STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555135	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Springs Care Center	1441 Michigan Avenue Beaumont, CA 92223

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 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** 47202 Based on interview and record review, the facility failed to ensure education and resources regarding Advance Directive (AD - written statement of a person's wishes regarding medical treatment) were provided to one of the three residents reviewed for AD (Residents 44), and or the Resident Representative (RP). This failure had the potential for Resident 44 and the RP to remain uneducated and uninformed about AD and could result in the facility being unable to know and honor the resident's wishes regarding medical treatment. Findings: On July 23, 2024, Resident 44's record was reviewed. Resident 44 was admitted to the facility on [DATE]. A review of Resident 44's History and Physical, dated June 9, 2024, indicated Resident 44 cannot make decisions. A review of Resident 44's Minimum Data Set (an assessment tool), dated June 12, 2024, indicated, Resident 44 had severely impaired cognitive skills. A review of Resident 44's Advance Directive Acknowledgement Form, dated June 10, 2024, indicated Resident 44 had not executed an Advance Directive. There was no documented evidence education and information about AD was provided to Resident 44 or the RP in the medical record. On July 24, 2024, at 9:42 a.m., during a concurrent interview and review of Resident 44's medical record with the Social Service Director (SSD), she stated if a resident does not have an AD, she would offer resources and education to the resident and/or the RP. The SSD stated, Resident 44 had no AD and she did not provide resources and education to Resident 44. The SSD stated she should have provided the resident resources and education and should have documented in the resident's records. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 25, 2024, at 1:41 p.m., the Director of Nursing (DON) was interviewed. The DON stated, upon admission, the licensed nurses would screen the resident regarding AD, and the SSD would follow-up. The DON stated, if the resident had no AD, the AD should be offered, educated should be provided, and information should be given to the resident and or RP. A review of the facility Policy and Procedure titled, Advance Directives, dated September 2022, indicated, .If the resident or representative indicates that he or she has not established advance directives .the facility staff will offer assistance in establishing advance directives .staff will document in the medical record the offer to assist .or decline assistance .

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50309 Based on observation, interview, and record review, the facility failed to ensure for one of seven residents reviewed for environment (Resident 28) was provided with a clean, safe, and comfortable environment when: 1. The resident's call light button (a device that alerts healthcare staff for help in a facility) cord was damaged and cracked. In addition, the staff did not report the damaged and cracked call light button cord to maintenance for replacement. This failure had the potential to prevent Resident 28 from receiving assistance as needed. 2. The cabinet above the sink inside the bathroom had rust buildup on the bottom shelf. This failure had the potential to place Resident 28 at risk of living in an unkempt and un-homelike environment. Findings: 1. On July 23, 2024, at 10:34 a.m., during a concurrent observation and interview with Resident 28 in the resident's room, the call light button cord was found to be cracked and with exposed wires. Resident 28 stated he used the call light for help but was not aware his call light was damaged. On July 24, 2024, at 3:04 p.m., during a concurrent observation, interview, and review of the facility document titled, Maintenance Log with the Maintenance Supervisor (MS) in Resident 28's room, the MS stated Resident 28's call light is cracked. The MS further stated the call light should be in proper condition so the resident can call for assistance. The MS stated there was no work order for the resident's call light and and he had not been made aware of the need to replace it. On July 24, 2024, at 3:47 p.m., an interview with Certified Nurse Assistant (CNA) 1, she stated Resident 28's call light was frayed (damaged) and might not work. CNA 1 stated residents should have undamaged call light to call for help as needed. CNA 1 stated nursing staff should have checked and informed Maintenance. CNA 1 further stated the call light should have been repaired. 2. On July 23, 2024, at 10:34 a.m., during an observation inside of Resident 28's bathroom, the bottom shelf of the cabinet above the sink had orange and brown discoloration. On July 24, 2024, at 3:04 p.m., during a concurrent observation and interview inside Resident 28's bathroom with the MS, the MS stated, the lower shelf is rusted. The MS stated he was responsible for making sure the resident's living areas are kept in good condition. The MS further stated there should not be rust on the shelf. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 24, 2024, at 3:49 p.m., during a concurrent observation and interview with CNA 1 inside Resident 28's bathroom, CNA 1 stated Resident 28's bathroom cabinet had rust on it. CNA 1 further stated the cabinet should not be in like that and residents should be comfortable and live in a home-like environment. On July 25, 2024, at 5:40 p.m., the Director of Nursing (DON) was interviewed. The DON stated, the resident's cabinet should be clean with no rust build up. The DON stated, staff should report to the Maintenance Supervisor when things in the resident's room need maintenance. The DON stated, resident comfort and safety are always the priority. A review of facility policy and procedure titled, Maintenance Service, undated, indicated, .The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times .Functions of maintenance personnel include, but are not limited to maintaining the building in good repair .providing routinely scheduled maintenance service to all areas.

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F 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50433

Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care Ombudsman (LTC Ombudsman - an agency reponsible for advocating on behalf of residents) of a discharge for one of two residents (Resident 39) reviewed for closed records.

This failure had the potential to result in the LTC Ombudsman not to be informed about Resident 39's plan of care and condition.

Findings:

On July 25, 2024, Resident 39's record was reviewed. Resident 39 was admitted to the facility on [DATE], with a diagnosis which included dementia (a group of brain disease that causes loss of memory) and Alzheimer's (a type of dementia).

A review of Resident 39's Minimum Data Set (an assessment tool), dated April 5, 2024, indicated, Resident 39 had Brief Interview of Mental Status (quick assessment to check a person's thinking, memory, and overall mental functioning) Score of 5 (severe cognitive impairment).

A review of Resident 39's Discharge Summary Report, dated June 3, 2024, indicated, .discharged to Acute Hospital .

There was no documented evidence that the facility notified the LTC Ombudsman of Resident 39's transfer.

On July 25, 2024, at 9:05 a.m., during a concurrent interview and review of Resident 39's medical record with the Social Service Director (SSD), she stated when residents are transferred or discharged from the facility, a letter is sent to the LTC Ombudsman to notify them of the resident's discharge. The SSD further stated notification is important for resident safety and continuity of care.

The SSD stated Resident 39 was discharged on [DATE], and she did not send the discharge notice to the LTC Ombudsman, she further stated I missed it, and I did not see that the notification letter was not sent. The SSD stated she should have sent Resident 39's discharge notice to the LTC Ombudsman.

On July 25, 2024, at 9:21 a.m., during a concurrent interview and review of Resident 39's medical record with the Medical Records Director (MRD), he stated, when residents are discharged or transferred from the facility, a written letter is sent to the LTC Ombudsman to indicate a discharge or transfer was initiated. The MRD stated there was no record of the LTC Ombudsman receiving a notification letter regarding Resident 39's discharge from the facility. The MRD further stated the LTC Ombudsman should have been notified of Resident 39's discharge.

(continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 25, 2024, at 1:37 p.m., during an interview with the Director of Nursing (DON), she stated the process for transfers or discharges requires the SSD to send the discharge notice to the LTC Ombudsman within 72 hours of discharge or transfer. The DON stated Resident 39 was discharged on [DATE], and the discharge notice was not sent to the LTC Ombudsman. The DON further stated the SSD should have sent the discharge notice to the Ombudsman. A review of the facility policy and procedure titled, Transfer or Discharge, Facility-Initiated dated October 2022, indicated, .Notice of Discharge after Transfer .If discharge is initiated by the facility after .transfer to the hospital .The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman .Notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident .

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 50433 Based on interview and record review, the facility failed to ensure the comprehensive assessments for six of 22 sampled residents (Residents 14, 34, 49, 51, 53, and 82) were completed within 14 calendar days after admission. This failure had the potential for residents to not receive resident centered care (care focusing on the needs of individuals) for Residents 14, 34, 49, 51, 53, and 82. Findings: On July 25, 2024, at 11:20 a.m. a concurrent interview and review of the Minimum Data Set (MDS - an assessment tool) comprehensive assessments were conducted with the MDS Nurse. The MDS nurse stated comprehensive assessment should be completed within 14 days after admission. The MDS nurse stated, it is important to complete the resident's MDS on time and submit to Center for Medicare Services (CMS - an agency that manages various aspects of healthcare delivery and funding) within 14 days to assess the residents' health status and provide a resident-centered care plan. The MDS nurse stated the comprehensive assessments for Residents 14, 34, 49, 51, 53, and 82 were not completed within 14 days of admission, as required. On July 25, 2024, at 5:38 p.m., an interview was conducted with the Director of Nursing (DON). She stated the comprehensive assessment should have been completed within 14 days, and completing them within the timeframe is important to provide a resident centered care plan. On July 25, 2024, the policy MDS Completion and Submission Timeframes dated July 2017 was reviewed. It indicated, .The assessment coordinator or designee is responsible for .resident assessments .submitted to CMS .in accordance with current federal and state guidelines. A review of the facility document titled, RAI OBRA-required Assessment Summary dated October 2023, indicated, Assessment Type: Admission (Comprehensive) .MDS Completion Date .No Later Than .14th calendar day of the resident's (admitted + 13 calendar days).

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36684 Based on observation, interview, and record review, the facility failed to ensure, Licensed Vocational Nurse (LVN) 1, administered the medication Nifedipine (brand name of medication used for high blood pressure) ER (extended release) 20 milligrams (mg - unit of measurement) as ordered by the physician for one of seven residents (Resident 10) observed for medication administration. This failure has the potential for the resident to not receive the full therapeutic effects of the medication. Findings: On July 24, 2024, at 9:34 a.m., a medication administration observation was conducted with LVN 1 on Resident 10. LVN 1 proceeded to prepare Resident 10's medications that included Nifedipine ER 20 mg one tablet. Indicated on the Nifedipine ER medication label instruction was to hold (not give) the medication if the systolic blood pressure reading (SBP- pressure in the arteries when the heart contracts) is less than 110 mmHg (millimeter of mercury - unit of measurement) and pulse rate is below 60 (normal pulse rate between 60 to 100 beats per minute - pulse rate to be taken by finding pulse on wrist or neck and count the number of beats for at least one minute). LVN 1 was observed to have taken Resident 10's blood pressure reading on her left arm. LVN 1 did not check Resident 10's pulse rate during the observation. In addition, LVN 1 was observed to not have an equipment such as timer, wrist watch, or clock, to use for checking the pulse rate. On July 24, 2024, at 9:50 a.m., LVN 1 administered Resident 10's medications by mouth, including the Nifedipine ER 20 mg one tablet. On July 24, 2024, Resident 10's record ws reviewed. Resident 10 was admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure). The physician's order, dated June 6, 2022, indicated to give one tablet of Nifedipine ER 20 mg once a day for hypertension and to hold if SBP below 110 (normal SBP reading below 120 mmhg) or pulse rate below 60. The care plan dated January 12, 2028, indicated, .Focus .Residentis (sic.) at risk for cardiac ditress related to: .Hypertension .Interventions .Monitor pulse rate and BP (blood pressure) as ordered . On July 24, 2024, at 10:00 a.m., an interview was conducted with LVN 1. LVN 1 stated he administered Resident 10's medications including the Nifedipine ER 20 mg one tablet. LVN 1 stated he checked Resident 1's pulse rate while he was checking the resident's blood pressure. LVN 1 stated he did not get an accurate pulse rate reading because he did not time it. LVN 1 stated he administered Resident 10's Nifedipine ER 20 mg without checking for an accurate pulse rate reading. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 25, 2024, at 9:20 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated LVN 1 should have checked Resident 10's pulse rate prior to giving the medication Nifedipine ER 20 mg. The DON stated LVN 1 should have followed the physician's order for pulse rate parameter prior to giving the medication. The DON stated Resident 10 may have a possible crash in her vitals signs if the ordered parameters were not followed as ordered by the physician. The undated facility policy and procedure titled, Policy & Procedure: Med Pass, was reviewed. The policy indicated, .Prepare the med correctly .administer the med correctly .Vital Signs .When vital signs are included in med order, vital signs are to be takenjust before medication is administered and by the med nurse. A vital sign taken by CAN (sic.) at the beginning of the shift shall NOT be valid .

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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** 36684 Based on observation, interview, and record review, the facility failed to ensure, an edema (swelling caused by too much fluid in the tissues) on the left upper and left lower extremity was appropriately assessed and a care plan was initiated and developed, for one of eight residents reviewed (Resident 24). This failure has the potential for the edema to not be monitored for complications and may also result to the delay in treatment of possible worsening symptoms. Findings: On July 23, 2024, at 10:34 a.m., an observation with a concurrent interview was condcuted with Resident 24. Resident 24 was alert, interviewable, and was sitting sitting on his wheelchair in the activities room. Resident 24's left arm and hand was observed to be swollen and not supported on the wheelchair arm rest. In a concurrent interview, Resident 24 stated the staff did not put any treatment, including elevating or icing, on his left arm and hand. On July 23, 2024, Resident 24's record was reviewed. Resident 24 was admitted to the facility on [DATE], with diagnoses including diabetes (high blood sugar) chronic obstructive pulmonary disease (type of lung disease that blocks airflow and make it difficult to breathe), atherosclerotic heart disease (type of heart disease) and cirrhosis of the liver (type of liver disease). The following documents were reviewed: - The COC/INTERACT ASSESSMENT FORM (SBAR) dated July 4, 2024, at 3:25 p.m., indicated the licensed nurse referred to Resident 4's physician resident's complain of pain to left arm and hand. The nursing notes indicated, .Licensed Nurse Notes .resident complained of pain to left arm, upon skin assessment resident noted with swelling to left arm with edema + 6 (edema grading(+) 1 and up to 2 millimeter [mm- unit of measurement] of depresison; rebounding immediately; + 2 is 3-4mm of depression, rebounding in 15 seconds or less; +3 is 5-6 mm of depression, reboubnding in 60 seconds and + 4 is rebound between 2-3 minutes with an 8 mm depression) . There was no documented evidence of an assessment conducted on the left arm that would include the size and appearance`of the swelling and edema identified on Resident 24 in July 4, 2024. In addition, there was no documented evidence of a care plan developed or initiated to address Reisdent 24's left arm swelling and edema. - The COC/INTERACT ASSESSMENT FORM (SBAR) dated July 13, 2024 at 2:49 p.m., indicated the licensed nurse referred to Resident 4's physician identified blister on his left upper arm. The nursing notes indicated, Resident left hand and arm still noted to be swollen with a blister to the upper arm. MD (medical doctor) notified and received new order for Lasix 20 milligrams (medication used to treat excess fluid in the body) Bid (two times a day) . - The physician's order dated July 13, 2024, indicated, Lasix Oral Tablet 20 MG .Give 1 tablet by mouth two times day for Edema on L (left) upper & (and) lower extremities . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the edema on Reisdent 24's left upper and lower extremities of an assessment conducted on the left upper and lower extremity edema that would include size and appearance, In addition, there was no documented evidence a care plan was developed and/or initiated to address the edema identified on Resident 24's upper and lower extremity. On July 23, at 3:30 p.m., an interview with a concurrent record review was conducted with the Director of Nursing (DON). The DON stated Resident 24's left arm was swollen because of the recurrent cellulities on Resident 24's left arm. The DON stated there was no documented evidence of an appropriate assessment conducted on Resident 24's left arm when it was identified as +6 edema on July 4, 2024, and the identified edema on the left upper and lower extremities in July 13, 2024. The DON stated the licensed nurses should have assessed and documented the size, and appearance if it was pitting or non-pitting. The DON stated there should have been a documentation on the daily or weekly nursing notes if the edema was decreasing in size. The DON stated she did not see any documentation that the monitoring of the size and appearance of edema on Resident 24 was done. The DON further stated she did not see documentation that a care plan was developed to address the identified edema on Resident 24 in July 4 and 13, 2024. The DON stated these should have been done by the licensed nurse when it was identified in July 4 and 13, 2024. The facility's undated policy and procedure titled, Policy and Procedure: Edema, was reviewed. The policy indicated, .Assessment for edema on the lower extremities will include palpation to identify presence of edema and documentation will include type of edema, extent, locatikon, symmetry and degree of pitting . Edema is usually graded from trace to 3+ or 4+ pitting edema . Further assessment may include weight .The attending physician may request measurements of ankle circumference and recording of intake and output . Chronic edema that was previously indetified and is currently under treatment will be monitored as indicated. Any signs/symptoms of shortmness of breath and/or increase in edema will be reported and orders will be obtained a sindicated . Residents will be monitored for symptoms of acute edema, including SOB (shortness of breath) or any other changes in the degree of edema and this will be reported to attending physician . The policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated March 2023, was reviewed. The policy indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and thier causes, and relevant clicnical decision making . When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers . Assessments of residenrs are ongoing and care plans are revised as information abou the residents' condition change .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309 Based on interview and record review, the facility failed for one of two residents (Resident 54), to address vision deficits when a recommendation for reading glasses was not followed up. This failure had the potential for Resident 54 to have a decline in his vision. Findings: On July 22, 2024, at 8:56 a.m., an interview with Resident 54 in his room, he stated he loved reading books and used to have readers. Resident 54 further stated having reading glasses could help him read better. A review of Resident 54's ADMISSION RECORD, printed date July 24, 2024, indicated, Resident 54 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss). A review of Resident 54's History and Physical dated May 28, 2024, indicated the resident had the capacity to make own decisions. A review of Resident 54's physician's order, dated May 21, 2024, indicated, .Eye-Health and Vision Consult with Follow-Up Treatment as indicated . A review of Resident 54's document from the optometrist (a healthcare professional who specialized in examining, diagnosing, and treating visual conditions), dated June 3, 2024, indicated, . RECOMMENDATIONS .New glasses . reading . On July 23, 2024, at 4:55 p.m., during a concurrent interview and review of Resident 54's optometry exam notes with the Social Service Director (SSD), she stated Resident 54 was seen by an optometrist on June 3, 2024, who recommended reading glasses. The SSD stated while the resident could benefit from this recommendations, it was not acted upon. The SSD stated, the recommendation should have been followed up immediately. On July 25, 2024, at 6:37 p.m., a concurrent interview and record review of Resident 54's optometry exam notes dated June 3, 2024, with the Director of Nursing (DON), she stated Resident 54 had recommendations for reading glasses. The DON further stated there was no follow-up on the recommendations and no documentation indicating that they had been addressed. On July 25, 2024, at 6:55 p.m., an interview was conducted with the SSD. The SSD stated she should have followed up on the reading glasses recommendation for Resident 54. The SSD stated the lack of follow-up could lead to vision problems for the resident. A review of the facility policy and procedure titled, Ancillary/Consultant Physician Services, dated March 2023, indicated, .Consultants provide the administrator with written, dated, and signed reports of each consultation visit. Such reports contain the consultant's findings and recommendations .The facility retains the professional and administrative responsibility for all services provided by consultants .

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	555135	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0689 Level of Harm - 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** 36038 Based on observation, interview, and record review, the facility failed to provide an environment free from accident hazards for one of four residents reviewed for accidents (Resident 41), when the resident tripped on an in-ground planter (a garden bed or a space dug into the ground where plants are grown) that was approximately 3.25 to 3.5 inch deep above the ground level. This failure resulted for Resident 41 falling and hitting her head on the picnic table, resulting in a periorbital hematoma (black eye- swelling and discoloration around the eye area) and a fracture of the nasal septum (broken or cracked part inside the nose that separated the two sides). Findings: On July 24, 2024, at 9 a.m., Resident 41 was observed walking independently by the nursing station and had dark purplish discoloration on both eyes. A review of the Resident 41's ADMISSION RECORD, dated July 23, 2024, indicated, Resident 41 was admitted to the facility on [DATE], with diagnoses which included dementia (loss of memory) and schizophrenia (a mental disorder). A review of Resident 41's History and Physical, dated November 5, 2023, indicated Resident 41 did not have the capacity to make decisions. A review of Resident 41's FALL RISK ASSESSMENT, dated June 30, 2024, indicated, .Score: 18 .a score of 18 or more is High Risk (very likely to fall) . A review of Resident 41's Progress Notes, indicated: - Dated July 15, 2024, .At around 1340 (1:40 p.m.), guard came to the nurses' station stating resident (Resident 41) was in the patio outside DON (Director of Nursing) .with a bloody nose .Upon assessment, resident was sitting on the side of the planter behind DON office crying and yelling. Noted with a cut to the bridge of her nose and bleeding .Resident was transferred out to (name of acute) for further evaluation . - Dated July 15, 2024, .Resident (Resident 41) returned to facility .Resident diagnosed with bilateral nasal fracture. Open wound approx. (approximately) 4x2cm (four by two centimeters) in size on the left side of the nose, with discoloration of the skin on and around the nose. Red drainage noted on left side of the nose with loose skin . - Dated July 16, 2024, .resident (Resident 41) noted with left and right periorbital hematoma and scab to the bridge of nose . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 41's CT Maxillofacial (Computed Tomography - uses radiologic and computer technology which evaluates the bones of the face), dated July 15, 2024, indicated, . Impression .Acute mildly displaced bilateral nasal bone fractures .Acute minimally displaced fracture of the anterior-superior (front and upper part) bony nasal septum . A review of Resident 41's IDT (Interdisciplinary Team - group of healthcare professionals who collaborate to develop and implement care plans for residents) Narrative, dated July 17, 2024, indicated, .Team met to discuss the fall that occurred on the outer patio. Resident (Resident 41) stepped off of the walking path and into a planter causing her to fall . On July 23, 2024, at 12:02 p.m., Licensed Vocational Nurse (LVN) 2 was interviewed. LVN 2 stated, on July 15, 2024, the facility guard came to the nurses station to report that Resident 41 had a fall. LVN 2 stated they reviewed the video of the incident. LVN 2 stated, Resident 41 tripped and hit her face on the table. On July 25, 2024, at 8:36 a.m., an interview was conducted with the Facility Guard (FG). The FG stated, after the afternoon smoking break, he heard a scream in the outer patio. The FG further stated he checked and saw Resident 41 sitting by the planter with bleeding from her nose. On July 25, 2024, at 4:04 p.m., a concurrent interview and observation of the outer patio were conducted with the DON. The in-ground planter where Resident 41 tripped was observed approximately 3.25 to 3.5 inches deep relative to the ground level. The DON stated, Resident 41 was walking in the outer patio toward the picnic table when the resident tripped in the in-ground planter and hit her face on the picnic table. The DON stated, Resident 41's fall could have been avoided if the in-ground planter was fixed to prevent tripping and falling. The DON further stated the resident fell due to the unevenness of the pavement and sustained a nasal fracture from the fall on July 15, 2024, at 1:30 p.m. A review of the facility policy and procedure titled, Promoting Safety, Reducing Falls, undated, indicated, .By simply focusing on fall preventions, caregivers can enhance the quality of life for residents .MAJOR RISK FACTORS .Extrinsic factors. These include risk factors outside the resident's body, such as environmental hazards (.uneven floors, highly patterned floors .) During a review of facility Policy titled, Grounds, dated May 2008, indicated, .Areas around the buildings (i.e. , sidewalks, patios, gardens, etc.) shall be maintained in a safe and orderly manner at all times .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36684 Based on observation, interview, and record review, the facility failed, for four of seven residents (Residents 46, 10, 40, and 76) to ensure: 1a. Resident 46 was provided privacy by Licensed Vocational Nurse (LVN) 1, when she assessed the resident for back pain; and 1b. Resident 10 was provided privacy by LVN 2, when he applied the Voltaren Cream (pain medication cream applied topically). These failured had the potential toi violate residents rights to privacy during medication administration. and 2a. Resident 40's narcotic medication Norco (brand name or narcotic pain medication) 5-325 milligrams (mg- unit of measurement) was documented as administered by the Licensed Nurse (LN) on June 18 and 27, 2024; and 2b. For Resident 76, the medication Ativan (anti-anxiety medication) was documented as administered by the LN on July 16 and 24, 2024. These failures resulted to the delay in the identification of drug discrepancies and possible medication diversion of controlled medications. Findings: 1a. On July 24, 2024, at 8:42 a.m., a medication pass observation on Resident 46 was conducted with LVN 1. Resident 46 was in bed, alert, and intervieweable. Resident 46's bed was right next to the door and was visible from the hallway. Resident 46 stated he had a back pain. LVN 1 proceeded to assist resident to a sitting position to further assess him. Resident 46 sat on his bed facing the doorway, and removed his shirt. LVN 1 was observed to assess Resident 46' back for pain. Resident 46 can be seen from the hallway sitting on his bed without his shirt while being assessed. LVN 1 was observed to not have closed the door and/or pull Resident 46's privacy curtain around his bed to provide privacy during her assessment. On July 24, 2024, at 10:44 a.m., an interview was conducted with LVN 1. LVN 1 stated Resident 46 complained of back pain during her medication pass so she assessed him. LVN 2 stated she should have provided privacy by closing the door and/or pulling the prIvacy curtain around the resident; 1b. On July 24, 2024, at 9:34 a.m., a medication pass observation on Resident 10, was conducted with LVN 2. LVN 2 prepared Resident 10's medication which included Voltaren Arthritis gel to be applied topically on Resident 10's left knee. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On July 24, 2024, at 9:54 a.m., Resident 10 was lying in bed next to the window, the door to the resident's room was left open and Resident 10 can be seen from the hallway. LVN 2 informed Resident 10 he will apply the Voltaren cream on her left knee. Resident was observed to have pulled her left leg pants up to expose her left knee and LVN 1 proceeded to apply the Voltaren cream topically on Resident 10's left knee. LVN 1 was observed to not have provided privacy by closing the privacy curtain around Resident 10's bed and/or closing the door to the resident's room prior to applyiing the Volatern cream on Resident 10's left knee. On July 24, 2024, at 10: 35 a.m., LVN 2 was interviewed. LVN 2 stated he should have provided priivacy on Resident 10 before he applied the Voltaren cream on Rqesident 10's exposed left knee. LVN 2 stated Resident 10 had already pulled her left leg pant up so he did not think of providing privacy at that time. The facility's undated policy and procedure titled, Policy & Procedure: Med Pass, was reviewed. The policy indicated, .RESIDENT RIGHTS/PRIVACY .Any administration of medications that MAY embarass the resident, or MAY embarass other resident or visitors, is to be done in a provate area .Examples include . Administering treatments .Applying pastes. 2a. On July 24, 2024, at 12:10 p.m., an interview with a concurrent record review on Resident 40's narcotic medication was conducted with LVN 3. Resident 40 was admitted to the facility on [DATE]. with diagnoses that included dementia (memory loss). The physician's order dated June 4, 2024, indicated to give Norco Oral Tablet 5-325 mg by mouth every 6 hours as needed for moderate to severe pain. The document titled, ANTIBIOTIC OR CONTROLLED DRUG RECORD, indicated the LN signed out the Norco medication on June 16, 2024 at 5:00 p.m. and June 27, 2024, at 4:00 p.m. The electronic Medication Administration Record (eMAR), dated June 1 to 30, 2024, did not indicate if the medication Norco 5-325 as given to Resident 40 on June 16, 2024 at 5:00 p.m. and June 27, 2024, at 4:00 p. m. There was no documented evidence the medication Norco was given to Resident on June 16, 2024 at 5:00 p. m. and June 27, 2024, at 4:00 p.m. In a concurrent interview, LVN 3 stated the facility's process on giving as needed (PRN) pain medications. LVN 3 stated when a resident asked for as PRN pain med, the LN should assess the resident's pain and pain level, offer non-pharmacological treatement, if ineffective to check the physician order for PRN pain med. LVN further stated the LN should evaluate after a cuple of hours if the PRN pain medications administered was effective. LVN 3 stated the LN should document in the eMAR if the PRN pain medication was given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 3 stated there was no documented evidence the LN who siigned out the medication Norco from the ANTIBIOTIC OR CONTROLLED DRUG RECORD, on June 16, 2024 at 5:00 p.m. and June 27, 2024, at 4:00 p.m. was documented as given to the resident. LVN 3 stated the LN should have documented in eMAR if the prn Norco 5-325 mg was given to Resident 40 on e 16, 2024 at 5:00 p.m. and June 27, 2024, at 4:00 p. m. 2b. On July 24, 2024, at 12:25 p.m. an interview with a concurrent record review on Resident 76's narcotic medication was conducted with LVN 3. Resident 76 was admitted to the facility on [DATE], with diagnoses including anxiety. The physician's order dated July 16, 2024, indicated to give Ativan 0.5 mg orally evcery siz hours as needed (PRN) for anxiety manibfested verbalization of anxiousness. The document titled, ANTIBIOTIC OR CONTROLLED DRUG RECORD, indicated the LN signed out the PRN Ativan 0.5 mg on July 16, 2024 ay 4:05 p.m. and July 20, 2024, (time not legible). The electronic Medication Administration Record (eMAR) dated July 1 to 31, 2024, did not indicate if the PRN Ativan 0.5 mg was given to Resdient 76 by the LN. There was no documented evidence the PRN Ativan 0.5 mg was documented as given to Resdient 76 by the LN on July 16, 2024 ay 4:05 p.m. and July 20, 2024, (time not legible). In a concurrent interview, LVN 3 stated there was no documented evidence the LN who signed out the PRN Ativan 0.5 mg from ANTIBIOTIC OR CONTROLLED DRUG RECORD on July 16, 2024 ay 4:05 p.m. and July 20, 2024, (time not legible), documented in the eMAR if these were given toi Resident 76. LVN 3 stated the LN should have documented in the eMAR if the the signed out PRN Ativan 0,5 mg was given to Resident 76 on those dates The facility's undated policy and procedure titled, Policy &Procedure: Med Pass, was reviewed. The policy indicated, .Prepare the med correctly, administer the med correctly, and chart the med pass correctly . The facility's undated policy and procedure titlerd, PREPARATION AND GUIDELINES .CONTROLLED MEDICATIONS . was reviewed. The policy indicated, .[NAME] a controlled drug is administered, the licensed nurse administerng the medication immediately enters the following informaiton on the accountability record and the medication administration record (MAR) . Date and time of administration . Amount administered . Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply . Initials of the nurse administering the dose on the MAR after the medication is administered . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated policy and procedure titled, Documentation of Medication Administration, was reviewed. The policy indicated, .The facility shall maintain a medication administration record to document all medication administered . A nurse .shall document all medications administered to each resident on the resident's medication administration record . Administration of medication must be documented immediately after (never before) it is given .Documentaion must include .date and time of administration .signature and title of the person admisnitering the medication . resdient response to the medication, if applicable (e.g. PRN (as needed), pain medication, etc .)

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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** 36684 Based on observation, interview, and record review, the facility failed to ensure the following medications were not stored readiliy available for use in the medication cart and medication room: - One bottle of Nutricia UTI Stat Liquid 30 FL Oz (Fluid Ounce - unit of measurement) 887 milliliters (unit of measurement) with an expiration date of [DATE]; - Four acetaminophen suppositories 650 milligrams (mg-unit of measurement) labeled for use on a resident that expired [DATE]; and - One vial of Comimaly Intramuscular Suspension 30 MCG (micrgogram- unit of measurent)/0.3ml (type of Covid{(highly contagious type of respiratory infection}vaccine) labeled for use on a resident that was discharged from the facility on [DATE]. This failure has ther potential for the residents to receive expired and/or ineffective medications. Findings: On [DATE], at 11:37 a.m., an interview was conducted with Registered Nurse 1 (RN) 1. RN 1 stated all medications stored in the medication cart one (1) was readily available for use. On [DATE], at 11:50 a.m., an observation, interview, and record review, was conducted with Licensed Vocational Nurse (LVN) 3. Stored in medication cart 1 were the following: - One bottle of Nutricia UTI Stat Liquid 30 FL Oz with an expiration date of [DATE]; and - Four acetaminophen suppositories 650 milligrams (mg-unit of measurement) labeled for use on a resident that expired [DATE]. In concurrent interview, LVN 3 stated the Nutricia UTI Stat Liquid 30 FL Oz was expired and it should not have been stored in the medication cart readily available for use. LVN 3 stated it was a supplement and she should have checked for the expiration date. LVN 3 further stated it was not good to use on the residents. LVN 3 stated the four acetaminophen suppositories 650 milligrams labeled for use on Resident 53, should have been pulled out from the medication cart when the resident was discharged [DATE]. LVN 3 stated the acetaminpohen suppositories should have been placed in the medication room for disposal. LVN 3 stated the acetaminophen suppositories should not have been stored in the medication cart readily available for use. On [DATE], at 12:30 p.m., an inspection of the medication room was conducted with LVN 4. LVN 4 stated the medications stored in the medication room were readily available for use. (continued on next page)

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Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Found stored in the medication refrigerator was one vial of Comimaly Intramuscular Suspension 30 MCG/0.3 ml vial labeled for use on Resident 60. In a concurrent interview, LVN 4 stated Resident 60 has been discharged and the medication should have been pulled out from the medication refrigerator and stored in the cabinet designated for dinscontinued medication. LVN 4 stated the Comimaly Intramuscular Suspension 30 MCG/0.3ml labeled for use on Resident 60 should have been removed and disposed of. On [DATE], at 9:30 a.m., an interrview was conducted with the Director of Nursing (DON). The DON stated the expired one bottle of Nutricia UTI Stat Liquid 30 FL Oz and discontinued medications of Resident 53 (acetaminophen suppositories) and Resident 60 (Comimaly Intramuscular Suspension 30 MCG/0.3 ml vial) should have been pulled out and wasted and should not have been stored in the medication cart and medication room readily available for use. The DON stated this is to prevent a possible medication error by the licensed nurses. On [DATE], the following records were reviewed: - Resident 53 as admitted to the facility on [DATE] and expired in the facility on [DATE]; and - Resident 60 was admitted to the facility on [DATE] and was discharged to home on [DATE]. The facility's undated policy and procedure titled, Storage of Medication, was reviewed. The policy indicated, . The facility stores all drugs and biologicals in a safe, secure, and orderly manner .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destructed as indicated .

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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.

47202

Based on interview and record review, the facility failed to ensure dietary staff could carry out the functions of food and nutrition services safely and effectively when [NAME] (CK) 1, Dietary Aide (DA) 3 and DA 4 were unable to accurately describe the cooldown process for hot food and ambient food temperatures.

This failure had the potential to place residents at risk for food borne diseases (illness that result from ingestion of contaminated food) that can cause sickness and or death.

Findings:

On July 23, 2024, at 11 a.m., during an interview with DA 3 of the cooldown process for hot food and ambient food temperatures inside the kitchen, she stated the hot food cooldown temperature starts at 186 degrees. DA 3 stated the temperature should be checked after two hours, with a goal temperature of 140 degrees. DA 3 further stated she would check the food temperature after another 2 hours with a goal temperature of 34 degrees.

DA 3 stated the cooldown process for ambient food temperature, like tuna salad is after the food was made, it should be placed in the refrigerator and checked after four hours, with a goal temperature of 40 degrees. DA 3 further stated if the food did not reach the goal temperature after four hours, she would place the tuna back in the refrigerator for another two hours. DA 3 stated the total cooldown time for ambient food temperature was six hours.

On July 23, 2024, at 11:15 a.m., during an interview with DA 4 regarding the cool down process for ambient food temperature, DA 4 stated, after the food was made, the food should be placed in the refrigerator and checked after four hours, with a goal temperature of 40 degrees. DA 4 further stated if the food did not reach the goal temperature after four hours, she will place the food back in the refrigerator for another two hours. DA 4 stated the total cooldown time for ambient food temperature was six hours.

On July 23, 2024, at 11:25 a.m., during an interview with CK 1 regarding the cooldown process for ambient food temperature, like tuna salad is after the food was made, the food should be placed in the refrigerator and check after four hours, with a goal temperature of 40 degrees. CK 1 further stated if the food did not reach the goal temperature after four hours, she will place it back in the refrigerator for another hour. CK 1 stated, the total cooldown time for ambient food temperature was five hours.

On July 24, 2024, at 3:13 p.m., during an interview with the Registered Dietitian (RD). The RD stated the cooldown process for ambient food temperature, such as tuna, requires the food to be at 40 degrees or less within 4 hours and if that temperature was not achieved the food must be discarded.

The RD stated the hot food cooling process, as starting at 140 degrees then cooling to 70 degrees within two hours, and to 40 degrees within four hours, for a total cooling time of six hours.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RD stated her expectation was for the dietary staff to follow the policy and procedure for rapid cooling of hazardous food to ensure the safety of the facility's residents. A review of the facility policy and procedure titled, Safe Cooling Method, dated 2019, indicated, .All cooked food not prepared for immediate use will be cooled to keep bacteria from developing .Within 2 hours from 140 F to 70 F .within another 4 hours from 70 degrees to 40 degrees .total 6 hours . A review of the facility policy and procedure titled, Safe Cooling Method, dated 2019, indicated, .For Ambient Temperature .Food shall be cooled within 4 hours to 40 degrees or less if prepared from room temperature like canned tuna .If food does not reach 40 degrees .Discard food . A review of the facility document titled, Job Description Cook, dated 2019, indicated, .Assures all food items . meet safety and sanitation standards according to State and Federal regulations .Properly stores and refrigerates necessary items .according to the latest FDA Food Code . A review of the facility document titled, Job Description Dietary Aide/Dishwasher, dated 2019, indicated, . Prepares hot and cold foods .Practice safety .according to facility policy .

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 50204 Based on observation, interview, and record review, facility failed to provide assistive devices such as plate guard (equipment to prevent food from falling off the plate), for two of eight residents (Resident 13 and Resident 58) observed during mealtime. This failure had the potential for Resident 13 and 58 not meeting the daily nutritional needs, which could lead to weight loss. Findings: a. On July 22, 2024, at 12:05 p.m., a concurrent observation and interview were conducted with Resident 13 in the dining room. Resident 13 was observed scooping the food onto her plate but the food fell off the plate. She stated the food was spilling out of the plate and stated oops my food just fell . On July 24, 2024, at 12:30 p.m., Licensed Vocational Nurse (LVN) 6 was interviewed. LVN 6 stated, Resident 13 spilled food on the floor. LVN 6 stated, Resident 13 could eat by herself, a plate guard should have been provided to prevent food from spilling. On July 24, 2024, at 12:45 p.m., during an interview with the Director of Nursing (DON), she stated Residents13 should have been evaluated and provided assistive eating device. The DON further stated if residents are unable to eat the food properly, residents might not meet their nutritional needs, which could lead to weight loss. b. On July 22, 2024, at 12:15 p.m., a concurrent observation and interview were conducted with Resident 58, inside the resident's room. Resident 58 was observed eating be herself, with food spilling from the plate. Resident 58 had difficulty scooping the food served. Resident 58 stated, the food had spilled off the plate and was on the surface of the overbed table. Resident 58 further stated I can't see the half of the steak .Where did it go? It was noted that one half of the steak fell to the resident's left side and the other half to the right side. On July 22, 2024, at 12:53 p.m., during an observation and interview with the Infection Preventionist (IP), she stated Resident 58's food was falling off the plate, and an assistive device was needed to prevent the food from falling off the plate. The IP further stated, REsident 58 should have an assistive device such as a plate guard. On July 24, 2024, at 12:45 p.m., during an interview with the Director of Nursing (DON), she stated Resident 58 should have been evaluated and provided assistive eating device. The DON further stated if resident unable to eat the food properly, resident could not meet nutritional needs which could lead to weight loss. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy and procedure titled, Assistive Devices and Equipment, dated January 2020, indicated, .facility maintains and supervises the use of assistive devices and equipment for residents .certain devices and equipment that assists resident mobility, safety and independence are provided for residents . specialized eating utensils and equipment .

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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. 47202 Based on observation, interview, and record review, the facility failed to ensure a sanitary environment, to prepare, and serve food in accordance with professional standards for food service safety when: 1. The toaster dial control had a build up of brown-yellowish grime. 2. Multiple cutting boards had yellowish discoloration, deep cuts, indentations, and damaged. 3. The left and right sides of the oven, the front inside surfaces of the left and right oven doors showed brown discoloration. (cross reference F908) 4. The front metal areas of two meal tray carts were stained with brown discoloration. (cross reference F908) These failures had the potential to place residents at risk for food borne diseases (illness that result from ingestion of contaminated food) that can cause sickness and or death. Findings: On July 22, 2024, at 8:30 a.m., during a concurrent walk-through observation and interview inside the kitchen with the Dietary Manager (DM), the following were observed: 1. One toaster had brown-yellowish grime buildup in the front dial control. The DM stated the the toaster is old and needs to be replaced, and the brown-yellowish discoloration was grime build-up. The DM further stated grime should not have been present, as it could cross-contaminate food and cause foodborne illness. 2. One blue cutting board was had multiple deep cuts, indentations, and damaged. Further observed were two green cutting boards with yellowish discoloration, multiple deep cuts, and indentations. The DM stated the blue cutting board was damaged with parts of the plastic lifted, and the green cutting boards had deep cuts, indentations with yellowish discoloration from food residue. The DM stated the cutting boards should not be like that, the surface should be clean, smooth, and undamaged to prevent the growth of microorganisms (germs) that could cause cross contamination and food borne illness. 3. The left and right sides of the oven and the front inside surfaces of the left and right oven doors had brown discoloration. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM stated the equipment is old, and the brown discoloration was rust. The DM further stated the oven should not be like that, the rust can fall into the resident's food, causing cross-contamination and leading to food borne illness. 4. On July 23, 2024, at 2:44 p.m., during a concurrent observation of mealt tray carts and interview inside the kitchen with the Registered Dietician (RD) and the Maintenance Assistant (MA), the following were observed: - The front right metal area of cart #3 was reinforced with another metal and had brown discoloration. - The front right metal area of cart #4 had brown discoloration. The RD stated the front right corners of the two meal tray carts were wearing out, with surfaces that were not smooth and had brown discoloration. The RD stated the meal tray carts should not have rust and should have a smooth surface to prevent bacterial growth, which could cause cross-contamination and lead to food borne illness. The MA stated the metal at the front right corner of meal tray cart #3 had been welded with a different metal and both carts #3 and #4 had brown discoloration, the MA further stated the brown discoloration was due to corrosion and deterioration. On July 24, 2024, at 3:13 p.m., during an interview with the RD, she stated her expectation was for the kitchen to be clean, with no grime or dust and all equipment to be in safe operating condition, free from corrosion, deterioration, and damage. The RD stated the toaster should be clean with no grime build up, as grime could cross-contaminate food and lead to foodborne illness. The RD stated cutting boards should not have deep indentation, damage, and stain. The RD further stated plastic particles from damaged cutting boards could get into food and the indentations can harbor bacteria, leading to cross- contamination and foodborne illness. The RD stated any decomposition on any kitchen equipment should not be present and rust is a food safety hazard that can fall into food causing cross-contamination and cause foodborne illness. A review of the facility policy and procedure titled, Sanitizing Equipment and Surfaces, undated, indicated, . Dietary staff should ensure that all equipment .are clean and in good condition . A review of the facility policy and procedure titled, Cutting Board Cleaning, undated, indicated, .All cutting boards should be clean and in good condition .Dietary staff to ensure all cutting boards are in good condition . A review of the facility policy and procedure titled, Maintenance, undated, indicated, .Kitchen Appliances . inspect all .appliances in the kitchen to determine that they are working properly .are undamaged . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled, Maintenance Service, dated December 2009, indicated, . Maintenance .shall be provided to all areas of the building .and equipment .maintaining .the equipment in a safe and operable manner at all times . A review of FDA (Food and Drug Administration) Food Code 2022, Section 4-501.12 Cutting Surfaces, indicated, .Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize .As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces . A review of the FDA Food Code 2022, 4-101.11 Equipment Characteristics, indicated, .FOOD-CONTACT SURFACES of EQUIPMENT .shall be .(D) to have a smooth, easily cleanable surface and .(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition . A review of the FDA Food Code 2022, Annex 4-501.11 Equipment Good Repair and Proper Adjustment, indicated, .Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed .Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309 Based on observation, interview, and record review, the facility failed to provide safe and sanitary storage of personal food for one of one resident (Resident 56) when two expired bags of marshmallows were found inside the resident's closet and were readily available for consumption. This failure had the potential to place Resident 56 at risk for foodborne diseases (illness that result from ingestion of contaminated food). Findings: On [DATE], at 5:17 p.m., a review of Resident 56's medical records indicated he was admitted to the facility on [DATE]. A review of Resident 56's History and Physical, dated [DATE], indicated he had a fluctuating capacity to understand and make decisions. On [DATE], at 9:40 a.m., during a concurrent observation and interview inside Resident 56' room, two bags of expired marshmallows were found in the resident's closet. One of the bags was opened and had a hardened texture. Resident 56 stated the marshmallows were gifts from last Christmas (7 months ago). Resident 56 further stated, I snack on them occasionally. On [DATE], at 3:04 p.m., during a concurrent observation and interview inside Resident 56's room with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 56 had two bags of expired marshmallows indisde his closet readily available to eat. LVN 5 further stated if Resident 56 consumes the expired marshmallows, it could cause stomach upset. On [DATE], at 3:30 p.m., during a concurrent observation and interview inside Resident 56's room with Nursing Assistant (CNA) 1, she stated Resident 56 had two expired bags of marshmallows inside his room closet. CNA 1 further stated, the expired marshmallows should not have been there because they could cause stomachache if consumed. On [DATE], at 5:26 p.m., during an interview with the Director of Nursing (DON), she stated her expectation was that expired food should have been discarded and not readily available for consumption by the resident. The DON further stated if a resident ate expired food, it could cause stomach issues. A review of the facility policy and procedure titled, Resident's Refrigerator/Freezer Storage, undated, indicated, .7. Only cooked/packaged items are allowed to be stored .8. Food items that are expired or beyond the best buy date are discarded .

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36684 Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were observed when: 1. Registered Nurse (RN) 2, did not perform the appropriate hand hygiene prior to, in between, and after a resident contact during a blood sugar check and administration of insulin (medication used for high blood sugar) for one of seven residents observed (Resident 4); and 2. For one of two residents (Resident 347), when a Physical Therapy Assistant (PTA) failed to perform hand hygiene and disinfect ankle weights used after providing care on the resident, who is on an enhanced barrier precautions (EBP - infection prevention and control practices that can help reduce the spread of infection). These deficient practice had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and spread of diseases and infection to the facility staff, residents, and visitors. Findings: 1. On July 24, 2024, at 3:46 p.m., an observaiton with a concurrent interview was conducted with RN 2. RN 2 stated Resident 4 was due for a blood sugar check. The following were observed: - At 3: 49 p.m, RN 2 found Resident 4 in the front lobby and brought her back to her room. RN 2 was observed to not wear gloves or perform hand hygiene before and after pushing Resident 4's wheelchair to her room; - At 3:50 p.m., RN 2 explained to Resident 4 she will check her blood sugar, RN 2 wore gloves and proceeded to check Resident 4's blood sugar using the glucometer machine (device used to check bloos sugar level). RN 2 was observed to not have perfomed hand hygiene prior to and after checking Resident 4's blood sugar; - At 4:05 p.m., RN 2 went back to the medication cart and stated she will check Resident 4's the physician orders for insulin. RN 2 wore gloves while she disinfected the glucometer machine, disposed of the used needle and blood sugar test strip in the sharps container, and threw the used alcohol swab and plastic cup in the trash. RN 2 removed used gloves and donned new a new pair of gloves and stated she will prepare Resident 4's insulin. RN 2 proceeded to check Res 4's physician's order for insulin and stated she will need one unit of insulin from the KwikPen (type of insulin brand). RN 2 was not observed to have performed hand hygiene between cleaning her medication cart and equipment and preparing Resident 4's insulin; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 4:10 p.m., RN 2 went back to Resident 4's room and explained the procedure of insulin administration to the resident. RN 2 donned a new pair of gloves and proceeded to administer the insulin via KwikPen on Resident 4's right upper arm. RN 2 went back to the medication cart and disposed of the used needle, plastic cup, and alcohol swab. RN 2 recorded the insulin administered to Resident 4. RN 2 was not observed to have performed hand hygiene prior to and after administering insulin to Resident 4. In a concurrent interview, RN 2 stated the facility's policy on hand hygiene practice during blood sugar checks and administration of insulin on residents. RN2 stated she forgot to perform hand washing prior to and after checking Resident 4's blood sugar and prior to and after the administartion of insulin. RN 2 stated she should have washed her hands prior to and after checking Resident 4's blood sugar and prior to and after the administration of Resident 4's insulin. On July 24, 2024, at 4:45 p.m., the Infection Preventionist (IP) Nurse was interviewed. The IP nurse stated the expectation was the licensed nurses should wash their hands before and after performing a blood sugar check and before and after administering insulin on a resident, even if gloves were worn during the procedure. The IP Nurse stated RN 2 should have washed her hands prior to and after checking Resident 4's blood sugar, prior to and after administering Resident 4's insulin. The facility's policy and procedure titled, Insulin Administration, dated March 2023, was reviewed. The policy indicated, .Purpose .To provide guidelines for the safe administration of insulin .Steps in the Procedure . Wash hands .Check blood glucose per physician order or facility protocol .Check the order for the amount of insulin .Select an injection site .Clean injection site .Depress the plunger and remove the needle .Dispose of needle in designated container .Wash hands . 50309 2. During an observation on July 23, 2024, at 9:19 a.m., the PTA was observed entering an isolation room (special hospital rooms that keep patients separate from other people while they receive medical care) wearing a gown and gloves prior to performing therapy on resident. The PTA was observed applying ankle weights around the residents' lower legs. During a concurrent observation and interview with the PTA, on July 23, 2024, at 9:32 a.m., the PTA was observed not performing hand hygiene after removing her gloves and not disinfecting the ankle weights after use. The PTA stated, she should have performed hand hygiene and disinfected the weights before bringing them outside of the room because of infection control and the spread of germs to other residents and staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on July 24, 2024, at 3:36 p.m., with the Infection Prevention Nurse (IPN), the IPN stated resident was on EBP due to foley catheter use. IPN stated hand hygiene was important to prevent the spread of infection which could lead to an outbreak. IPN stated staff are expected to follow the EBP guidelines posted outside the resident's door, and further stated the PTA should have washed her hands and disinfected the ankle weights after rehab exercise. Resident 347's record was reviewed. Resident 347 was admitted to the facility on [DATE], with diagnoses which included multidrug-resistant organisms (MDRO - bacteria that have become resistant to certain antibiotics) and extended spectrum beta-lactamase (ESBL - a strain of bacteria that is hard to treat) in his urine. During a review of the facility policy and procedure titled, Cleaning and Disinfecting Non-Critical Resident-Care Items,, undated, indicated the policy is to provide guidelines for disinfection of resident care items .Section sub-titled Equipment and Supplies .indicated the following equipment and supplies will be necessary .soap and water, disinfectant solution, wipes, paper towels and PPE as needed. During a review of the facility policy and procedure titled, Policies and Practices- Infection Control, undated, indicated, The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections .Preventing Spread of Infection .the facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. During a review of the facility policy and procedure titled, Enhanced Barrier Precautions, dated June 2024, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .5. EBPs are indicated for residents with wounds and or indwelling medical devices regardless of MDRO colonization .8. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038 Based on interview and record review, the facility failed to ensure that one of five residents reviewed for immunizations (Resident 58) was offered the pneumococcal vaccine (vaccines against the bacterium Streptococcus pneumoniae [bacteria that can cause pneumonia]). This failure had the potential for Resident 58 not fully protected against pneumonia (infection of lungs). Findings: A review of Resident 58's ADMISSION RECORD, indicated, .Resident 58, is [AGE] year old, admitted to the facility on [DATE], with diagnoses which included chronic obstructive lung disease (COPD-respiratory problem). On July 24, 2024, at 8:37 a.m., during a concurrent interview and review of Resident 58's immunization record, with the Infection Preventionist (IP), the IP stated Resident 58 received one dose of pneumococcal (PPSV23) on april 24, 2023. The IP stated residents who received one dose of Pneumococcal (PPSV23) should be offerred a second dose of pneumococcal (PCV20) after one year. The IP further stated the facility follows current CDC (Centers for Disease Control and Prevention - responsible for protecting public health and safety) guidelines. The IP stated there was no documentation that Resident 58 was offerred the second dose of the pneumococcal vaccine after one year from the initial dose. During a review of the facility policy and procedure titled, Policy: Pneumococcal immunization, dated February 1, 2023, indicated, .The facility will offer pneumococcal vaccines to all residents to ensure that all residents are up to date with pneumococcal vaccination based on CDC guidance . During a review of CDC Website - www.cdc.gov/pneumococcal /hcp/vaccination, the document titled Pneumococcal Recommendation, dated June 27, 2024, indicated, .Previously received only PPSV23: PCV 15 OR 1 dose PCV20. Administer either PCV15 or PCV20 at least 1 year after the last PPSV23 dose .

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F 0908

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Keep all essential equipment working safely.

47202

Based on observation, interview, and record review, the facility failed to ensure, one toaster, two oven doors, the left and right sides of the oven and four meal tray carts were maintained in a safe operating condition.

These failures had the potential to place residents at risk for food borne diseases (illness that result from ingestion of contaminated food) that can cause sickness and or death.

Findings:

On July 22, 2024, at 8:30 a.m., during a concurrent observation and interview inside the kitchen of the toaster with the Dietary Manager (DM), the toaster dial had chipped and peeled plastic film. The DM stated the toaster was old and needs to be replaced. The DM further stated bacteria can grow into the chipped and peeled areas, can cross contaminate the food and cause food-borne illness.

On July 22, 2024, at 8:40 a.m., during a concurrent observation and interview inside the kitchen with the DM, the left and right sides of the oven were observed with chipped and peeled paint, and had brown discoloration. During further observation, the front inside surfaces of the left and right oven doors had brown discoloration.

The DM stated the equipment is old, the brown discoloration was rust and the oven paint was chipped and peeled. The DM further stated the oven should not be like that, the rust and peeled paint can fall into the resident's food, causing cross contamination leading to foodborne illness.

On July 23, 2024, at 2:44 p.m., during a concurrent observation and interview inside the kitchen of meal tray carts with the Registered Dietician (RD) and the Maintenance Assistant (MA), the following were observed:

- The left and right sides of four meal tray carts were with chipped and peeled vinyl sticker.

- The front right metal area of cart #3 was reinforced with another metal and had brown discoloration.

- The front right metal area of cart #4 had brown discoloration.

The RD stated the left and right sides of the four meal tray carts were with chipped and peeled vinyl sticker and the front right corner metal of the two meal tray carts were wearing out, the surface is not smooth and with brown discoloration, further stated rust is brown in color.

The RD stated the meal tray carts should have no rust, have a smooth surface, no chipping or peeling to prevent bacterial growth that could cause cross contamination and lead to food borne illness.

The MA stated the metal at the front right corner of meal tray cart #3 was welded with a different metal and both cart #3 and cart #4 was with brown discoloration, the MA further stated the brown discoloration was corrosion and deterioration.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On July 24, 2024, at 3:13 p.m., during an interview with the RD, she stated her expectation was all the kitchen equipment should be in a safe operating condition, free from corrosion, deterioration and damages. The RD stated rust, peeled paint, or any decomposition on any kitchen equipment should have not been there. The RD further stated rust, peeled paint, vinyl or platic is a food safety hazard that can fall into food and could cross contaminate and cause foodborne illness. A review of the facility policy and procedure titled, Maintenance, undated, indicated, .Kitchen Appliances . inspect all .appliances in the kitchen to determine that they are working properly .are undamaged . A review of the facility policy and procedure titled, Maintenance Service, dated December 2009, indicated, . Maintenance .shall be provided to all areas of the building .and equipment .maintaining .the equipment in a safe and operable manner at all times . A review of the Federal and Drug Administration (FDA) Food Code 2022, 4-101.11 Equipment Characteristics, indicated, .FOOD-CONTACT SURFACES of EQUIPMENT .shall be .(D) to have a smooth, easily cleanable surface and .(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition . A review of the FDA Food Code 2022, Annex 4-501.11 Equipment Good Repair and Proper Adjustment, indicated, .Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed .Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk .

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NAME OF PROVIDER OR SUPPLIER Highland Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Michigan Avenue Beaumont, CA 92223	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50204 Based on observation, interview, and record review, the facility failed to provide a comfortable homelike environment for one of eight residents (Resident 87) when multiple damaged window blinds were observed. This failure had the potential to disrupt the residents' daily living needs and environment. Findings: On July 22, 2024, at 11:30 a.m., during a concurrent observation and interview with Resident 87's room. Multiple damaged blinds were observed. Resident 87 stated it is too bright and she used curtains to block the light coming through the damaged blinds. On July 24, 2024, at 8:19 a.m., during an interview with the Maintenance Supervisor (MS), He stated he was aware about the damaged window blinds in Resident 87's room. He stated, the blinds need to be replaced. On July 24, 2024, at 8:35 a.m., during an interview with the Facility Administrator (FA), the FA stated she was aware that the damaged window blinds needed to be repaired. The FA further stated the blinds should have been replaced or repaired to provide home like environment for the residents. A review of facility policy and procedure titled, Maintenance Service, dated December 2009, indicated, .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .maintaining the building in good repair .