Access Guidelines and Procedures (undated) showed the dressing were routinely changed every seven days and as needed. The documentation in the medical records includes the appearance of the insertion site, site problems, or any amount of the catheter out of the skin, and the arm circumference. Document in treatment record prior to dressing change, compared to measurement from admission. 1. Medical record review for Resident 12 was initiated on 6/19/24. Resident 12 was admitted to the facility on [DATE], and readmitted to the facility n 6/7/24. On 6/19/24 at 0950 hours, an observation and concurrent interview was conducted with RN 1 at Resident 12's bedside. Resident 12 was observed with two lumen PICC line on the right upper arm with transparent dressing dated 6/19/24. RN 1 verified Resident 12's right upper arm PICC line. RN 1 stated the dressing was changed when Resident 12 was admitted last night. RN 1 was asked about the assessments that a licensed nurse would perform upon a dressing change. RN 1 stated the assessment included signs and symptoms of infection on the insertion site and measurement the length of the external catheter. When asked what else the licensed needed to measure, RN 1 stated the width of the catheter. Review of Resident 12's acute care hospital medical records showed the midline/extended dwell catheter was placed on 5/31/24, with the measurement of the size and length of the catheter. However, further review of Resident 12's medical record failed to show the length of the external catheter and arm circumference above the insertion site were obtained upon admission to the facility. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 12's Order Summary Report dated 6/19/24, showed a physician's order dated 6/19/24, to change the catheter site on the right upper arm dressing with transparent dressing: on admission, every week, and as needed; observe site for complications; and measure external catheter length and arm circumference. Review of Resident 12's plan of care showed a care plan addressing the use of PICC line dated 6/10/24. Interventions included to obtain the measurement of external catheter length and upper arm circumference as per the physician's order. On 6/19/24 at 1011 hours, an interview and concurrent medical record review for Resident 12 was conducted with RN 1. RN 1 verified Resident 12 was admitted back to the facility on [DATE], with the right upper arm PICC line. RN 1 verified and acknowledged there were no documentation of Resident 12's PICC line assessment upon admission. RN 1 stated there should have been an assessment of Resident 12's PICC line upon admission and weekly as a basis for measurement. On 6/20/24 at 1314 hours, an interview and concurrent medical record review for Resident 12 was conducted with the Administrator. The Administrator was informed and verified the above findings. 39453 2. On 6/18/24 at 0838 hours, Resident 539 was observed in bed. Resident 539 was observed with a double lumen catheter on the right arm connected to a bag of D5NS (5% dextrose and 0.25% normal saline solution) at 75 ml per hour. The midline catheter dressing on the right arm was observed with dried blood showing through the transparent dressing and was not labeled and dated. Medical record review for Resident 539 was initiated on 6/18/24. Resident 539 was admitted to the facility on [DATE]. Review of Resident 539's Order Summary Report showed a physician's order dated 6/12/24, to flush IV non-valved central line with 10 ml of normal saline before medication. Review of Resident 539's plan of care showed a care plan problem dated 6/12/24, addressing the potential for infection related to PICC line. The interventions/task included to measure the external catheter length and upper circumference for PICC line, midline, and central line as ordered. Review of Resident 539's IV Administration Record for June 2024 did not show the external catheter length and upper circumference of the right arm for Resident 539 were measured. Further review of Resident 539's medical record did not show any measurements performed for the external catheter length of the midline catheter and upper circumference of the right arm for Resident 539. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 1242 hours, an interview and concurrent medical record review for Resident 539 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 539 was admitted from the acute care hospital with a midline catheter on the right arm. RN 1 stated Resident 539 was administered the IV hydration and IV antibiotics through the midline catheter. RN 1 stated the external catheter length of the midline catheter and arm circumference of the right arm should be measured upon the resident's admission and during a dressing change. RN 1 stated the midline line catheter dressing should be changed weekly, and the RN during NOC (2400 to 0700 hours) shift usually changed the dressing. When asked to show any documentation of the measurement of the external catheter length and upper circumference of the right arm for Resident 539, RN 1 could not find any documentation. On 6/19/24 at 1306 hours, an observation of Resident 539 and concurrent interview was conducted with RN 1. Resident 539 was observed in bed and his midline catheter dressing on the right arm was observed with dried blood showing through the transparent dressing and was not labeled and dated. RN 1 verified the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure five of five residents (Residents 8, 12, 16, 79, and 86) reviewed for respiratory care were provided the appropriate respiratory care when: * The facility staff administered oxygen to Resident 8 without a physician's order and care plan to address oxygen use and monitoring of oxygen saturation level when the resident was using the oxygen continuously. *The facility failed to ensure Residents 12 and 86's nasal cannula (flexible tube to deliver oxygen to the nose) tubing were dated, labeled, and not touching the floor for Resident 12. *The facility failed to ensure Resident 16's CPAP (continuous positive airway pressure, a machine that uses mild air pressure to keep breathing airways open) mask was stored in a bag when not in use. * The facility failed to ensure Resident 79's oxygen tubing and humidifier were dated and labeled. In addition, the facility failed to ensure Resident 79's CPAP mask was stored in a bag when not in use. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: 1. Review of the facility's P&P titled Oxygen Administration dated 8/14 showed to check the physician's order for liter flow and method of administration. Medical record review for Resident 8 was initiated on 6/19/24. Resident 8 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. On 6/18/24 at 1100 and 1545 hours, Resident 8 was observed lying in bed wearing an oxygen nasal cannula attached to an oxygen concentrator machine (machine to provide continuous flow of oxygen) with a setting of three liters per minute. On 6/19/24 at 0900 hours, Resident 8 was observed lying in bed wearing an oxygen nasal cannula attached to an oxygen concentrator machine with a setting of two and half liters per minute. On 6/19/25 at 0950 hours, an interview was conducted with CNA 1. CNA 1 was asked if Resident 8 had been using oxygen. CNA 1 stated Resident 8 had been receiving oxygen continuously since he had been readmitted two days ago. On 6/19/24 at 1000 hours, LVN 2 was summoned to the Resident 8's room. Resident 8 was observed lying in bed wearing an oxygen nasal cannula attached to an oxygen concentrator machine with a setting of two and half liters per minute. LVN 2 acknowledged the resident had been receiving the oxygen at two and half liters per minute since the morning. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER St Edna Subacute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1929 N. Fairview Street Santa Ana, CA 92706	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 1005 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 was asked to show the physician's order regarding the oxygen order. LVN 2 was unable to provide documentation and stated she would call the physician to inform of Resident 8's use of oxygen. LVN 2 acknowledged there was no care plan to address Resident 8's oxygen use and oxygen monitoring while resident was on oxygen. 39670 2. On 6/19/24 at 0946 hours, Resident 12 was observed in bed asleep. Resident 12's bedside was observed with an oxygen concentrator machine with the oxygen tubing nasal cannula undated and unlabeled on the floor. Medical record review for Resident 12 was initiated on 6/19/24. Resident 12 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 12's Order Summary Report dated 6/19/24, failed to show a physician's order for the use of oxygen therapy for Resident 12. On 6/19/24 at 0950 hours, an observation and concurrent interview was conducted with RN 1 at Resident 12's bedside. RN 1 verified the oxygen concentrator machine at bedside with the oxygen tubing unlabeled on the floor. RN 1 stated the oxygen tubing should have been labeled and placed in the respiratory bag when not in use. 3. On 6/18/24 at 0954 hours, during the initial tour of the facility, Resident 86 was observed in his wheelchair with an oxygen tank at the back and the oxygen tubing undated and unlabeled hung on the handle of the wheelchair. In addition, an oxygen concentrator machine at Resident 12's bedside was observed with unlabeled and undated oxygen tubing. Medical record review for Resident 86 was initiated on 6/19/24. Resident 86 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 86's Order Summary Report dated 6/19/24, showed a physician's order dated 2/9/24, to administer oxygen at two liters per minute continuously every shift and as needed via nasal cannula for shortness of breath. On 6/18/24 a 1152 hours, an observation and concurrent interview was conducted for Resident 86 with LVN 1. LVN 1 stated the portable oxygen tank at the back of Resident 86's wheelchair was used for the resident when he attended activities or going around the facility. LVN 1 verified the oxygen tubing was unlabeled, undated, and placed on the handle of the wheelchair. Also, LVN 1 verified the oxygen tubing on the oxygen machine was undated and unlabeled. LVN 1 stated the oxygen tubing should have been labeled and placed in the respiratory plastic bag when not in use. On 6/20/24 at 1314 hours, an interview and concurrent medical record review was conducted for Residents 12 and 86 with the Administrator. The Administrator was informed and verified the above findings. 39453 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 6/18/24 at 0827 hours, during the initial tour of the facility, Resident 16 was observed in bed. A CPAP mask was observed on top of the bedside table and was not stored in a bag. Resident 16 stated he used the CPAP every night. On 6/18/24 at 1215 hours, an observation for Resident 16 and concurrent interview was conducted with LVN 13. Resident 16 was observed sitting in a wheelchair in his room. A CPAP mask was observed on top of the bedside table and not stored in a bag. LVN 13 verified the above findings. LVN 13 stated the CPAP mask and tubing should be stored in a bag when not in use. Medical record review for Resident 16 was initiated on 6/18/24. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 16's Order Summary Report showed the following physician's orders: - On 5/31/24, to connect CPAP mask to oxygen delivery source and deliver at same rate ordered for continuous oxygen every night; - On 5/31/24, to turn CPAP on at 2100 hours, and off at 0700 hours or when patient awakes. Empty water reservoir (if present on unit), rinse, wipe clean and replace the distilled water prior to use. Pressure at four to 20 cm of water via mask; and - On 6/2/24, to clean mask, tubing and headgear with hot soapy water, rinse and allow to air every week, and to clean humidifier reservoir with hot soapy water, rinse, dry and refill with distilled water every week on Sundays. On 6/21/24 at 1038 hours, an interview and concurrent medical record review was conducted for Resident 16 with the DON. The DON verified the above findings. The DON stated the CPAP mask and tubing should be stored in a bag when not in use. 50967 5. Review of the facility's P & P titled Oxygen Administration dated August 2014 showed to Label humidifier with date and time opened. Change humidifier and tubing per facility procedure. On 6/18/24 at 0950 hours, during the initial tour of the facility, Resident 79 was observed lying in bed wearing an oxygen nasal cannula attached to a humidifier and oxygen concentrator machine with a setting of three liters per minute. Resident 79's nasal cannula tubing and humidifier were not labeled and dated. In addition, a CPAP mask was observed on top of the bedside drawer and not stored in a bag. On 6/18/24 1105 hours, an observation and concurrent interview was conducted with LVN 8 at Resident 79's bedside. LVN 8 verified the oxygen tubing and humidifier were not labeled and dated and the CPAP mask was on top of bedside drawer and was not stored in the bag. Medical record review for Resident 79 was initiated on 6/18/24. Resident 79 was admitted to the facility on [DATE]. Review of Resident 79's Order Summary Report showed the following physician's orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/31/24, to administer oxygen at two to four liters per minute via nasal cannula continuous; and - On 6/05/24, to apply CPAP on as needed when lethargic, low saturation levels below 85% in the daytime, and strict application at night. On 6/20/24 0758 hours, an interview was conducted with the ADON. The ADON stated the oxygen tubing and storage bag was changed every Wednesday by the night shift LVN and should be labeled with the resident's name, date, and room number. However, the ADON stated the humidifier was changed when empty but should be labeled and dated when changed. The ADON also stated the CPAP mask was supposed to be stored in the plastic storage bag when not in use. On 06/20/24 1413 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the needs of the residents for two of five residents (Residents 7 and 23) reviewed for unnecessary medications and one nonsampled resident (Resident 339). In addition, the facility failed to ensure the process for opening the E-kit was followed and failed to ensure the controlled count were documented each shift. * The facility failed to ensure Resident 7's carvedilol, losartan, and furosemide (medication to treat high blood pressure) were administered and held as ordered. * The facility failed to ensure Resident 7 had an insulin coverage for blood sugar results between 351-401 mg/dl, and had a physician's order to notify the physician for blood sugar of less than 70 mg/dl. * The facility failed to ensure the parameter to administer Glucose Oral Gel 40% was clarified to address the need for intervention for signs of low blood sugar for Resident 23. * The facility failed to ensure Resident 23's insulin sliding scale order included the blood sugar results between 71-149 mg/dl * The facility failed to ensure Resident 23's order for lisinopril (medication to treat high blood pressure) was clarified regarding the parameters when to hold the medication. * The facility failed to ensure Resident 23's order for metoprolol (medication to treat high blood pressure) was administered as ordered by the physician. * The facility failed to ensure Resident 339's order for valsartan (medication to treat hypertension) was clarified for parameters when to hold the medication. * The facility failed to keep an accurate log of the PO E-kit when it was opened. * The facility failed to ensure the controlled count was signed for every shift. These failures had the potential to negatively affect the residents' health and well-being. Findings : Review of the facility's P&P titled Medication Administration-General Guides dated 11/2021 showed the medications are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so. The medications are administered in accordance with the written orders of the attending physician. 1.a. Medical record review for Resident 7 was initiated on 6/20/24. Resident 7 was admitted to the facility on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's Order Summary Report dated 6/19/24, showed the following orders dated: - 5/13/24, for carvedilol tablet 3.125 mg one tablet by mouth two times a day for hypertension and to hold if SBP less than 110 mmHg or HR less than 60 beats per minute. - 6/10/24, for furosemide 40 mg one tablet by mouth two times a day for HTN and to hold if SBP less than 90 mmHg or signs of dehydration -6/10/24, for losartan potassium 25 mg one tablet by mouth one time a day and to hold if SBP less than 90 mmHg or DBP less than 55 beats per minute. Review of Resident 7's MAR for June 2024 showed the following documentation: - carvedilol tablet 3.125 mg was documented as administered on 6/13/24 at 0900 hours, and Resident 7's SBP was 108 mmHg. - carvedilol tablet 3.125 mg was documented as administered on 6/20/24 at 0900 hours, and Resident 7's SBP was 100 mmHg. - fusosemide 40 mg was documented as held on 6/18/24 at 0900 hours, and Resident 7's SBP was 108 mmHg. - furosemide 40 mg was documented as held on 6/19/24 at 0900 hours, and Resident 7's SBP was 100 mmHg. - furosemide 40 mg was documented as held on 6/19/24 at 1700 hours, and Resident 7's SBP was 102 mmHg. - losartan potassium 25 mg was documented as held on 6/18/24 at 0900 hours, and Resident 7's SBP was 108 mmHg. - losartan potassium 25 mg was documented as held on 6/19/24 at 0900 hours, and Resident 7's SBP was 100 mmHg. On 6/21/24 at 1101 hours, an interview and concurrent medical record review was conducted with the ADON for Resident 7. The ADON verified the findings and stated the carvedilol medication should not have been administered at 0900 hours on 6/13 and 6/20/24; the losartan medication should have been administered at 0900 hours on 6/18 and 6/19/24; and the furosemide medication should have been administered on 6/18 and 6/19/24 at 0900 hours and 6/19/24 at 1700 hours, as ordered by the physician. b. Review of Resident 7's Order Summary Report dated 6/19/24, showed the following physician's orders: - dated 5/13/24, for Humalog Solution 100 unit/ml (Insulin Lispro Human (medication to lower blood sugar), inject per sliding scale: If BS 70-150 mg/dl = 0 units (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BS 151-200 mg/dl = 2 units BS 201-250 mg/dl = 4 units BS 251-300 mg/dl = 6 units BS 301-350 mg/dl = 8 units BS 351-400 mg/dl = ____ BS greater than 401 mg/dl, give 10 units then call MD, subcutaneously before meals for diabetes The insulin sliding scale order did not include coverage for BS levels from 351 to 401 mg/dl. In addition, there was no physician's order for any interventions in the event Resident 7's BS level below 70 mg/dl. On 6/21/24 at 1101 hours, an interview and concurrent medical record review was conducted with the ADON for Resident 7. The ADON verified the above findings. 2.a. Medical record review for Resident 23 was initiated on 6/20/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Order Summary Report dated 6/19/24, showed the following physician's orders dated: - 4/19/24, for Glucose Oral Gel 40% (Dextrose (Diabetic Use) 32 ml by mouth every 15 hours as need for low blood sugar mild to moderate give if BG 50-7 mg/dl with any of the following: shaking, sweating, anxiety, headache, visual changes, mood changes, drowsiness. The physician's order was not clear on the parameters on when to give. - 4/19/24, for Humalog Solution 100 unit/ml (Insulin Lispro (Human) Inject as per sliding scale as follows: If BS 150-200 mg/dl= 2 units BS 201-250 mg/dl= 4 units BS 251-300 mg/dl = 6 units BS 301-350 mg/dl= 8 units BS 351-400 mg/dl= 10 units If BS greater than 401 mg/dl, then call MD, subcutaneously before meals for diabetes Give glucose 40% if BS is less than 50-70 mg/dl (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 23's physician's order for insulin sliding scale coverage failed to show an order to address for blood sugar between 71-149 mg/dl. Review of Resident 23's June 2024 MAR showed multiple occasions the resident's blood sugar results were in the ranges of 71-149 mg/dl. The blood sugar levels documented in the June 2024 MAR were coded at 4 which was identified in the Chart Codes of the MAR as BS was outside of the ordered parameters. However, the physician's orders did not show the parameters for the blood sugar levels of 71-149 mg/dl. On 6/21/24 at 1502 hours, an interview and concurrent medical record review was conducted with the ADON for Resident 23. The ADON verified the findings and stated the order for the Glucose 40% needed to be clarified to have the parameter for blood sugar levels between 50-70 mg/dl, not 50-7 mg/dl. Furthermore, the ADON verified the sliding scale coverage should have included an order for zero insulin coverage for blood sugar levels of 71-149 mg/dl. b. Review of Resident 23's Order Summary Report dated 6/19/24 showed the physician's orders dated: - 4/19/24, for lisinopril (medication to treat high blood pressure) oral tablet 20 mg one tablet by mouth in the morning for HTN and to hold if SBG less than 110 mmHg or HR less than 60 beats per minute. On 6/21/24 at 1502 hours, an interview and concurrent medical record review was conducted with the ADON for Resident 23. The ADON was asked what the SBG meant for the parameters to hold for the lisinopril. The DON stated the SBG meant Sugar Blood Glucose, and the parameter was supposed to be SBP for systolic blood pressure. c. Review of Resident 23's MAR for May 2024 showed an order dated 4/19/24, for metoprolol tartrate 25 mg one tablet by mouth two times a day for HTN, to hold for SBP less than 100 mmHg or HR less than 50 beats per minute. However, on the the following dates, Resident 23's blood pressure and pulse readings were recorded as follows: - 5/8/24 at 1700 hours, BP 109/65 mmHg and pulse 67 beats per minute, coded as 5. - 5/9/24 at 0900 hours, BP 102/68 mmHg and pulse 74 beats per minute, coded as 4. - 5/9/24 at 1700 hours, BP 106/68 mmHg and pulse 70 beats per minute, coded as 5. - 5/10/24 at 1700 hours, BP 108/68 mmHg and pulse 68 beats per minute, coded as 5. - 5/11/24 at 1700 hours, BP 108/65 mmHg and pulse 70 beats per minute, coded as 5. - 5/12/24 at 1700 hours, BP 106/68 mmHg and pulse 65 beats per minute, coded as 4. - 5/14/24 at 0900 hours, BP 103/76 mmHg and pulse 65 beats per minute, coded as 4 - 5/14/24 at 1700 hours, BP 108/71 mmHg and pulse 68 beats per minute, coded as 5. Review of the MAR Chart Codes showed the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4 = TPR/BP/BS outside order parameters 5 = Hold/See Progress Notes On 6/21/24 at 1502 hours, an interview and concurrent medical record review for Resident 23 was conducted with the ADON. The ADON verified for the above blood pressures and pulses for Resident 23, the medications were held when the blood pressures and pulses were within the parameters to administer the medication, and the medication should have been given to Resident 23 as ordered by the physician. 3. Medical record review for Resident 339 was initiated on 6/19/24. Resident 339 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 339's Order Summary Report dated 6/19/24, showed a physician's order dated: - 6/19/24, for valsartan (medication to treat high blood pressure) oral tablet 80 mg give 1.5 tablet by mouth in the morning for hypertension, to hold if BP less than 110 mmHg or HR less than 60 beats per minute. The physician's order for the valsartan did not show if the parameter to hold the medication was for the SBP or DBP. On 6/19/24 at 1223 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 verified the order for Valsartan needed to specify to hold the medication if SBP less than 110 mmHg. 4. Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy dated 2/2020 showed when an emergency or stat dose of a medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication, complete the emergency 3-kit slip and re-seal the emergency supply. An entry is made in the emergency log book containing all required information. Review of the facility's Emergency Kit Pharmacy Log sheet showed the following instructions: 1. Submit orders to the pharmacy. 2. Contact pharmacy to obtain authorization from the pharmacist before removing item from the E-kit. 3. Enter information completely on E-kit log. 4. Place the white copy in E-kit binder and return yellow copy with the E-kit to the pharmacy. 5. Reseal E-kit. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 1445 hours, a medication room inspection for Medication Room A was conducted with RN 3. During the inspection, a PO E-kit labeled #201 was observed with two red ziplock ties. RN 3 stated the two red ziplock ties meant the E-kit was opened. When asked for the E-kit log, RN 3 stated she was not sure about the facility's system of keeping the logs. On 6/18/24 at 1547 hours, an interview was conducted with the ADON. When asked for the facility's process about opening the E-kit, the ADON stated when the E-kit was opened, the green ziplock ties were cut, then the nurses filled out the paper inside the E-kit to include the resident's name, date, and the dose taken out from the E-kit. When asked if the facility kept a log, the ADON stated no. The pharmacy E-kit was later found with the last entry dated 2/24/24 at 2123 hours, when Oxycodone (medication to treat pain) 5 mg was taken out of the E-kit. On 6/18/24 at 1558 hours, the ADON opened the PO E-kit to find out when the E-kit was last opened. The E-kit log showed the PO E-kit was opened on 6/18/24 at 0900 hours. One tab of Cipro (an antibiotic to treat infection) 250 mg was taken out of the E-kit for Resident 34. The E-kit log also did not show the signature of the licensed nurse who removed the medication from the E-kit. The E-kit log instructions showed to place the white copy in the E-kit binder and return the yellow copy with E-kit to the pharmacy then reseal E-kit. During the interview with the ADON, RN 3 was also present. RN 3 verified the white sheet and the yellow sheet of the E-kit log were still attached together, and stated the white sheet should have been placed in the E-kit binder. 5.a. Review of the facility's P&P titled Controlled Substance Storage dated 8/2019, showed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including the emergency supply, is conducted by two licensed nurses and is documented. On 6/20/24 at 1315 hours, a medication cart inspection of Medication Cart A was conducted with LVN 14. During the medication cart inspection, the binder for narcotic count was checked. During the review of the Controlled Count Verification form, the following dates were observed with missing licensed nurses' signatures: - 5/27/24, oncoming and offgoing for the day shift - 5/30/24, offgoing for the day shift - 6/1/24, offgoing for the NOC shift - 6/3/24, oncoming and offgoing for the day shift - 6/8/24, offgoing for the day shift - 6/8/24, offgoing for the PM shift - 6/11/24, offgoing for the NOC shift and oncoming for the NOC shift - 6/17/24, offgoing for the NOC shift and oncoming for the NOC shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 6/18/24, offgoing for the day shift - 6/20/24, oncoming for the day shift When LVN 14 was asked what the Controlled Count Verification was for, LVN 14 stated the form was for taking over the medication cart and signing for narcotics after the count. LVN verified the findings and stated the narcotic sheet should have been signed after counting with the offgoing nurse. b. On 6/20/24 at 1414 hours, a medication cart inspection of Medication Cart B was conducted with LVN 8. During the medication cart inspection, the binder for narcotic count was checked. During the review of the Controlled Count Verification form, the following dates were observed with missing licensed nurses' signatures: - 6/2/24, offgoing for the NOC shift - 6/5/24, oncoming for the NOC shift LVN 8 verified the findings.

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F 0757

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident's drug regimen must be free from unnecessary drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39453

Based on interview and medical record review, the facility failed to ensure four of five final sampled residents (Residents 7, 17, 78, and 540) reviewed for unnecessary drugs were free from unnecessary drugs.

* The facility failed to ensure Resident 540's heart rate was checked prior to administering the amiodarone (a medication that works directly on the heart tissue and slows the nerve impulses in the heart) and carvedilol (a medication that works by affecting the nerve impulses in the body such as the heart, and slows the heart beat and decreases blood pressure) medications nor the resident's blood glucose checked prior to administering insulin glargine (a long-acting insulin) as per the physician's orders.

* The facility failed to ensure Resident 7's order for losartan (medication to treat high blood pressure) and ProStat had diagnoses for the medications ordered by the physician.

* The facility failed to ensure Resident 17's heart rate was checked prior to administering metoprolol succinate (a beta-blocker, a medication a medication that works by affecting the nerve impulses in the body such as the heart, and slows the heartbeat and decreases blood pressure) as per the physician's orders.

* The facility failed to ensure Resident 78's blood glucose was checked before meals as per the physician's orders.

These failures had the potential for the residents to receive unnecessary medications and develop significant side effects.

Findings:

1. Medical record review for Resident 540 was initiated on 6/18/24. Resident 540 was admitted to the facility on [DATE].

Review of Resident 540's Order Summary Report showed the following physician's orders:

- On 4/11/24, to inject 15 units of insulin glargine subcutaneously at bedtime. Hold for blood glucose less than 100 mg/dl;

- On 3/15/24, to administer carvedilol 3.125 mg one tablet by mouth two times a day. Hold if SBP less than 110 mmHg or heart rate less than 60 beats per minute; and

- On 6/1/24, to administer amiodarone 200 mg one tablet by mouth two times a day. Hold for heart rate less than 60 beats per minute.

Review of Resident 540's MAR for June 2024 showed Resident 540 was administered the following:

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The amiodarone medication was administered on 6/1 to 6/20/24 at 0900 and 1700 hours, and 6/21/24 at 0900 hours. The MAR did not show the heart rate was checked prior to administering the amiodarone medication. - The carvedilol medication was administered on 6/1 to 6/20/24 at 0900 and 1700 hours, and 6/21/24 at 0900 hours. The MAR showed only the blood pressure was checked but did not show the heart rate was checked prior to administering the carvedilol medication. -Insulin glargine medication was administered on 6/1 to 6/21/24 at 2100 hours. The MAR did not show the blood glucose was checked prior to administering the insulin glargine medication. Further review of Resident 540's medical record did not show the resident's heart rate was checked prior to administering the amiodarone and carvedilol medications nor the resident's blood glucose checked prior to administering the insulin glargine, per the physician's orders. On 6/21/24 at 1023 hours, an interview and concurrent medical record review for Resident 540 was conducted with the ADON. The ADON verified there was no documentation to show Resident 540's heart rate was checked prior to administering the amiodarone and carvedilol medications nor the resident's blood glucose checked prior to administering the insulin glargine as per the physician's orders. 50953 2. Medical record review for Resident 7 was initiated on 6/20/24. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report dated 6/19/24, showed the physician's orders dated: - 6/10/24, for losartan potassium 25 mg one tablet by mouth one time a day for HTN and to hold if SBP less than 90 mmHg or DBP less than 55 mmHg. - 5/20/24, for Pro-Stat (protein supplement) Oral Liquid (Amino Acids-Protein Hydrolysate) 30 ml by mouth three times a day. Howerver, these physician's orders did not include the diagnosis for the use of these medications. On 6/21/24 at 1101 hours, an interview and concurrent medical record review for Resident 7 was conducted with the ADON. The ADON verified Resident 7's physician's orders for the use of Losartan Potassium and Pro-Stat did not have diagnoses and should have had diagnoses for the medications ordered. 50967 3. Medical record review for Resident 17 was initiated on 6/21/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report showed a physician's order dated 5/18/24, to administer metoprolol succinate ER tablet 24 hours 25 mg one tablet by mouth in the morning for HTN and to hold if SBP less than 110 mmHg or HR less than 60 beats per minute. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 17's MAR for May and June 2024 showed Resident 17 was administered the following medications: - metoprolol succinate was administered on 5/19 to 5/31/24 at 0900 hours, and 6/1 to 6/21/24 at 0900 hours. The MAR did not show the heart rate was checked prior to administering the metoprolol succinate medication. On 06/21/24 1648 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Review of the facility's P&P titled Blood Sugar Monitoring dated 2006, showed to check physician's order for blood sugar testing frequency. Documentation may include: date, time, and blood glucose level. Medical record review for Resident 78 was initiated on 6/21/24. Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's H&P examination on 6/21/24, showed diagnosis of diabetes mellitus (elevated blood sugar as a result from the pancreas does not make enough insulin or any at all, or when the body is not responding to the effects of insulin properly). Review of Resident 78's MAR for May and June 2024 failed to show documentation the blood glucose was checked on the following dates 5/2, 5/8-5/11, 5/15, and 5/20-5/21/24 at 1600 hours; and 6/1, 6/3, 6/7-6/9, 6/14, and 6/15/24, at 1630 hours. On 06/21/24 at 1652 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 7 and 540) reviewed for unnecessary drugs were free from unnecessary psychotropic drugs (any drug that affects brain activity associated with mental processes and behavior). * The facility failed to ensure the physician's order for lorazepam (antianxiety medication) 0.5 mg as needed for Resident 540 was limited to a 14-day duration. In addition, the facility failed to show documentation by the attending physician or prescribing practitioner for the rationale for the extended time in the medical record. Furthermore, the facility failed to develop a care plan to address the lorazepam use. * The facility failed to ensure Resident 7's behavior was monitored for the use of duloxetine (medication to treat depression) These failures had the potential for the Residents 7 and 540 to develop significant side effects from the psychotropic drugs. Findings: Review of the facility's P&P titled Psychotropic Medication Management dated 12/2017 showed the following: - Clinically necessary PRN psychotropic drug orders are limited to 14 days. If the prescribing practitioner determines a need for continued PRN use beyond the original 14 days, it is accompanied by supporting documentation in the electronic health record including the rationale for continued use and duration. 1. Medical record review for Resident 540 was initiated on 6/18/24. Resident 540 was admitted to the facility on [DATE]. Review of Resident 540's Order Summary Report showed a physician's order dated 5/24/24, to administer lorazepam 0.5 mg one tablet by mouth every six hours as needed for anxiety manifested by inability to relax for 30 days. Review of Resident 540's MAR for May and June 2024 showed Resident 540 was administered the lorazepam medication on 5/24/24 at 1759 hours, and 6/7/24 at 1943 hours. Review of Resident 540's plan of care did not show a care plan problem was developed to address the lorazepam use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 540's medical record did not show documentation by the attending physician or prescribing practitioner for the rationale for the extended time related to the use of lorazepam medication for Resident 540. On 6/20/24 at 1356 hours, an interview and concurrent medical record review for Resident 540 was conducted with the ADON. The ADON verified the above findings. The ADON stated Resident 540 might have been admitted from the hospital with the lorazepam medication order, and the licensed nurse only followed what was ordered from the hospital. The ADON verified the lorazepam medication order was beyond the 14-day duration, and the attending physician or prescribing practitioner did not document the rationale for the extended time related to the use of lorazepam medication for Resident 540. The ADON also verified there was no care plan developed to address the lorazepam use. 29461 2. Review of the facility's P&P titled Psychotropic Medication Management dated 12/2017 showed observed or reported behaviors, effectiveness of non-drug approaches, and monitoring of medication side effects are to be documented in the EHR. Medical record review for Resident 7 was initiated on 6/20/24. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report dated 6/19/24, showed a physician's order dated 5/14/24, for duloxetine HCL Capsule Delayed Release Particles 30 mg give one capsule by mouth two times a day for depression m/b verbalization feeling sadness. Further review of Resident 7's Order Summary Report failed to show a physician's order to monitor Resident 7 for depression m/b verbalization of feeling sadness. Review of Resident 7's MAR failed to show the resident was being monitored for depression m/b verbalization of feeling sadness. On 6/21/24 at 1436 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 1. When asked for the facility's process when a resident was prescribed psychotropic medication, RN 1 stated an informed consent was obtained as ordered by the physician, discussed with the family, side effects were monitored, effectiveness of the medications was monitored, and the behavior was monitored. RN 1 stated the behavior monitoring should have been in the supplementation order, under the antidepressant behavior monitoring. RN 1 verified there was no order to monitor Resident 7 for depression m/b verbalization of feeling sadness.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. * The facility's medication error rate was 10.34%. One of three licensed nurses (LVN 7) was found to have made errors during the medication administration observation for two nonsampled residents (Residents 66 and 339). This failure had the potential to negatively impact the resident's heal outcomes. Findings: Review of the facility's P&P titled Medication Administration-General Guidelines dated 11/2021 showed the medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The medications are administered in accordance with written orders of the attending physician. 1. On 6/19/24 0836 hours, a medication administration observation for Resident 66 was conducted with LVN 7. LVN 7 prepared the following medications for Resident 66: - carvedilol (medication to treat high blood pressure) 3.125 mg one tablet. The medication bubble pack showed the directions to hold the medication if SBP less than 110 mmHg or HR less than 60 beats per minute. LVN 7 was observed checking Resident 66's blood pressure prior; however, LVN 7 was observed not checking Resident 66's HR. On 6/19/24 at 0842 hours, LVN 7 proceeded to crush the carvedilol medication and mixed it with water in preparation for medication administration. LVN 7 stated she was ready to administer the medication to Resident 66. LVN 7 was asked to stop from administering the carvedilol medication to Resident 66 because the resident's HR was not checked and there was a parameter to hold if the HR was less than 60 beats per minute. LVN 7 stated she did not see the parameter ordered; however, LVN verified there was an order for a parameter to hold if HR less than 60 beats per minute. On 6/19/24 at 0849 hours, LVN 7 went inside Resident 66's room to check the resident's HR which was 67 beats per minutes. LVN 7 administered the carvedilol medication via GT. Medical record review for Resident 66 was initiated on 6/19/24. Resident 66 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 66's Order Summary Report showed the following physician's order dated 4/15/24: - carvedilol 3.125 mg one tablet via GT two times a day for hypertension. Hold if SBP <110 mmHg or HR<60 beats per minute. - Multi-Day Tablet (supplement) one tablet via GT in the morning for supplement. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 1223 hours, an interview was conducted with LVN 7. LVN 7 verified there was no multivitamin on hand, no medication available from Central Supply, and the medication was not administered to Resident 66 as ordered. 2 . On 06/19/24 at 0921 hours, a medication administration observation for Resident 339 was conducted with LVN 7. LVN 7 prepared and administered the following medications: - aripiprazole (antipsychotic medication to treat symptoms of mental illness) one tablet - dexamethasone (medication to treat inflammation) 2 mg two tablets - finasteride (medication to treat enlarge prostate) 5 mg one tablet - hydralazine HCL (medication to treat high blood pressure) 25 mg one tablet and to hold if SBP less than 110 mmHg or HR less than 60 beats per minute - Keppra (medication to treat seizures) 500 mg one tablet - memantine HCL (medication to treat moderate to severe dementia) one tablet - valsartan (medication to treat high blood pressure) 80 mg 1.5 tablet and to hold if BP less than 110 mmHg or HR less than 60 beats per minute Medical record review for Resident 339 was initiated on 6/19/24. Resident 339 was admitted to the facility on [DATE]. Review of Resident 339's Order Summary Report showed a physician's order dated 6/19/24, for Lactulose (medication to treat constipation) Oral Solution 10 gm/15 ml give 15 ml orally in the morning for bowel management. The Lactulose was not administered to Resident 339 during the medication administration observation. On 6/19/24 at 1222 hours, an interview was conducted with LVN 7. LVN 7 verified the Lactulose medication was not administered as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage. * The facility failed to properly label an opened tuberculin solution with the open date to include the year it was opened. * The facility failed to remove the expired dextrose (a sterile solution used to provide the body with extra water and carbohydrates) injection solution. * The facility failed to remove the expired Heparain (blood thinner to prevent clots) lock flush solution. * The facility failed to store Gamunex-C (medication used to strengthen the body's natural defense system to lower the risk of infection in persons with a weakened immune system) 10% vials as per storage instructions. * The facility failed to ensure the refrigerator containing medications was kept in sanitary condition. * The facility failed to ensure an unused/unopened insulin Gargine (medication to treat diabetes) pen was stored inside a refrigerator. * The facility failed to to dispose the unused and sealed Heparin vials in the designated disposal bins. * The facility failed to ensure the oral meds were stored separately from IV dextrose solution. *The facility failed to ensure the sealed Lispro (medication to treat diabetes) insulin pen was stored inside a refrigerator. *The facility failed to ensure the medication bottles were kept clean and free of sticky residue. *The facility failed to ensure medication for a discharged resident was removed from the treatment cart. *The facility failed to ensure the treatment supplies were kept in a sanitary condition. *The facility failed to ensure an expired alcohol wipe was not kept inside the medication cart. *The facility failed to ensure the documentation on the blood glucose control log, of the serial number of the blood glucose machine, matched the serial number on the glucose machine. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The facility failed to ensure the treatment medication was not left unattended on the resident's bedside table left in the hallway for Resident 30. These failures had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Storage of Medications dated ,d+[DATE] showed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. Medication requiring storage at room temperature are kept at temperature ranging from 15 degree C (59 degrees F) to 30 degrees C(86 degrees F). Intravenously administered medications are keep separately from orally administered medication. Review of the facility's P&P titled Disposal of Medications and Medication-Related Supplies dated ,d+[DATE] showed unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed. Review of the facility's P&P titled Appendix 3: Requirements for Specific Medications and Reagents, undated, showed the PPD Manitoux expires 30 days after opening. Review of the facility's P&P titled Storage of Medications dated ,d+[DATE] showed Orally administered medications are kept separate from externally used medications, such as suppositories, liquids and lotions. 1.a. On [DATE] at 1445 hours, a medication room inspection for Medication Room A was conducted with RN 1. During the inspection, the following was observed: - One bottle of Tuberculin (a purified protein derivative-used to perform skin test to screen for tuberculosis) with an open date of ,d+[DATE]. No documentation of year it was opened. - three bags of 5% Dextrose Injection USP 1000 ml, unsealed, with expiration date of [DATE]. - one bag of 0.9% Sodium Chloride USP 1000 ml, unsealed, with an expiration date of [DATE]. - two bags of 20 mEq Potassium Chloride 1000 ml, sealed with an expiration date of ,d+[DATE]. - one bag of 10% Dextrose Injection 1000 ml, sealed, with an expiration date of ,d+[DATE] - three bags of Sodium Chloride Injection 0.9% 1000 ml with fill date of [DATE], ordered for 5 days only for Resident 130. - Gamunex-C 10% 60 gram dose vials with an expiration date of [DATE]. Storage instruction : Room temperature, cool and dry place. However, the medication was stored inside the refrigerator. - Five Heparin lock flush solution 5 ml vials with an expiration date of [DATE]. - Unopened box of Insulin Glargine pen (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The medication refrigerator was observed with white residue on the inside of the refrigerator door and the base of the drawer inside the refrigerator. RN 1 verified all the findings. On [DATE] at 1615 hours, RN 3 showed an unused Insulin Glargine pen for Resident 41. RN 3 stated the medication was pulled from Medication Cart B. RN 3 verified the insulin pen was unused, no open date, and should have been stored in the refrigerator until ready to be used. b. On [DATE] at 1616 hours, an inspection of Medication Cart C was conducted with RN 4. During the medication cart inspection, the following were observed: - 12 hour mucus relief expectorant Extended Release tablets stored in the same drawer with accucheck machine, sodium chloride injection 1000 ml with an expiration date of ,d+[DATE], two house supply of glucagon 1 mg e-kits with expiration dates of ,d+[DATE] and ,d+[DATE]. - The sharps container on the right side of Medication Cart C was observed with Heparin solution vials, some were sealed. RN 4 verified all the findings. When asked where the unused Heparin vials should be disposed, RN 4 did not give a response other than, I don't use Heparin. On [DATE] at 0900 hours, an interview was conducted with the ADON regarding the drug disposal. The ADON stated the medications were disposed of inside the white and blue incinerator bin inside the medication room, and when full, the bin was placed inside the locked biohazard room and someone from outside company will pick up the bin. c. On [DATE] at 1315 hours, an inspection of Medication Cart A was conducted with LVN 14. During the medication cart inspection, the following was observed: - The bottom drawer of the medication cart was observed with one sticky bottle of Pro-Stat concentrated liquid protein medical food, wild cherry punch; and one sticky bottle of iron supplement liquid - A bottle of Eye Drops Original with an expiration date of ,d+[DATE], without a resident's name and no open date. - Two boxes of Diclofenac Sodium (medication to treat pain and other symptoms of arthritis of the joints such as inflammation, swelling, stiffness, and joint pain) Topical Gel 1% were stored in the bottom drawer of the medication cart, next to the PO liquid and tablet medications. - Lispro insulin Pen for Resident 31 with no open date was observed in the top drawer of the medication cart LVN 14 verified all the findings. d. On [DATE] at 1409 hours, a Treatment Cart inspection for Treatment Cart A was conducted with LVN 3. During the treatment cart inspection, the following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A tube of Nystatin Cream (medication to treat yeast or fungal infection in the skin) was observed. Per LVN 3, the medication was for a resident who was no longer in the facility and should have been removed from the treatment cart - Combine Abdominal Pad, 8 x 10, observed and felt with yellow sticky residue. LVN 3 verified the findings. e. On [DATE] at 1414 hours, an inspection of Medication Cart B was conducted with LVN 8. During the medication cart inspection, the following was observed: - One container of Good Earth Based Alcohol wipes with expiration date of [DATE], was inside the medication cart. - The Blood Glucose Monitor Quality Control Log had inaccurate documentation of the Assure Platinum Blood Glucose Meter Serial # from ,d+[DATE]-[DATE]. The form showed documentation of Meter Serial # , d+[DATE]; however, the Assure Platinum Blood Glucose Machine being used had a Meter Serial #,d+[DATE]. LVN 8 verified the findings. LVN 8 further stated there was no other glucometer inside Medication Cart B. 39453 2. Medical record review for Resident 30 was initiated on [DATE]. Resident 30 was readmitted to the facility on [DATE]. Review of Resident 30's Order Summary Report showed the following physician's orders dated [DATE]: - To apply collagenase powder (a topical medication used for removing damaged or burned skin to allow for wound healing) to sacrum topically every day for pressure injury (injuries to the skin and tissue below the skin that are due to pressure on the skin for a long period of time) for 30 days; - To apply Dakin's external solution 0.25% (a dilute solution of sodium hypochlorite used to treat or prevent infection) to sacrum topically, soaked for 10 minutes and rinse with normal saline every day for pressure injury for 30 days; - To apply Silvadene external cream (a topical antibiotic medication used to treat of prevent infection) 1% to sacrum topically, then apply calcium alginate dressing (a highly absorbent dressing made of calcium-alginate, ideally used for superficial and cavity wounds) and seal with bordered gauze every day for pressure injury for 30 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0901 hours, a wound care observation for Resident 30 was conducted with LVN 3. LVN 3 was observed preparing the wound treatment medications and supplies. LVN 3 was observed placing the Silvadene cream in a medication cup, collagen powder, Dakin's solution, calcium alginate dressing, saline wash, silicone foam bordered dressing, gauze sponges and gloves on an overbed table. LVN 3 was observed placing the table with medications by Resident 30's door, in the hallway. LVN 3 was then observed walking away and leaving the table with medications unattended. Two CNAs were observed standing by Resident 30's door, and one maintenance staff was observed across the hallway. Residents were also observed passing by the hallway. LVN 3 was observed taking a towel from the linen closet. A medication cart was also observed parked near the linen closet, blocking LVN 3's view of the table with medications. LVN 3 came back and covered the medications with a towel. On [DATE] at 1020 hours, an interview and concurrent medical record review for Resident 30 was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 verified she left the wound treatment medications on the table unattended when she walked away to get a towel in the linen closet.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Edna Subacute and Rehabilitation Center	1929 N. Fairview Street Santa Ana, CA 92706

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 39856 Based on observation, interview, and facility document review, the facility failed to ensure the Certified Dietary Manager (CDM) who was responsible to oversee the food services department was competent in managing the day-to-day functions of the food services department. Failure to employ staff with the skills and abilities to effectively implement departmental processes in accordance with standards of practice, may jeopardize the health and well-being of the 122 residents who received food prepared in the kitchen. Findings: Review of the facility's matrix showed 122 residents who consumed food prepared in the kitchen. Review of the facility's document titled Director of Food Services signed and dated by the CDM on 4/18/11, showed the primary purpose of the Director of Food Services was to assist the RD in planning, organizing, developing and directing the overall operation of the Food Services Department in accordance with current federal, state and local standards, guidelines and regulations governing our facility, and as may be directed by the Administrator, to assure that quality nutritional services are provided on a daily basis and that the Food Service Department is maintained in a clean, safe and sanitary manner. During the annual recertification survey from 6/18/24 to 6/21/24, multiple issues were found in the main kitchen, including: missing documentation of cooling for TCS (time/temperature control for safety foods), food preparation surfaces were not sanitized properly, lack of a thawing process for meats, lack of adequate hand washing, food preparation equipment was not clean and in good working condition, lack of adequate hair covering by multiple food service workers, kitchen equipment was not clean, the kitchen environment was not clean, the kitchen floor was not in a cleanable condition, the ice machine and food preparation sink did not have an air gap, the Vietnamese menus did not have puree recipes, a nutritional analysis, were not updated periodically and did not reflect the standard of practice for IDDSI, the American menu puree recipes were not followed for puree ham, puree green peas and puree sweet potatoes, nutritive content of pureed foods was not preserved, meal substitutes were not equivalent in nutritive value, essential kitchen equipment was not maintained in safe operationing condition, three kitchen employees were not competent in their daily job duties and the kitchen was not free of pests. Cross references to F812; F803 examples #1, #2, #3, #4, #5; F804; F806; F908; F802; and F925. On 6/20/24 at 1044 hours, an interview was conducted with the Administrator. The Administrator was asked how he ensured his managers were competent in their job functions. The Administrator stated he had worked for the facility for only three months. The Administrator stated the RD did a monthly audit of the kitchen, employees get annual evaluations, and they meet in the QAPI (quality assessment and performance improvement), a data driven and proactive approach to improving the quality of care and services.

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 39856 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the kitchen staff were competent in the position related duties when: 1. Three of 11 kitchen staff (Cooks 1, 2 and DA 1) failed to follow proper hand hygiene. 2. Two of 11 kitchen staff (Cooks 1 and 2) failed to monitor and be competent in knowledge of the cool down procedure for TCS (time/temperature control for safety) foods. 3. One of 11 kitchen staff (Cook 2) failed to sanitize food preparation surfaces. 4. One of 11 kitchen employees (DA 1) failed to perform the following : a. DA 1 did not know the correct temperature of the rinse cycle of the dish machine, b. Demonstrate how to test the sanitizing solution of the dish machine according to the manufacturer guidelines, and c. Demonstrate how to test the sanitizing solution of the manual ware washing sink according to the manufacturer guidelines. These failures had the potential for unsafe food handling practices which could lead to food borne illness in the 122 vulnerable residents who received food prepared in the kitchen. Findings: Review of the facility's matrix showed 122 residents who consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Hand washing techniques effective 2/2009 showed hand washing is to be done after removal of medical, surgical or utility gloves, and after scraping or racking dishes on the soiled end of the dish machine. a. Review of the facility's job description titled Dietary Aide signed by [NAME] 1 on 4/18/11, showed Safety and Sanitation: Follow established Infection Control and Universal Precautions policies and procedures when performing daily tasks. Review of the facility's document titled Inservice Lesson Plan and Attendance Record Hand washing dated 4/18/23 and 11/14/23, showed [NAME] 1 was in attendance on 11/14/23. On 6/19/24 at 1051 hours, during the puree food preparation, after she touched multiple surfaces with ungloved hands, [NAME] 1 donned a pair of gloves without washing her hands on two separate occasions. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24 at 1159 hours, an observation of the lunch meal tray line was conducted with [NAME] 1. [NAME] 1 was cooking ham with gloved hands. [NAME] 1 removed her gloves and donned a new pair of gloves but did not wash her hands. b. Review of the facility's job description titled [NAME] signed by [NAME] 2 on 4/23/24, showed the essential job duties included comply with all food safety sanitation and infection control procedures. The CDM was not able to provide an in-service education training regarding hand washing after 11/14/23. On 6/18/24 at 1043 hours, [NAME] 2 touched the trash can to discard her used gloves, then donned new gloves without washing her hands. On 6/18/24 at 1052 hours, an interview was conducted with [NAME] 2. [NAME] 2 stated her hands were not dirty, so she did not wash her hands. [NAME] 2 stated she changed her gloves only. On 6/19/24 at 1125 hours, an observation of the puree preparation of the Vietnamese foods was conducted with [NAME] 2. After the Vietnamese foods had been pureed, [NAME] 2 removed her gloves and donned a new pair of gloves without washing her hands. c. Review of the employee's file for DA 1 showed no job description. Review of the facility's document titled General Orientation showed DA 1 was hired on 1/8/24. The CDM was not able to provide an in-service education training regarding hand washing after 11/14/23. On 6/18/24 at 1450 hours, DA 1 was observed to load soiled dishes into the dish machine with gloved hands. DA 1 removed his gloves, put his hands in the sanitizing solution in the red bucket then removed clean dishes from the dish machine. DA 1 then donned a new pair of gloves and continued loading soiled dishes into the dish machine. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed the employees must wash their hands between the glove changes. Cross reference to F812, example #4. 2. According to the USDA Food Code 2022, Section 3-501.14 (A) Cooked time/temperature control for safety food shall be cooled: (1)Within 2 hours from 135 Fahrenheit (F) to 70 F and (2) Within a total of six hours from 135 F to 41 F or less. According to the USDA Food Code 2022 Section 3-501.14 Cooling (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as canned tuna. Review of the facility's document titled Cooling Log undated showed the internal temperature of the food must be reduced from 140 degrees to 70 degrees in two hours and cooled from 70 degrees to 41 degrees in four hours. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of the facility's job description titled Dietary Aide signed by [NAME] 1 on 4/18/11, showed to prepare the food, etc., in accordance with sanitary regulations as well as with our established policies and procedures. The CDM was not able to provide documentation of an in-service education training on the cool down process for TCS foods was provided for the kitchen employees in the past year. On 6/18/24 at 0809 hours, during the initial kitchen tour, a large bowl covered with foil labeled Tuna salad dated 6/17/24, was observed in the walk-in refrigerator. On 6/20/24 at 1016 hours, using the Maintenance Director as a translator, an interview was conducted with [NAME] 1. [NAME] 1 stated the cooling log was used for the cold mixed salads such as tuna, egg salad or chicken salad. [NAME] 1 provided the cooling log, but the tuna salad dated 6/17/24 was not listed on the cooling log. [NAME] 1 was asked to describe the cool down process used to cool TCS foods. [NAME] 1 stated when the food was finished cooking, the temperature was taken every two hours. When asked what the food temperature should be in two hours, [NAME] 1 stated 41 degrees. [NAME] 1 was asked if she could read English. [NAME] 1 stated she could read English. [NAME] 1 was asked to refer to the cool down log and was asked again what the food temperature should be in two hours. [NAME] 1 stated 40-41 degrees. b. Review of the facility's job description titled [NAME] signed by [NAME] 2 on 4/23/24, showed the essential job duties included comply with all food safety sanitation and infection control procedures. The CDM was not able to provide documentation of an in-service education training on the cool down process for TCS foods was provided for the kitchen employees for the past year. During the initial tour of the kitchen on 6/18/24 at 809 hours with the Registered Dietitian (RD), a container of partially cooked chicken was observed in the walk-in refrigerator dated 6/18/24. The temperature of the partially cooked chicken was 91.4 degrees Fahrenheit (F). On 6/18/24 at 1014 hours, the temperature of the partially cooked chicken in the walk-in refrigerator was observed to be 75 degrees F. On 6/18/24 at 1104 hours, an interview was conducted with [NAME] 2. When asked about the chicken, [NAME] 2 stated she prepared the chicken around 0800 hours for the lunch meal. She cooked the chicken in boiling water for a few minutes, then marinated the chicken in the refrigerator. [NAME] 2 did not monitor the time or temperature of the chicken. On 6/18/24 at 1111 hours, an interview was conducted with the RD and CDM. The RD and CDM confirmed the time and temperature of the food heated then refrigerated prior to food service was not monitored. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed TCS foods cooked and cooled should be monitored for time and temperature on the cooling log. The RD also stated she did not check the cooling log for TCS foods during her monthly kitchen audit. Cross reference to F812 example #1. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. According to the USDA Food Code 2022, Section 3-304.14 (B) (1), cloths in-use for wiping counters and other equipment surfaces shall be held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114 and laundered daily as specified under 4-802.11. Review of the facility's P&P titled Safe Food Handling-Policy No 604 dated 2/2009 showed the cloths used for wiping food spills on food contact surfaces will be stored in a sanitizing solution between uses during the day. Review of the facility's job description titled [NAME] signed by [NAME] 2 on 4/23/24, showed the essential job duties included to comply with all the food safety sanitation and infection control procedures. The CDM was not able to provide documentation of an in-service education training on sanitizing of food preparation surfaces was provided for the kitchen employees for the past year. On 6/18/24 at 1043 hours, during a kitchen observation, [NAME] 2 used a paper towel to wipe the food preparation counter and Robot Coupe (a device used to puree food). On 6/18/24 at 1052 hours, an interview was conducted with [NAME] 2. [NAME] 2 stated she used the paper towel to wipe the counter because it was wet. She usually used the cleaning cloth stored in the sanitizing solution to wipe the food preparation counter. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed a paper towel should not be used in place of a cleaning cloth stored in the sanitizing solution to clean the food preparation counters. The RD stated the cleaning cloths should be stored in the sanitizing solution between uses. Cross reference to F812, example #2. 4.a. Review of the facility's P&P titled dish machine usage dated 2/2009 showed in part, Check the temperature of the wash and rinse cycles, verifying that both meet the temperature posted on the dish machine. Review of the dish machine operational requirements located on the dish machine showed minimum wash temperature 120 degrees Fahrenheit (F) and minimum rinse temperature 120 degrees F. Review of the facility's document titled Dish machine temperature and Sanitizing Agent Log for the month of June, showed on 6/18/24 for lunch time the dish washing, the wash temperature was 120 degrees F and the rinse was 130 degrees F. Review of the facility's job description titled Dietary Aide signed by [NAME] 1 on 4/18/11, showed to prepare food, etc., in accordance with sanitary regulations as well as with our established policies and procedures. Review of the facility's document titled Inservice Lesson Plan and Attendance Record titled Dishwasher Machine Proper Temperature dated 6/19/24, showed a video was given by the Maintenance Director. DA 1 was not in attendance. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 1448 hours, an observation of the dish machine and concurrent interview was conducted with DA 1 using the CDM as a translator. The dish machine temperature dial showed the wash temperature of the dish machine was 100 degrees F and the rinse temperature was 108 degrees F. DA 1 was asked to read the dish machine temperature of the rinse cycle on the temperature dial. The DA stated the dish machine temperature of the rinse cycle was 100 degrees F. The DA was asked if 100 degrees was ok. The DA 1 stated 100 degrees F was ok. DA 1 was then asked to check the dish machine temperature log. After looking at the dish machine temperature log, DA 1 agreed the dish machine rinse temperature was too low. The CDM stated DA 1 had only been working at the facility for two months. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed all kitchen employees should be competent in dish machine procedures. Cross reference to F908 example #2. b. Review of the facility's P&P titled Dish Machine Usage dated 2/2009 showed in part, if using a low temperature machine, check the sanitizer level using a litmus test strip. Record data on the dish machine temperature log. Review of the facility's document titled Dish machine temperature and Sanitizing Agent Log showed the minimum ppm (parts per million) for the sanitizing agent should be 50 ppm. Review of the employee file for DA 1 did not include a job description. Review of the facility's document titled General Orientation showed DA 1 was hired on 1/8/24. The CDM was not able to provide documentation of an in-service education training on the dish machine sanitizing agent was provided for the kitchen employees for the past year. On 6/18/24 at 1448 hours, an observation of the dish machine and concurrent interview was conducted with DA 1 using the CDM as a translator. The DA 1 was asked to test the sanitizing solution of the dish machine. DA 1 dipped the sanitizing solution test strip into the dish machine rinse water. The sanitizing solution test strip was a dark purple color. The DA was asked to compare the sanitizing solution test strip to the ppm indicator on the bottle of the test strip. The DA did not know what the required ppm of the sanitizing test strip should be for the dish machine rinse water. The CDM stated DA 1 had only been working at the facility for two months. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed all employees should be competent in dish machine procedures. c. Review of the facility's P&P titled Manual Cleaning and Sanitizing dated 2/2009 showed in part, Sanitizing Method: Immersion for a least 30 seconds in a sanitizing solution of 220 ppm of quaternary ammonia . Review of the employee file for DA 1 did not include a job description. Review of the facility's document titled General Orientation showed DA 1 was hired on 1/8/24. The CDM was not able to provide documentation of an in-service education training on the manual ware washing sink was provided for the kitchen employees for the past year. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 1448 hours, an interview regarding the manual ware washing process was conducted with DA 1 using the CDM as a translator. DA 1 was asked to demonstrate how to test the sanitizing solution in the third compartment of the manual ware washing sink. DA 1 was unable to demonstrate how to test the sanitizing solution of the manual ware washing sink. The CDM told DA 1 how to test the sanitizing solution in Spanish. After dipping the sanitizing solution test strip in the sanitizing solution for ten seconds, DA 1 was asked what the ppm of the sanitizing solution should be. DA 1 did not answer. The CDM stated 200-300 ppm. The CDM stated, He's not getting it, even in Spanish he doesn't understand. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed all the employees should be competent in manual dish washing procedures. On 6/20/24 at 1033 hours, an interview was conducted with the CDM. The CDM was asked how she trained new kitchen employees. The CDM stated the new employees were given general orientation by the DSD. The new kitchen employees were assigned to work with a seasoned kitchen employee for five to seven days. The CDM was asked how she determined the new employee was competent once trained? The CDM stated if the new employee had worked for three weeks, they were deemed competent. The CDM confirmed training of the new employees was not documented. The CDM was asked about kitchen in-service training. The CDM stated both she and the RD gave in-service training. When asked how often in-service trainings were given to the kitchen staff, the CDM stated an in-service training was given as needed depending on if they have made a mistake or need an update on customer service. When asked what topics were covered in the in-service training, the CDM stated the topics depended on what was going on. The CDM was asked how the employees' competency was measured on the information covered in the in-service. The CDM stated no test was given on the information covered in the in-service, but she could watch them demonstrate the in-service topic.

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39856

Based on observation, interview, and facility document review, the facility failed to ensure the American and Vietnamese menus met the resident's nutritional needs when

* The Vietnamese menus did not have puree recipes.

* The Vietnamese menus did not have a nutritional analysis.

* The Vietnamese menus were not updated periodically.

* The Vietnamese menus did not reflect the standard of practice for IDDSI (International Dysphagia Diet Standardization Initiative).

* The American menu puree recipes were not followed for puree ham, puree green peas, and puree sweet potatoes.

* The facility failed to ensure the coleslaw was served to Residents 51 and 115 as per the spreadsheet.

* The facility failed to ensure lettuce, tomato, and onions with the hamburger were served to Resident 16.

These failures had the potential for the residents not receiving adequate nutrition, and appropriate food texture based on their diet.

Findings:

1. According to the International Dysphagia Diet Standardization Initiative (IDDSI) https://iddsi.org, Puree food is characterized as able to retain its shape.

On 6/19/24 at 1125 hours, an observation of the puree rice preparation for the Vietnamese puree menu was conducted with [NAME] 2 and the CDM. [NAME] 2 stated she made the rice with more water; one part rice to three parts water. [NAME] 2 blended the rice in the Robot Coupe (RC- a device that pureed foods). The pureed rice was put in a pan after blending. The puree rice consistency was similar to applesauce, it did not hold its shape. When [NAME] 2 was asked what consistency the puree food should be, she stated the puree rice consistency was ok. The CDM told [NAME] 2 she could add thickener if she needed to. [NAME] 2 did not add any thickener to the puree rice.

On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD stated the puree food should have a mashed potato consistency, and not be runny. The RD also expected the puree recipes to be followed ensure the correct consistency of puree foods.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/21/24 at 1350 hours, an interview was conducted with the CDM. The CDM stated the Vietnamese menus were old; and had been in place at the facility for more than five years. The CDM confirmed the Vietnamese menus did not have any recipes for the pureed foods. 2. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD was asked if the Vietnamese menus had a nutritional analysis (an analysis of the menu to ensure the RDI (Recommended Dietary Intake-the average daily dietary intake level that is sufficient to meet the nutrient requirements of 98% of healthy individuals in a particular life stage and gender group). The RD stated the Vietnamese menus were old and there was no nutritional analysis for the Vietnamese menus. On 6/21/24 at 1350 hours, an interview was conducted with the CDM. The CDM stated the Vietnamese menus were implemented more than five years ago and a nutritional analysis was not available. 3. Review of the facility's document titled Weekly Menu Guide Vietnamese undated showed a four week cycle; Week 1, Week 2, Week 3, and Week 4. Review of the facility's document titled Daily Menu Guide Vietnamese Week 4: Tuesday showed the document was undated. On 6/21/24 at 1350 hours, an interview was conducted with the CDM. The CDM stated the Vietnamese menus were old, implemented more than five years ago and the four week cycle menu was the only menu they had for Vietnamese food. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD stated the Vietnamese menus had been in place at the facility a long time, the menus were in place when she started at the facility a year ago. The RD acknowledged the menu cycle was four weeks and undated. 4. Review of the IDDSI Framework showed IDDSI consisted of a continuum of eight levels (0-7), where drinks are measured from Levels 0-4, while foods are measured from Levels 3-7. Level seven of foods was regular and easy to chew, Level six was soft and bite sized, Level five was minced and moist, Level four was pureed and Level three was liquidized. https://iddsi.org, Review of the facility's document titled Diet Spreadsheet for the American menu dated 6/18/24, showed Regular texture diet, soft bite size texture diet, minced/moist texture diet, and puree texture diets. Review of the facility's document titled Daily Menu Guide Vietnamese Week 4 :Tuesday undated showed Regular texture diet, mechanical texture diet and puree texture diet. On 6/18/24 at 1155 hours, the CDM provided the diet spreadsheets for the American and Vietnamese menus. When asked why the Vietnamese menus did not match the American menus for the textured diets, the CDM stated the Vietnamese menu was old and it was the only Vietnamese menu the facility had. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD was asked how the facility was following the IDDSI guidelines for the residents who received the Vietnamese menu and were on a mechanically altered diet. The RD stated she did not have an answer for that. The RD acknowledged the Vietnamese menu spreadsheets did not match the American menu spreadsheets and did not follow the IDDSI guidelines. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the facility's document titled Grilled Ham dated 5/15/24 showed, Instructions: 1. Place 4.5 ounces slice of ham on preheated 350 degrees Fahrenheit (F) grill. 2. [NAME] on both sides until internal temperature of final product reaches 155 degrees F for 17 seconds. Review of the facility's document titled Grilled Ham puree dated 5/15/24, showed Instructions: 1. Grilled Ham 20 portions 4.5 ounces, prepare according to regular recipe. Food thickener 1/4 cup plus one Tablespoon, 2. 5 cup water or stock. 2. Process until smooth using one ounce slurry per portion. On 6/19/24 at 1051 hours, an observation of the puree preparation for the American menu was conducted with [NAME] 1 using the CDM as a translator. [NAME] 1 stated she was preparing 25 servings of puree ham. The CDM stated the ham used for the puree diets was a different type of ham than the regular diet. When asked how [NAME] 1 prepared the ham, she stated the ham cooked for the pureed diets was thinly sliced, previously cooked in the oven in a steam table pan. The pureed ham was not grilled as the regular ham recipe showed. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed all the recipes should be followed. a. Review of the facility's document titled [NAME] peas dated 5/15/24, showed for 96 portions, Instructions: Heat peas by steaming or boiling until tender. Margarine 1 1/2 cup, two Tablespoon, 1 5/8 teaspoon salt, 1 5/8 teaspoon pepper. Add margarine, salt and pepper to cooked peas. Review of the facility's document titled [NAME] Peas pureed dated 5/15/24, showed for 64 portions 1/2 cup each, Instructions: 1. Prepare according to regular recipe. Food Thickener 1/2 cup, three Tablespoons. 2. Process until smooth using 1/2 teaspoon food thickener per serving. On 6/19/24 at 1051 hours, an observation of the puree preparation for the American menu was conducted with [NAME] 1 using the CDM as a translator. [NAME] 1 stated she was preparing 25 portions of peas. When asked how the green peas were cooked, [NAME] 1 stated the peas were frozen and she cooked the peas in hot water. [NAME] 1 set aside five Tablespoons of thickener. [NAME] 1 measured 25 1/2 cup servings of green peas into the RC and sprinkled an unmeasured quantity of thickener into the RC then blended. [NAME] 1 placed the puree peas in a pan. The puree peas were a smooth mashed potato consistency. [NAME] 1 then added the rest of the thickener to the peas in the pan and stirred the product. When asked why [NAME] 1 added more thickener when the puree peas were already the correct consistency, [NAME] 1 stated because the recipe stated to use the thickener. When asked if [NAME] 1 pureed food to a certain consistency she did not answer. On 6/20/24 at 1430 an interview was conducted with the RD. The RD confirmed all recipes should be followed. b. Review of the facility's document titled Whip Sweet Potato dated 5/25/24, showed for 140 servings 1/2 cup each, Instructions: 1. Heat yams to 155 degrees F for 15 seconds 2. Drain and place yams in mixing bowl. 3. Whip on high speed about two minutes. Three 1/4 quart hot milk, margarine or butter 13 ounce 5. Add hot milk and margarine, whip on high speed until light and creamy. Review of the facility's document titled Whip Sweet Potato Puree dated 5/15/24 showed, for 20 servings 1/2 cup each, Instructions: 1. Prepare according to regular recipe. 2. Process until smooth and desired consistency. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 1051 hours, an observation of the puree preparation for the American menu was conducted with [NAME] 1 using the CDM as a translator. When asked how the sweet potatoes were cooked, [NAME] 1 stated the sweet potatoes were canned. [NAME] 1 stated she opened the can, put the sweet potatoes in a pan then put the pan of sweet potatoes into the oven. [NAME] 1 stated she was making 25 servings of sweet potatoes 1/2 cup each (#8 scoop). [NAME] 1 placed the previously baked sweet potatoes in the RC and blended them. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed all recipes should be followed. 39453 6. Review of the facility's Diet Spreadsheet X-format, Cycle Day 31 dated 5/14, 6/18, 8/27, and 10/01, showed to serve coleslaw for lunch meal. a. On 6/18/24 at 1255 hours, during the dining observation, Resident 115 was observed in his room, with lunch tray at the bedside. Lunch tray was observed with fish fillet, potato wedges, and two rolls. The coleslaw was not observed on the lunch tray. When asked if he wanted coleslaw, Resident 115 answered yes, and he stated he had a coleslaw before, and he liked it. Medical record review for Resident 115 was initiated on 6/18/24. Resident 115 was admitted to the facility on [DATE]. Review of Resident 115's H&P examination dated 6/7/24, showed Resident 115 had the capacity to understand and make decisions. Review of Resident 115's meal ticket dated 6/18/24, for lunch showed Resident 115 was not allergic to any vegetables or did not dislike coleslaw. b. On 6/18/24 at 1250 hours, during the dining observation, Resident 51 was observed in her room, with lunch tray at the bedside. Lunch tray was observed with fish fillet, potato wedges, and two rolls. The coleslaw was not observed on the lunch tray. When asked if she wanted coleslaw, Resident 51 nodded. Medical record review for Resident 51 was initiated on 6/18/24. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's H&P examination dated 4/22/24, showed Resident 51 had the capacity to understand and make decisions. Review of Resident 51's meal ticket dated 6/18/24, for lunch showed Resident 51 was not allergic to any vegetables or did not dislike coleslaw. On 6/18/24 at 1258 hours, an observation for Residents 51 and 115 and concurrent interview was conducted with the ADON. The ADON verified the above findings. The ADON verified a coleslaw salad was not served to Residents 51 and 115. (continued on next page)

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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. 39856 Based on observation, interview, and facility document review, the facility failed to ensure the nutritive content of the pureed foods for the American menu, in particular the pureed vegetables were preserved when the pureed vegetables were cooked and held in a hot oven more than one hour prior to meal service. This failure had the potential to not meet the nutritional needs of the 23 residents who received an American menu pureed diet. Findings: Review of the reference titled How Cooking Affects the Nutrient Content of Foods, dated 11/7/19, showed the following nutrients are often reduced during cooking: water-soluble vitamins: vitamin C and the B vitamins - thiamine (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxine (B6), folic acid (B9), and cobalamin (B12). https://www.healthline.com/nutrition/cooking-nutrient-content Review of the facility's document titled Production Recipe, [NAME] peas, pureed dated 5/15/24, showed to prepare frozen green peas according to the regular recipe. Process until smooth using 1/2 teaspoon food thickener per serving. Reheat to a minimum temperature of 165 degrees F (Fahrenheit - a unit of measure) or higher for 15 seconds. Hold at minimum required temperature or higher for service. On 6/19/24 at 0959 hours, an observation of the puree preparation for the American menu and concurrent interview was conducted with [NAME] 1 using the CDM as an interpreter. [NAME] 1 stated she cooked the green peas in hot water at 0945 hours. [NAME] 1 pureed the previously cooked peas then placed the pureed peas in a pan covered with foil. At 1023 hours, the pureed peas were placed in the oven at 450 degrees F until the lunch meal tray line began at 1200 hours. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed pureed foods should be cooked to preserve nutritive value.

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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 39856

Based on observation, interview, and facility document review, the facility failed to provide a meal substitute equivalent in nutritive value when:

* The pureed ham served to 23 of 122 residents who received an American menu puree diet had a higher sodium content than the regular ham and,

* The grilled cheese sandwich served to Resident 7 was not equivalent in protein to the entree served.

Theses failures had the potential for residents who received a meal alternate from the kitchen to not meet their nutritional needs.

Findings:

Review of the lunch meal tray ticket report dated 6/19/24, showed 23 residents received a pureed diet.

1. Review of the facility's recipe titled Grilled Ham dated 5/15/24, showed 1. Place 4.5-ounce slice of ham on preheated 350 degrees F (Fahrenheit) grill. 2. [NAME] both side until internal temperature of final product reaches 155 degrees F for 17 seconds.

Review of the facility's recipe titled Grilled Ham puree dated 5/15/24, showed for ingredients and instructions:

1. Grilled Ham 4.5 ounces prepare according to regular recipe. 2. Process until smooth using one ounce slurry per portion.

Review of the facility's document titled Diet Spreadsheet for the American menu dated 6/19/24, showed for the lunch meal, the entree for regular diets was grilled ham 4.5 ounces. Puree diets were to receive 4.5 ounces of pureed grilled ham.

Review of the nutrition facts of the Buffet Master Ham used for the regular texture ham showed 4.5 ounces (126 grams) provided 642 mg (milligrams; a unit of measure) of sodium.

Review of the nutrition facts of the Ham sliced smoked used for the puree texture ham showed for 4.5 ounces (126 grams) provided 831 mg of sodium.

On 6/19/24 at 0959 hours, an observation of the puree preparation was conducted with [NAME] 1 using the CDM (Certified Dietary Manager) as a translator. The ham used for the puree diets was thinly sliced and resembled luncheon meat. When asked about the ham, the CDM stated it was a different ham product than the ham used for regular texture diets.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 1346 hours, a test tray of the regular and puree textured diets was conducted with the CDM and RD. Both the CDM, RD, and surveyors confirmed the puree ham had a strong salty taste compared to the grilled ham used for the regular texture diets. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed recipes should be followed for puree foods. The RD added the facility used a different ham for the puree ham because they did not purchase enough of the ham used for the regular texture diets. The RD confirmed meal substitutes should be equivalent in nutritive value to the menu item substituted. 2. Review of the facility's document titled Diet Spreadsheet dated 6/18/24, showed for the lunch meal, the entree was breaded fish fillet, four ounces. Review of the nutrition facts of the breaded [NAME] (fish fillet) served for lunch on 6/18/24, showed 3.6 ounces provided 12 grams of protein. Review of the facility's document titled Production Recipe, Grilled Cheese Sandwich undated showed, Ingredients: sliced American cheese, white bread 1 oz slice. 1. Place three ounces cheese between two slices of bread. Review of the nutrition facts of the pasteurized process American cheese used to make the grilled cheese sandwich showed, two slices of cheese equivalent to 28 grams or one ounce, provided five grams of protein. Therefore, three ounces of American cheese per the grilled cheese sandwich recipe was equivalent to six slices of American cheese. Medical record review for Resident 7 was initiated on 6/19/24, showed Resident 7 was admitted to the facility on [DATE]. During a lunch meal observation on 6/18/24 at 1259 hours, Resident 7 was eating a grilled cheese sandwich in place of the breaded fish fillet entree. During a lunch meal tray line observation on 6/19/24 at 1206 hours, an interview was conducted with DA 5. DA 5 prepared a grilled cheese sandwich. DA 5 stated she made the grilled cheese sandwich with two slices of American cheese and two slices of bread. An interview was conducted on 6/20/24 at 1430 hours with the RD. The RD confirmed a meal substitute should be equivalent in nutritive value as the entree served for that same meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39856 Based on observation, interview, facility document review and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed when: 1. The cool down process for time, temperature control for safety (TCS) food, food that need to be kept at specific temperatures to prevent bacteria growth and foodborne illnesses, was not monitored. 2. Food preparation surfaces were not sanitized properly. 3. A thawing process was not followed for meats. 4. Hand washing was not performed for three of eleven kitchen staff. 5. Food preparation equipment was not clean and in good working condition. 6. Hair restraints were not worn properly for six out of ten kitchen employees. 7. Kitchen equipment was not clean. 8. The kitchen environment was not clean. 9. The kitchen floor was not in a cleanable condition. 10. The ice machine and a food preparation sink did not have an air gap. These failures posed the risk for food borne illnesses in highly susceptible resident population of 122 facility residents who received food prepared in the kitchen. Findings: Review of the facility matrix showed 122 of 133 resident who consumed food prepared in the kitchen. 1.a. According to the USDA Food Code 2022, Section 3-501.14 (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F) and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. Review of the facility document titled Cooling Log undated showed internal temperature of food must be reduced from 140 degrees to 70 degrees in two hours and cooled from 70 degrees to 41 degrees in four hours. During the initial tour of the kitchen on 6/18/24 at 0809 hours, with the Registered Dietitian (RD), a container of partially cooked chicken was observed in the walk-in refrigerator dated 6/18/24. The temperature of the partially cooked chicken was 91.4 degrees Fahrenheit (F). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 1014 hours, the temperature of the partially cooked chicken in the walk-in refrigerator was observed to be 75 degrees F. On 6/18/24 at 1104 hours, an interview was conducted with [NAME] 2. When asked about the chicken, [NAME] 2 stated she prepared the chicken around 0800 hours for the lunch meal. She cooked the chicken in boiling water for a few minutes, then marinated the chicken in the refrigerator. [NAME] 2 did not monitor the time or temperature of the chicken. On 6/18/24 at 1111 hours, an interview was conducted with the RD and CDM. The RD and CDM confirmed time and temperature of food partially cooked or heated, then refrigerated prior to food service was not monitored. b. According to the USDA Food Code 2022 Section 3-501.14 Cooling (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as canned tuna. On 6/18/24 at 0809 hours, during the initial kitchen tour, a large bowl covered with foil labeled Tuna salad dated 6/17/24, was observed in the walk-in refrigerator. On 6/20/24 at 1016 hours, using the MD as a translator, an interview was conducted with [NAME] 1. [NAME] 1 stated the cooling log was used for cold mixed salads such as tuna, egg salad or chicken salad. [NAME] 1 provided the cooling log, but the tuna salad dated 6/17/24, was not listed. There was only one entry Beef dated 6/17/24, on the cooling log for 2024 On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed TCS foods cooked and cooled should be monitored on the cooling log. The RD also stated she did not check the cooling log for TCS foods during her monthly kitchen audit. 2. According to the USDA Food Code 2022, Section 3-304.14 (B) (1), cloths in-use for wiping counters and other equipment surfaces shall be held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114 and laundered daily as specified under 4-802.11. Review of the facility's P&P titled Safe Food Handling-Policy No 604 dated 2/2009 showed cloths used for wiping food spills on food contact surfaces will be stored in a sanitizing solution between uses during the day. On 6/18/24 at 1043 hours, during a kitchen observation, [NAME] 2 used a paper towel to wipe the food preparation counter and Robot Coupe (a device used to puree food). On 6/18/24 at 1052 hours, an interview was conducted with [NAME] 2. [NAME] 2 stated she used the paper towel to wipe the counter because it was wet. She usually used the cleaning cloth stored in the sanitizing solution to wipe the food preparation counter. On 6/19/24 at 1023 hours, a used cleaning cloth was observed on the food preparation counter and not stored in the bucket. On 6/19/24 at 11:51 hours, a dirty paper towel was observed on the food preparation counter and another dirty paper towel observed in the food preparation sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed a paper towel should not be used in place of a cleaning cloth stored in the sanitizing solution to clean food preparation counters. The RD stated cleaning cloths should be stored in the sanitizing solution between uses. 3. According to the USDA Food Code 2022 Annex 6 Food Processing Criteria, (F) Recommendations for Safe Curing of Meat and Poultry, (3) HACCP (Hazard Analysis and Critical Control Point: food safety management system that aims to reduce the risk of foodborne illness by identifying and controlling potential problems before they occur) (b) Raw Material Handling (i) Thawing must be monitored and controlled to ensure thoroughness and to prevent temperature abuse. Improperly thawed meat could cause insufficient cure penetration. Temperature abuse can cause spoilage or growth of pathogens. Review of the facility's P&P titled Safe Food Handling- Policy No 604 dated 2/2009 showed frozen foods are thawed during the cooking process, under refrigeration or immersion under running portable water of a temperature of 70 degrees F or lower. On 6/18/24 at 0809 hours, during the initial kitchen tour with the RD and CDM, the following was observed: - Two pounds (lbs.) completely thawed pork dated 6/17/24 - 6/24/21; - Three 10 pounds completely thawed ground beef dated 6/17/24 - 6/24/24; - Two pounds thawed beef roast dated 6/17/24 - 6/24/24; and - Two bins containing four bags of partially thawed chicken dated 6/17/24 - 6/20/24. The RD stated meats were thawed for one to two days once removed from the freezer. The CDM stated the thawing process was three days for all meats, and the cook was responsible to date the thawing meats. The CDM was asked about the three 10-pound packages of completed thawed ground beef dated 6/17/24-6/24/24. When asked how the ground beef had completely thawed in less than 24 hours, the CDM stated she was not sure about that and agreed the ground beef should not be completely thawed in 24 hours. On 6/18/24 at 1100 hours, an interview was conducted with CDM. The CDM stated the weekend cook was responsible to pull the required meats from the freezer each weekend. On 6/18/24 at 1432 hours, an interview was conducted with [NAME] 3. [NAME] 3 stated he pulled meats from the freezer on Saturday 6/15/24. [NAME] 3 stated all meats have three days to thaw. When asked about the dates of 6/17/24 - 6/24/24, written on the labels observed on the meats, he stated someone must have changed the label, and he did not write those dates. On 6/18/24 at 1505 hours, an interview was conducted with the CDM. The CDM was questioned about the dates of the thawing meats in the walk-in refrigerator. The CDM stated if meats were pulled from the freezer on 6/15/24, the first thawing day would be 6/15/24. The CDM further stated the person who pulled the meats should write the label. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD stated meat should be thawed according to the thawing policy. 4. Review of the facility's P&P titled Hand washing techniques effective 2/2009 showed hand washing is to be done after removal of medical, surgical or utility gloves, and after scraping or racking dishes on the soiled end of the dish machine. On 6/18/24 at 1043 hours, [NAME] 2 touched the trash can to discard her used gloves, then donned new gloves without washing her hands. On 6/18/24 at 1052 hours, an interview was conducted with [NAME] 2. [NAME] 2 stated her hands were not dirty, so she did not wash her hands. [NAME] 2 stated she changed her gloves only. On 6/18/24 at 1450 hours, DA 1 was observed to load soiled dishes into the dish machine with gloved hands. DA 1 removed his gloves, put his hands in the sanitizing solution in the red bucket then removed clean dishes from the dish machine. DA 1 then donned a new pair of gloves and continued loading soiled dishes into the dish machine. On 6/19/24 at 1051 hours, during the puree food preparation, after she touched multiple surfaces with ungloved hands, [NAME] 1 donned a pair of gloves without washing her hands on two separate occasions. On 6/19/24 at 1125 hours, an observation of the puree preparation of the Vietnamese foods was conducted with [NAME] 2. After the Vietnamese foods had been pureed, [NAME] 2 removed her gloves and donned a new pair of gloves without washing her hands. On 6/19/24 at 1159 hours, an observation of the lunch meal tray line was conducted with [NAME] 1. [NAME] 1 was cooking ham with gloved hands. [NAME] 1 removed her gloves and donned a new pair of gloves but did not wash her hands. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed employees must wash their hands between glove changes. 5. According to the USDA Food Code 2022, Section 4-601.11 Food Contact Surfaces, Nonfood Contact Surfaces, and Utensils (A) Equipment, food contact surfaces and utensils shall be clean to sight and touch, (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. Review of the facility's P&P titled Ice Machine Sanitation dated 2/2009 showed the Ice machine is maintained and cleaned properly to ensure ice is served in a safe and sanitary manner. On 6/18/24 at 1016 hours, an observation of the ice machine was conducted with the MD. The chute of the ice machine (the interior area where ice is dropped into the ice storage bin) had a black residue when wiped with a paper towel. The MD confirmed the finding and agreed there should not be any residue inside the ice machine. a. On 6/18/24 at 0809 hours, during the kitchen tour with the CDM, the following food preparation equipment was observed and verified: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- three pots with black residue, - seven fry pans with hard black residue, - five muffin pans with black residue, and - three baking sheets with black residue. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed food preparation equipment should be clean. 6. Review of the facility's P&P titled Personnel Sanitation Standards dated 2/2009 showed hair must be restrained or covered via hat or hair net. During the lunch tray line observation on 6/19/24 at 1159 hours, [NAME] 1, DAs 4 and 5's hair was in a bun with the hair net not covering the hair on the back of her head. The CDM verified the findings. On 6/20/24 at 929 hours, DA 3's hair was in a bun with the hair net not covering the hair on the back of her head. On 6/20/24 1033 hours, DA 2's hair was in a bun with the hair net not covering the hair on the back of her head. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed all hair must be covered with a hair net when in the kitchen. 7. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. During the initial tour of the kitchen with the CDM on 6/18/24 at 0819 hours, a knife rack was observed to have a greasy residue and a plate warmer had food debris in the well. The CDM stated the knife rack was cleaned as needed and confirmed it was not clean. The CDM stated the maintenance department was responsible to clean the plate warmer. On 6/18/24 at 1016 hours, an interview was conducted with the Maintenance Director. The Maintenace Director was asked how often the plate warmer was cleaned, the Maintence Director stated maintenance was responsible for maintenance of the plate warmer but not cleaning. 8. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. During the initial tour of the kitchen on 6/18/24 at 0859 hours, with the CDM, the following were observed in the kitchen: (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The floor baseboard in the dry storeroom adjacent to the walk-in refrigerator had a black residue which resembled mold. The CDM stated the baseboard was under a shelf and difficult to reach therefore it was not cleaned. - The window above a food preparation counter was observed open. The screen to the window was had brown residue and was not clean. On 6/18/24 at 1016 hours, an interview was conducted with the Maintenance Director. The Maintenance Director confirmed the window screen was not clean and it was maintenance responsibility to clean the screen. a. On 6/19/24 at 1055 hours, an observation of the wall behind the dish machine and concurrent interview was conducted with the Maintenance Director. The wall behind the dish machine had a black residue on the caulking. The Maintenance Director confirmed the finding and stated he was not aware of the black residue. On 6/19/24 at 1057 hours, an interview was conducted with the CDM. The CDM confirmed she had not notified maintenance of the black residue on the wall behind the dish machine. 9. According to the USDA Food Code 2022 Annex 3 Section 4-201.11 Equipment and Utensils showed, Equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms, insects, and rodents. Review of the facility's P&P titled Kitchen Sanitation and Cleaning Schedules dated /2009 showed all floors in the food preparation and storage areas are washable and have a nonslip finish. During the initial tour of the kitchen with the CDM on 6/18/24 at 0859 hours, an observation of the kitchen floor was conducted. The floor surface was linoleum which was not intact exposing the concrete underneath. The CDM stated the Administrator was in the process of replacing the floor. On 6/19/24 at 0948 hours, an interview was conducted with the Administrator. The Administrator stated he just started working with the company two months ago. He was told the corporate of the company had looked at the floor and he would try to get a copy of the quote. On 6/20/24 at 1044 hours, an additional interview was conducted with the Administrator regarding the kitchen floor. The Administrator was asked about the floor quote, the Administrator stated he was not able to get a copy of the quote for the floor as of that time. As of the exit of the survey on 6/20/24, the floor quote had not been received. 10. According to the USDA Food Code 2022 Section 5-202.13 Backflow prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the observation of the ice machine on 6/18/24 at 1016 hours, with the Maintenance Director. The ice machine drainpipe was observed below the flood level rim of the floor sink. The Maintenance Director confirmed the finding and stated he would create an air gap. a. According to the USDA Food Code 2022 Section 5-402.11 Backflow Prevention. A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 6/18/24 at 1045 hours, an observation of a food production sink located under the kitchen window was conducted with the Maintenance Director. The drainpipe of the food production sink was plumbed directly to facility main drain. The Maintenance Director confirmed the food production sink did not have an air gap.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 39856 Based on interview and facility P&P review, the facility failed to ensure food brought to the facility by the family members or visitors was stored and prepared; and safe food handling practices were followed. This failure had the potential for unsafe food handling which could lead to food borne illness. Findings: Review of the facility P&P titled Use and Storage of Food Brought in by Family and Visitors dated 8/2023 showed, prepared food items brought in by the family or visitor must be labeled and dated. A. Facility may refrigerate labeled/dated prepared items in a designated unit or pantry refrigerator. On 6/19/24 at 0857 hours, an interview was conducted with the ADON. The ADON stated the facility did not allow storage of perishable food brought in by the family or visitors. The ADON stated the facility did not have a refrigerator for storage of food brought in by the family or visitors. The ADON added any food brought in by the family or visitors must be eaten and not stored. When asked if the family members or visitors were educated on safe food handling practices, the ADON stated the family members or visitors were told the policy rules, but nothing was given to the family or visitors in writing. The ADON stated she was not sure about safe food handling practices. On 6/19/24 at 0907 hours, an interview was conducted with the DSD regarding staff education on safe food handling practices. The DSD confirmed she had not educated staff on safe food handling practices.

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 49780 Based on observation, interview, and facility P&P, the facility failed to ensure the garbage was disposed properly when the cooked beans and egg shell were found on the ground at the back door of the kitchen. This failure had the potential to attract pests/rodents that carry diseases. Findings: According to the USDA Food Code 2022- Annex 3. Public Health Reasons, proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Garbage containers should be available wherever garbage is generated to aid in the proper disposal of refuse. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Review of the facility's P&P titled Garbage & Rubbish Disposal - Policy No 609 dated 2/09 showed all garbage and rubbish containing food waste shall be kept in containers. On 6/18/24 at 1051 hours, during a kitchen tour with the RD, the cooked beans with multiple flies and an egg shell were observed on the ground at the back door of the kitchen. The RD verified the findings and stated the cooked beans and egg shell should not be on the ground.

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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** 39683 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the complete and accurate medical records for four of 27 final sampled residents (Residents 7, 23, 56, and 540) and one of three closed record sampled residents (Resident 138). * Resident 7's POLST was not included in their medical record. * Resident 56's POLST was incomplete and did not show if the resident had an advanced directive. * Resident 540's POLST was not updated to show the resident had advance directive. * Resident 23's MAR was incomplete for medication administration. * Resident 138's medical record failed to show a CPR was initiated prior to paramedics' arrival. These failures had the potential for resident's care needs not being met as the clinical information were incomplete and/or inaccurate. Findings: 1. Medical record review for Resident 7 was initiated on [DATE]. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's medical record showed no documented evidnce of the resident's POLST. On [DATE] at 0742 hours, and interview and concurrent medical record review was conducted with LVN 9. LVN 9 stated all POLSTs were scanned into the residents' electronic health record (EHR) and the original document was placed in a binder at the nurses' station. LVN 9 reviewed the POLST binder and Resident 7's EHR and verified there was no POLST found for Resident 7. 2. Medical record review for Resident 56 was initiated on [DATE]. Resident 56 was admitted to the facility on [DATE]. Review of Resident 56's POLST dated [DATE], showed Section D did not show if the Resident 56 had or did not have an advance directive. On [DATE] at 0859 hours, an interview and concurrent record review was conducted with the SSD. The SSD stated the residents' POLSTs were reviewed and/or completed on admission. The SSD reviewed Resident 56's POLST and verified the POLST was incomplete and did not show if the Resident 56 had formulated an advanced directive. 39453 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Medical record review for Resident 540 was initiated on [DATE]. Resident 540 was admitted to the facility on [DATE]. Review of Resident 540's POLST dated [DATE], showed Resident 540 had no advance directive. Review of Resident 540's medical record showed an advance directive dated [DATE]. On [DATE] at 0906 hours, an interview and concurrent medical record review for Resident 540 was conducted with the SSD. The SSD verified the above findings. The SSD verified the POLST was not updated to show Resident 540 had an advance directive. 50953 4. Medical record review for Resident 7 was initiated on [DATE]. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report dated [DATE], showed a physician's order dated [DATE], for Carvedilol (medication to treat high blood pressure) 3.125 mg give one tablet by mouth two times a day for HTN and to hold if SBP less than 110 mmHg or HR less than 60 beats per minute. Review of Resident 7's MAR for [DATE] showed Carvdilol 3.125 mg was administered on [DATE]. However, the SBP for Resident 7 was documented 100 mmHg and the parameter was to hold if SBP less than 110 mmHg. On [DATE] at 1215 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 8. LVN 8 stated she held the medication for the date identified on the MAR and did not know as to why she documented the medication as given to Resident 7. LVN 8 showed the medication bubble pack for the Carvedilol 3.125 mg with the medication still inside the bubble pack for [DATE], and with a handwritten H for held medication. 5. Medical record review for Resident 23 was initiated on [DATE]. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Order Summary Report dated [DATE], showed the physician's orders dated: - [DATE], for isosorbide dinitrate (medication to treat high blood pressure) one tablet by mouth one time a day for HTN and to hold if SBP less than 110 mmHg or HR less than 60 beats per minute - [DATE], for Melatonin (medication to aid with sleep) 3 mg one tablet by mouth at bedtime for supplement to maintain circadian rhythym - [DATE], for Risperidone (medication to treat psychosis/mental disorder) 0.5 mg one tablet by mouth at bedtime for schizophrenia m/b angry outburst with no valid reason - [DATE], for metoprolol tartrate (medication to treat high blood pressure) 25 mg one tablet by mouth two times a day for HTN and to hold if SBP less than 110 mmHg or HR less than 60 beats per minute (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [DATE], for Senna Tablet (laxative) 8.6 mg two tablets by mouth two times a day for BM management, hold if loose stool - [DATE], for Humalog Solution 100 unit/ml (Insulin Lispro (Human)) Inject as per sliding scale as follows: If BS ,d+[DATE] mg/dl= 2 units BS ,d+[DATE] mg/dl= 4 units BS ,d+[DATE] mg/dl = 6 units BS ,d+[DATE] mg/dl= 8 units BS ,d+[DATE] mg/dl= 10 units If BS greater than 401 mg/dl, then call MD, subcutaneously before meals for diabetes Review of Resident 23's MAR for [DATE] showed no documentation of the following medications administered on [DATE]: - Blood sugar check with Humalog Solution sliding scale coverage at 1630 hours. - isosorbide dinitrate 30 mg, senna 8.6 mg, and metoprolol tartrate at 1700 hours. - Melatonin 3 mg and Risperidone 0.5 mg at 2100 hours. On [DATE] at 1502 hours, an interview and concurrent medical record review for Resident 23 was conducted with the ADON. The ADON verified and acknowledged the findings. 49258 6. Review of the facility's P&P titled Cardiopulmonary Resuscitation (CPR) dated [DATE], under the section for Documentation Guidelines, showed the documentation may include the time the CPR was started. Closed medical record review for Resident 138 was initiated on [DATE]. Resident 138 was admitted to the facility on [DATE]. Review of Resident 138's Order Summary Report showed a physician's order dated [DATE], showed Resident 138's code status of Full Cardiopulmonary Resuscitation (CPR). Review of Resident 138's Progress Notes dated [DATE] at 0345 hours, showed the RN Supervisor called the code at 0325 hours. Resident 138 was noted by the facility staff with no rise or fall of the chest, no respirations or heart sounds, the carotid pulse was unpalpable, and no lung sounds present. The 911 call was placed at 0318 hours. The progress notes further showed the Fire Department arrived at 0322 hours, and Resident 138 was pronounced dead at 0330 hours. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1145 hours, a telephone interview was conducted with LVN 12. LVN 12 stated Resident 138 was assigned to her at the Noc shift on [DATE]. LVN 12 stated she saw Resident 138 ,d+[DATE] minutes prior to the incident and observed Resident 138 resting with unlabored breathing. LVN 12 stated RN 2 went to Resident 138's room to assist with getting the urine sample from the foley catheter and observed Resident 138's chest was not rising. RN 2 palpated for Resident 138's pulse but it was absent, so they called a code. LVN 12 further stated Resident 138 was a full code and they initiated the CPR until the fire department arrived and took over. LVN 12 acknowledged the CPR initiation was not documented in Resident 138's progress note. LVN 12 further stated it was her first time to document for the incident and should have been more thorough following the guidelines for the CPR documentation. On [DATE] at 1534 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated per the facility's policy, the CPR initiation or the time it was started should be documented in the progress note. The DON verified there was no documentation of CPR initiation for Resident 138 prior to paramedics arrival on [DATE].

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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 39670

Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their infection control program in accordance with the facility's P&P.

* The facility failed to maintain an accurate infection control surveillance program for May 2024. The facility conducted surveillance only on the residents who exhibited signs and symptoms of an infection and were prescribed antimicrobial medications. The facility failed to ensure the Surveillance Data Collection Form was accurate to determine whether the resident's infection met the McGeer's criteria for true infection.

* The facility failed to ensure the clean linen were stored in a clean and sanitary manner in the laundry room.

* The facility failed to ensure Resident 539's indwelling urinary catheter drainage bag was not touching the floor.

* The facility failed to ensure the indwelling urinary catheter bag was off the floor and the staff to don the gown when provided indwelling urinary catheter care for Resident 8.

* The facility failed to ensure the trash was disposed properly. Two trash bins in the shower room were observed overflowing with soiled briefs, chucks, isolation gowns, and gloves which prevented the lid from closing.

*T he facility failed to perform hand washing before and after medication administration.

* The facility failed to maintain sanitary practices when counting the controlled medications.

These failures posed the risk for transmission of communicable diseases to other residents in the facility.

Findings:

1.a. Review of the facility's Infection Prevention Program dated 2012 showed the surveillance of infection with implementation of control measures and prevention of infections were on-going monitoring for infections among residents and subsequent documentation of infections that occur. The infection preventionist responsibility is to carry out the daily function of the infection prevention program. The resident's infection cases are monitored by the IP. The IP completes the line listing of infection monthly and report to the Infection Prevention Committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Antibiotic Stewardship Program dated 6/23 showed the infection preventionist coordinates antibiotic stewardship activities, maintains documentation, and serves as a resource for clinical staff. The program included antibiotic use protocol and system to monitor antibiotic use using the McGeer criteria to define infections. Documentation related to the program was maintained by the IP including the action plans, assessment forms, data collection forms for antibiotic use, and annual report. On 6/19/24 at 0940 hours, a concurrent interview and facility document review was conducted with the IP. The IP was able to provide the facility's Infection Control Surveillance and IP Program binder. Reviewed the facility's infection control surveillance log showed no data for infection control was documented for the months of January, February, and March 2024. The IP was asked about the facility's infection control data for the past six months. The IP verified and acknowledged the infection control data were available only for April 2024 when she started to work in the facility. The IP stated she did not know what happened about the infection control data of the facility for the previous months. The IP stated the Administrator was aware of the missing infection control information for the previous months. b. On 6/20/24 at 1010 hours, a concurrent interview, medical record review, and facility document review was conducted with the facility's IP. The IP was asked to describe the facility's infection surveillance program. The IP stated she used McGeer's criteria to determine if a resident had a true infection and would use the criteria to determine if a resident had an HAI or a CAI (community acquired infection). The IP stated she would determine whether the resident had an HAI or CAI based on the admitted ; a CAI would be determined within 2 days of admission; and after 2 days from admission, the infection would be an HAI. The IP stated she would complete the McGeer's criteria based on the antibiotics ordered by the physician. Review of the facility's infection surveillance data for the month of May 2024 showed the following data for HAIs, CAIs, and DMC (Did not meet criteria): 18 residents for CAI , 19 residents for HAI, and 5 residents for DMC. The documentation showed all residents determined to have either HAI, CAI, or DMC were also prescribed antimicrobial medications. Reviewed the surveillance data report for the month of May 2024 showed the following: * For Resident 44, the report completed on 5/13/24, showed the following: - Antibiotic treatment, Macrobid oral capsule 100 mg for urinary tract infection, was prescribed to start on 5/13/24. - Confirmed HAI for the criteria for the signs and symptoms included as burning on urination, and urine analysis report dated 5/13/24, results of 60,000 colonies per ml Escherichia Coli: Extended spectrum beta lactamase (ESBL, an enzyme produced by some bacteria that may make them resistant to antibiotics). * For Resident 127, the report completed on 5/30/24, showed the following: - Antimicrobial treatment, Fluconazole (antifungal medication) oral tablet, was prescribed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Confirmed HAI for the yeast in the urine identified on specimen collected in the hospital on 5/27/24. On 6/20/24 at 1145 hours, a follow-up interview was conducted with the IP. The IP verified the Surveillance Data Collection - Infection Control forms for Residents 44 and 127 were inaccurate and they did not meet McGeer's criteria for a true infection. The IP acknowledged she incorrectly classified Residents 44 and 127 as having an HAI; therefore, her monthly infection surveillance data was inaccurate. On 6/20/24 at 1340 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator was informed of the above findings and verified the findings. 39453 2. Review of the facility's P&P titled Laundry Manual (undated) showed the following: - Clean linen shall be stored, handled and transported in a way that precludes cross-contamination; - Clean linen shall be stored in clean, ventilated closets, rooms or alcoves used only for that purpose; - Clean linen not in covered storage shall be covered. On 6/18/24 at 1441 hours, a laundry area inspection was conducted with the Maintenance Director, and the following was observed: - Several freshly washed linen on a cart was observed touching a used yellow gown hanging on the wall; - A dusty air mover fan was observed on the clean linen cart, with several face towels observed on the lower shelf under the fan; - Several fitted sheets on the clean linen cart were observed touching a black jacket and a black bag hanging from the linen cart; - Several fitted sheets on another clean linen cart were observed touching a folded jacket and a sports drink - A water bottle was observed inside another clean linen cart; and - An uncovered portable linen cart was observed with folded linen by the laundry door, in the hallway. The Maintenance Director verified the above findings. 3. On 6/18/24 at 0838 and 0938 hours, during the initial tour of the facility, Resident 539 was observed in bed. Resident 539 was observed with an indwelling urinary catheter connected to a drainage bag. The indwelling urinary catheter drainage bag was observed touching 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

Medical record review for Resident 539 was initiated on 6/18/24. Resident 539 was admitted to the facility on [DATE].

Review of Resident 539's Order Summary Report showed a physician's order dated 6/12/24, for Foley catheter 16 French with 10 ml balloon to gravity drainage every shift.

On 6/18/24 at 1016 hours, an observation for Resident 539 and concurrent interview was conducted with LVN 13. LVN 13 verified the indwelling urinary catheter drainage bag was touching the floor.

32179

4. Medical record review for Resident 8 was initiated on 6/19/24. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE].

a. On 6/19/24 at 0900 hours, Resident 8 was observed lying in bed and the indwelling urinary catheter drainage bag was touching the floor.

On 6/19/24 at 1000 hours, LVN 3 was summoned to the Resident 8's Room. LVN 3 verified Resident 8's indwelling urinary catheter drainage bag was touching the floor. LVN acknowledged the urinary collection bag should not be touching the floor.

b. Review of the facility's P&P titled Enhanced Barrier Precaution dated 5/2024 showed the enhanced barrier precaution refers to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.

Review of Resident 8's Order Summary Report showed a physician order dated 6/18/24, for enhanced based precaution every shift for the indwelling urinary catheter and GT.

On 6/19/24 at 1020 hours, LVN 3 was observed entering Resident 8's room not wearing the isolation gown. A sign for Enhanced Based Precaution to don the gown and gloves while caring for devices and giving medical treatment was posted outside Resident 8's room.

On 6/19/24 at 1045 hours, LVN 3 was asked if she knew Resident 8 was placed on enhanced based precaution. LVN 3 stated she aware of it; however, she was forgot to don the gown. LVN 3 verified the finding.

5. On 6/19/24 at 1030 hours, an inspection of the shower room was conducted with the Maintenance Director. A large, wheeled trash barrel in the shower room adjacent to Room A was observed with the lid propped opened by soiled chuck, brief, and isolation gown. Another large trash barrel in the shower room adjacent to Room B was observed full and some trash such as a large coke cardboard and a large pizza box were collected outside the trash barrel. The Maintenance Director verified the findings.

50953

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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	6. Review of the facility's P&P titled Medication Administration-General Guidelines dated 11/2021 showed the person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, and before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations and medication given via enteral tubes. Examination gloves are worn when necessary (refer to specific administration procedures route). Review of the facility's P&P titled Hand Hygiene revised 11/2017 showed handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections. The staff must perform hand hygiene (even if gloves are used) at minimum before and after contact with resident and after removing the personal protective equipment (e.g. gloves, gown, and facemask) On 6/19/24 at 0838 hours, a medication administration observation for Resident 66 was conducted with LVN 7. LVN 7 did not perform hand washing before and after medication administration. On 6/19/24 at 0956 hours, an interview was conducted with LVN 7. LVN 7 verified the findings and stated she needed to wash her hands before and after medication administration. 7. On 6/20/24 at 1324 hours, during the inspection of Medication Cart A, a narcotic count was conducted with LVN 14. A plastic medication bottle containing Methadone 10 mg was removed from the narcotic drawer in the medication cart. LVN 14 took the medication tablets out of the bottle and poured the tablets on a white bond paper that she obtained from the top of her medication cart, and counted with a spoon. When asked if she had a medication tray to place the medications, LVN 14 stated she did not have any and did not have anything else to use.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 39856 Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in safe operating condition when: * The ice machine was not cleaned and sanitized in according to the manufacturer specifications. * The dish machine water temperature was below the manufacturer specifications for the wash and rinse cycles. * A metal screen door on the back door of the kitchen was not flush with the door jamb creating a gap. * A screen above a food preparation counter was not intact. * A fire sprinkler on the ceiling of the walk-in refrigerator had a brown residue resembling rust and was not intact with the ceiling of the walk-in refrigerator. These failures had the potential for the essential equipment to not function in the way it was intended. Findings: Review of the facility matrix showed 122 residents received food prepared in the kitchen. 1. Review of the ice machine manufacturer guidelines posted on the wall of the kitchen showed in part, the following: 6. Pour eight ounces or ten ounces or 12 ounces of [Scotsman Clear 1] ice machine scale remover (depending on ice machine model) into the reservoir. The unit will circulate the scale remover, then drain and flush it. 7. Mix a cleaning solution of one ounce ice machine scale removed to 12 ounces of water. 11. Wash the sensor and the adjustment screw with ice machine scale remover solution, rinse with clean water. Also wash the water distributor and curtain with the ice machine cleaner solution. 14. Create a solution of sanitizer by mixing one gallon of locally approved sanitizer and clean warm water. 15. Thoroughly wash all surfaces of the ice thickness sensor, water level sensor, curtain and water distributor with the sanitizer solution. 16. Wash all interior surfaces of the freezing compartment, including evaporator cover and right side panel liner with the sanitizer solution. 20. Pour the sanitizing solution into the reservoir until it is full. The unit will circulate the sanitizer, the drain and flush it. Ice Storage Bin: 2. Mix a solution of seven ounces of [Scotsman Clear 1] ice machine scale remover in 84 ounces of potable water and wash all interior surfaces of the ice storage bin to remove any mineral scale build up. 3. Mix a solution of sanitizer and thoroughly wash all interior surfaces of the ice storage bin. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 1016 hours, an interview was conducted with the Maintenance Director regarding the cleaning of the ice machine. The Maintenance Director stated he cleaned the ice machine once a month. The Maintenance Director stated he cleaned the ice machine by pouring one ounce of undiluted scale remover into the ice machine reservoir and let the scale remover run through the machine. The Maintenance Director further stated he then mixed seven ounces of scale remover with one to two gallons of water to clean the ice machine parts and ice storage bin. To sanitize the ice machine, the Maintenance Director stated he ran one ounce of undiluted sanitizer through the machine then sanitized the ice machine parts and storage bin with three to four ounces of sanitizer mixed with one gallon of water. On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed the ice machine manufacturer cleaning instructions should be followed when cleaning and sanitizing the ice machine. 2. Review of the dish machine operational requirements located on the dish machine showed minimum wash temperature 120 degrees Fahrenheit (F) and minimum rinse temperature 120 degrees F. On 6/18/24 at 1448 hours, an observation of the dish machine and concurrent interview was conducted with DA 1 using the CDM as a translator. The dish machine temperature dial showed the wash temperature of the dish machine was 100 degrees F and the rinse temperature was 108 degrees F. DA 1 confirmed the wash and rinse temperatures were too low. The CDM stated she would contact the Maintenance Director. On 6/19/24 at 1052 hours, an additional observation of the dish machine was conducted. The dish machine temperature dial showed the wash temperature of the dish machine was 106 degrees F and the rinse temperature was 114 degrees F. On 6/19/24 at 1054 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the water needed to run for a few minutes to bring the hot water to the dish machine in order to reach the minimum temperatures. 3. On 6/18/24 at 1016 hours, an observation of the metal screen door of the back door of the kitchen and concurrent interview was conducted with the Maintenance Director. The metal screen door was not flush with the door jamb (a side post or surface of a doorway or window) which created a gap. The Maintenance Director confirmed the finding and stated the door was like that when he started working at the facility two years ago. The Maintenance Director agreed the gap between the metal screen door and the door jamb was a problem. 4. During the initial tour of the kitchen with the CDM on 6/18/24 at 0819 hours, a window above the food preparation sink was observed with a screen that was bent and torn. On 6/18/24 at 1016 hours, an observation of the screen above the food preparation sink and concurrent interview was conducted with the Maintenance Director. The Maintenance Director confirmed the screen was not intact and he was responsible to repair the screen. 5. During the initial tour of the kitchen with the CDM and RD on 6/18/24 at 0819 hours, the ceiling of the walk-in refrigerator had a fire sprinkler with a brown residue which resembled rust. The fire sprinkler was not intact with the ceiling of the walk-in refrigerator. (continued on next page)

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 1016 hours, an interview was conducted with the Maintenance Director regarding the fire sprinkler on the ceiling of the walk-in refrigerator. The Maintenance Director confirmed the fire sprinkler was not intact and should be replaced.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were complete and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for three of three residents (Residents 30, 79 and 87) reviewed for side rails. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Bed Rails dated 10/2022 showed the following: - Bed rails are adjustable metal or rigid plastic bars that are attached to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eight lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to side rails, bed side rails, grab bars and assist bars; - Entrapment is an event in which a resident is caught, trapped, or entangeled in the space in or about the bed rail; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assessment should asses resident's risk of entrapment between mattress and bed rail or in the bed rail itself; - The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes ensuring that the bed's dimensions are appropriate for the resident by confirming that the bed rails are appropriate for the size and weight of the resident using the bed, installing bed rails using the manufacturer's instructions and specifications to ensure a proper fit, inspecting and regularly checking the mattress and bed rails for areas of possible entrapment, and ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/ or depth. A concurrent observation, medical record review, and facility document review for Residents 30, 79, and 87 showed the residents' bed entrapment assessments were not completed or the bed inspection gap measurements for Zones 2, 3, and 7 were recorded. For example: 1. On 6/18/24 at 0913, during the initial tour of the facility, Resident 30 was observed lying in bed with bilateral grab rails elevated. Resident 30 stated she held on to the grab rails when she was repositioned to her side. Medical record review for Resident 30 was initiated on 6/18/24. Resident 30 was readmitted to the facility on [DATE]. Review of Resident 30's Order Summary Report showed a physician's order dated 1/25/24, for bilateral grab bars as an enabler for bed mobility, turning and repositioning. Review of Resident 30's plan of care showed a care plan problem dated 1/25/24, to address the use of bilateral grab bars as enabler for bed mobility, transfers, turning and repositioning. The goal was for the facility to ensure all seven zones of entrapment for bed rail use were compliant with recommended guidelines. The interventions/tasks included the facility to ensure proper installation of bed rails complying with the suggested recommendations relating to the seven zones of entrapment and to continue residents if those using the bed rails are susceptible to entrapment. On 6/20/24 at 0836 hours, an interview and concurrent facility document review for Resident 30 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the bed inspection including the entrapment assessment of all the beds in the facility. The Maintenance Director stated he used the Bionix safety measuring device to measure the entrapment zones on each of the bed, and documented the results in the worksheet form, to which he showed the Bed System Measurement Device Test Results Worksheet for each of the resident's bed in the facility. Review of Resident 30's Bed System Measurement Device Test Results Worksheet dated 2/16/24, showed the bed assessment passed, and arrows leading to Zones 1 and 4 were encircled. The worksheet showed, P was circled for Zone 1, and the P nor the F were not circled for Zone 4. The worksheet failed to show the assessments of the entrapment for Zones 2, 3, and 7 applicable for Resident 30's grab bars. When asked about the P and F indicated on the different zones in the worksheet form, the Maintenance Director was not able to identify what those letters mean. When asked about the assessments of the entrapment, the Maintenance Director verified the bed entrapment assessments for Zones 2, 3, and 7 were incomplete. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39670 2. On 6/18/24 at 1025 hours, and 6/19/24 at 0926 hours, Resident 87 was observed in bed with both upper side rails elevated. Medical record review for Resident 87 was initiated on 6/19/24. Resident 87 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 87's Order Summary Report dated 6/19/24, showed a physician's order dated 1/29/24, for bilateral grab bars as an enabler for bed mobility and repositioning. Review of Resident 87's Side Rail Rationale Screen form dated 1/29/24, showed the side rails were indicated and served as an enabler to promote independence. Review of Resident 87's Bed System Measurement Device Test Results Worksheet form dated 1/29/24, showed the entrapment zones of the bed with side rail. However, there was no measurement for the entrapment Zones 6 and 7 - measurement of the bed headboard and the mattress and the footboard and the mattress. Also, for entrapment Zone 4, there was no circled indication for P or F. On 6/20/24 at 0803 hours, an interview was conducted for Resident 87 with CNA 3. CNA 3 verified Resident 87's use of side rails. CNA 3 stated Resident 87 was able to assist during ADL care by holding onto the side rail while turning to the side and repositioning. On 6/20/24 at 0818 hours, an interview was conducted for Resident 87 with RN 1. RN 1 stated the licensed nurses were responsible for the assessment of the residents who were using side rails. RN 1 stated the Maintenance Director was made aware of a physician's order for side rails and responsible for the bed entrapment assessment. On 6/20/24 at 0836 hours, an interview and concurrent facility document review was conducted for Resident 87 with the Maintenance Director. The Maintenance Director stated he was responsible for maintaining, checking the beds once a year and as needed if there were any changes. The Maintenance Director stated he was responsible for assessing the entrapment zones on each bed with side rails using the weighted cone liked device and if the device pass through the gap between the mattress and the rail, then the gap was too wide. The Maintenance Director was asked about the documentation and verified the use of the Bed System Measurement Device Test Results Worksheet form. The Maintenance Director was asked about the entrapment assessment for the bed in room [ROOM NUMBER] A for Resident 87. The Maintenance Director verified the bed ID number and the room number for Resident 87. When asked about the result on what P and F meant when he encircled them, the Maintenance Director acknowledged he did not know what the P and F standed for. When asked about the entrapment zones of the bed with side rail, the Maintenance Director was unable to mention the correct entrapment zones of the bed with side rails and unable to explain what the entrapment zones were. On 6/20/24 at 1309 hours, an interview and concurrent facility document review was conducted for Resident 87 with the Administrator. The Administrator was informed of the above findings and verified the findings. 50967 (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 6/18/24 at 0950 hours, and 06/19/24 at 0851 hours, Resident 79 was observed lying in bed with bilateral grab bars elevated. Medical record review for Resident 79 was initiated on 6/18/24. Resident 79 was admitted to the facility on [DATE]. Review of Resident 79's H&P examination dated 6/13/23, showed Resident 79 had the capacity to understand and make medical decisions. Review of Resident 79's Order Summary Report showed a physician's order dated 6/05/24, for bilateral grab bars when in bed to facilitate independent mobility. Review of Resident 79's Bed System Measurement Device Test Results Worksheet dated 12/27/23, showed the bed assessment passed and the arrow leading to Zone 1 was encircled. The worksheet showed, P and F were circled for Zone 1. The worksheet failed to show the assessments of the entrapment for Zones 2, 3, and 7 applicable for Resident 79's grab bars. On 06/20/24 at 0758 hours, an observation and concurrent interview was conducted with the ADON. The ADON verified Resident 79's use of bilateral grab bars. On 06/20/24 at 0834 hours, a concurrent interview and document review was conducted with the Maintenance Director. The Maintenance Director verified he documented the entrapment assessment on the Bed System Measurement Device Test Results Worksheet. The Maintenance Director verified the above findings. On 6/20/24 at 1413 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the kitchen and dining room were free of pests. This failure posed the risk of the residents residing in the facility to be exposed to pests. Findings: 1. Review of the facility's P&P titled Pest Control dated 2/2009 showed in part, 3. Garbage is held, transferred, and disposed of in a manner that does not create a breeding place for insects or rodents. 6. Windows and vents must be screened with at least 16-mesh per square inch screens. 7. Gaps and cracks in doorframes and thresholds are repaired . 8. All foods are kept tightly covered or wrapped. 9. Spills are cleaned up as they occur. Keep the kitchen clean. Review of the facility's documents titled Professional Pest Management Service Inspection Report dated 5/22 and 6/12/24, showed the facility was treated for roaches, ants, spiders, and mosquitoes. During the initial tour of the kitchen on 6/18/24 at 0819 hours, one fly was observed in the kitchen. An open window directly above a food preparation counter had a screen with a bent frame and was ripped. On 6/18/24 at 1027 hours, an interview was conducted with the Maintenance Director. The Maintenance Director confirmed the screen above the food preparation counter was not intact. The Maintenance Director stated he was responsible to clean and repair the screen. A metal screen door was observed on the back door of the kitchen. The metal screen door hinges had been replaced causing the metal screen door to not be flush with the door jamb. There was a gap between the door jamb and the metal screen door. The Maintenance Director confirmed the metal screen door was not flush with the door jamb causing a gap. The back door of the kitchen led to the side of the building where the kitchen stored boxes to be discarded. Food debris was observed on the ground next to the back door of the kitchen. The Maintenance Director confirmed the finding and agreed it was a problem. On 6/18/24 at 1045 hours, an additional observation of the side of the building outside the back door of the kitchen and concurrent interview was conducted with the Maintenance Director. Multiple flies were observed swarming around the food debris on the ground. The Maintenance Director confirmed the observation and stated the kitchen should keep the side of the building outside the back door of the kitchen clean. On 6/19/24 at 0959 hours, a fly was observed in the kitchen on the tray line. On 6/19/24 at 1159 hours, a fly was observed on a sheet pan covered with foil on the tray line. On 6/20/24 at 0915 hours, an interview was conducted with the Maintenance Director. The Maintenance Director was asked how the facility prevented flies in the kitchen. The Maintenance Director stated there was a fly trap in the kitchen. The Maintenance Director confirmed the fly trap was not monitored because it was electric. The Maintenance Director agreed there should not be flies in the kitchen. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 1430 hours, an interview was conducted with the RD. The RD confirmed there should not be flies in the kitchen. 32179 2. Medical record review for Resident 47 was initiated on 6/19/24. Resident 47 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of the H&P examination dated 12/11/23, showed Resident 47 was able to comprehend and follow verbal commands. Review of the Order Summary Report dated 6/19/24, showed a physician's order dated 12/14/23, to have a regular with chopped meat diet. On 6/18/24 at 1230 hours, Resident 47 was observed eating in the dining room. The flies were observed flying around in the dining room and landed in Resident 47's food plate and the resident was eating the food on the plate. On 6/18/24 at 1240 hours, an interview was conducted with LVN 4. LVN 4 acknowledged there were flies in the dining room. She was trying to wave the flies with her hand, so it would not landed in the resident's plate. LVN 4 stated the flies might get in through the side door when people going out and in sliding door.