STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Post Acute	320 North Crawford Street Willows, CA 95988

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, the facility failed to maintain a sanitary, comfortable, and homelike environment when: 1. Varnish was worn off the wooden handrails in Unit 1 (hallway between Rooms 27-34 and hallway between Station 1 nurses' desk and patio). 2. Wall paint was scratched or in disrepair in Rooms 6, 10, 30, and 37, and curtains were missing in room [ROOM NUMBER]. These failures violated all (68) facility residents' rights to a clean, comfortable, homelike environment; diminished their quality of life; and increased the potential risk for infection from exposure to germs on uncleanable surfaces. FINDINGS: 1. During a review of Infection Prevention and Control Program (IPCP), revised 10/2018, the policy indicated an IPCP is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection. The policy indicated an important facet of infection prevention includes following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). During a review of the CDC's website page, When and How to Clean and Disinfect a Facility, dated 11/2/22, indicated cleaning and disinfection of wood surfaces are not recommended. (https://www.cdc.gov/hygiene/cleaning/facility.html) During concurrent observation and interview with Environmental Services Director (ES D) on 4/2/24 at 12:13 PM, the reddish-brown varnish present on wooden handrails was worn off the handrails along the Unit 1 hallways. ES D stated handrails are wiped down a minimum of three times a day with Victory spray (a brand-name disinfectant cleaning solution); however, ES D stated the handrails were cleaned more frequently during the COVID pandemic, which she stated ruined the varnish on handrails. ES D acknowledged it is hard to maintain infection control on porous unvarnished wood surfaces. 2. During an observational facility tour on 4/2/24 at 10:25 AM, there were no curtains in room [ROOM NUMBER], and the wall paint was scratched off in several places. (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: 555151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of room [ROOM NUMBER] on 4/3/24 at 10:02 AM, there was an approximately 7-inch by 7-inch circle of paint peeled off to reveal the drywall (a type of board made from plaster, wood pulp, or other material used to form interior walls of houses) over the left side of Resident 25's bed just above bed level. During concurrent observation and interview with Director of Maintenance (DM) on 4/3024 at 3:07 PM, DM stated the walls and curtains were fixed in Rooms 6, 10, 30, and 37, and handrails were in the process of being revarnished.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview and record review the facility failed to provide the necessary care to maintain good grooming and personal hygiene for 3 of 19 (Resident 6, 22, 56) sampled residents when: 1. Resident 6 had an unkept beard and mustache and his nails were long and dirty. 2. Resident 56 's and 22's hair was matted and sticking up. These failure had the potential to result in depression, poor self-esteem, denial of resident rights all of which could lead to negative clinical outcomes for these residents. Findings A review of the facility's policy titled Activities of Daily Living (ADLs), Supporting revised March 2018, indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 1. A review of Resident 6's face sheet indicated Resident 6 was admitted to the facility on [DATE], with diagnoses which included limitation of activities due to disability, muscle weakness, other lack of coordination and dementia. A review of Resident 6's Minimum Data Set (MDS, resident assessment) dated 1/14/24, indicated he required maximal assistance (the helper does more than half the effort) with personal hygiene (combing hair, shaving, washing/drying face and hands). A review of Resident 6's ADL Care Plan dated 1/3/24, indicated Resident 6's ADL care needs will be anticipated and met. There were no interventions with respect to his beard preference. During a concurrent observation and interview in Resident 6's room on 4/2/24, at 10:49 am, Resident 6 was observed lying in bed in a red flannel shirt. He had a white beard and mustache about 1.5 centimeters(cm) long and all different lengths, and His nails were grown about a half a cm beyond the end of all 10 fingers. There was brown material under each nail. Resident 6 stated that he needed to have his nails cut and that he would like to be shaved. During a concurrent observation and interview in Resident 6's room on 4/2/24, at 2:49 pm, Resident 6 indicated He would like to get his beard shaved and nails cut. He stated, It makes me feel horrible. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in the dining room on 4/3/24, at 9:41 am, Resident 6 was sitting in the dining room drinking coffee. He had his same red shirt on with white and brown stains on it. His beard and nails were the same as the day before. Resident 6 stated again that he wanted a shave. Recreation Assistance (RA) was in the dining room giving coffee to residents. RA indicated to the surveyor that Resident 6 had asked her for a shave and haircut, and she confirmed that he needed it. RA indicated that the CNA (Certified Nursing Assistant), was responsible to shave him, and that Resident 6 did not like to have a beard and preferred to be clean shaven because he had been in the military and that was still important to him. The RA stated, The whiskers are driving him nuts. During an interview and record review of the undated shower schedule on 4/3/24, at 9:44 am, with Certified Nursing Assistant (CNA) E, CNA E commented beards and nails are done with their showers. The shower/bath schedule identified that Resident 6's shower days were on Tuesday and Saturdays. CNA E confirmed she gave Resident 6 a shower on Saturday but did not shave him. She stated I do not know if he prefers to grow a beard. I guess I could ask him, but I have never asked him. During an interview on 4/3/24 at 10:00 am, with the Director of Staff Development (DSD), the DSD indicated that Wednesdays were the days the staff would clean and cut the resident's nails. He was unable to provide documentation of this task for any resident. The DSD stated, since October, they were using a new program for task documentation and the nail task should be in there, but it was not. In an interview on 4/4/24 at 9:54 am, the DSD confirmed that there was no care plan for Resident 6 to indicated he wanted to be kept clean shaven and there should have been. He stated, the residents should be asked this question. In an interview on 4/4/24, at 12:10 pm, CNA A and the Infection Preventionist (IP) were unaware of a specific day that nails were supposed to be trimmed or cleaned. 2. A review of Resident 56's face sheet indicated she was admitted on [DATE] with diagnoses of Dementia, Anxiety, lack of coordination and Limitation of Activities due to Disability. Resident 56 was on comfort care (care that aims to keep the resident comfortable). A review of Resident 56's MDS dated [DATE], indicated she was severely impaired for daily decision making. Section GG indicated Resident 56 required full assistance from staff with personal hygiene. A review of Resident 56's ADL care plan dated 11/20/23, indicated her ADL care needs will be anticipated and met. During a concurrent observation and interview in Resident 56's room on 4/2/24, at 12:46 pm, Resident 56 was laying in bed with gown on, and her hair was matted together and sticking up. Licensed Vocational Nurse (LVN) B confirmed that Resident 56's hair needed attention. LVN B indicated she would ask the CNA to brush her hair. A concurrent interview and record review of Resident 56's personal hygiene care documented by the CNA on 4/2/24, indicated personal cares were done at 11:35 am, one hour before the above observation, and not again for the rest of the day. The DSD confirmed the documentation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 22's face sheet indicated she was admitted on [DATE], with the diagnoses of Polymyositis (inflammation of many muscles), heart disease, anxiety, depression, and stroke (poor blood flow to brain causing cell death). Resident 22 was on Hospice (end of life care). A review of Resident 22's change of condition MDS dated [DATE], indicated she was moderately impaired for daily decision making. Resident 22 required full assistance from staff with personal hygiene. A review of Resident 22's ADL care plan revised 2/12/24, indicated Resident 22's ADL care needs will be anticipated and met. During a concurrent observation and interview in Resident 22's room on 4/2/24 at 12:43 pm, Resident 22 was lying in bed and her hair was matted together and sticking up. LVN B confirmed that Resident 22's hair needed to be brushed.

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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 0685

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Assist a resident in gaining access to vision and hearing services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49859

Based on interview, and record review, the facility failed to ensure timely vision services for one of seventeen sampled residents (Resident 416).

This failure resulted in continued vision issues and in Resident 416 feeling like giving up on getting his vision problems addressed.

Findings:

A record review of Resident 416's Minimum Data Set (MDS) (MDS, a resident assessment tool) indicated Resident 416 was admitted on [DATE], with diagnoses including Diabetes (high blood sugar), and Hypertension (high blood pressure). A review of Brief Interview for Mental Status screening (BIMS) (a cognitive assessment) dated 1/6/24, recorded a score of 14 indicating no cognitive impairment.

During an interview on 4/2/24 at 9:30 am, Resident 416 stated he had been at the facility for about a year and has a cataract in his left eye (a condition in which the eye lens becomes opaque, resulting in blurred vision and the leading cause of blindness in adults) that needs treatment, but no appointment had been made for this issue. This made him feel like giving up on getting his vision problems addressed.

During a review of Resident 416's Ophthalmology Consultation (ophthalmology, the branch of medicine dealing with the diagnosis and treatment of eye disorders) dated 8/25/23, the record indicated Resident 416 should be referred for cataract treatment for Quality of Life Enhancement.

During a review of Resident 416's Physician's Transportation Order dated 2/27/24, the record indicated Resident 416 was not referred for cataract treatment until 2/27/24, 6 months after Resident 416's ophthalmology consultation on 8/25/23, more than 1 year after his facility admission.

During an interview and concurrent record review with the Director of Nursing (DON) on 4/4/24 at 11:39 am the DON stated that Social Services usually make dental and vision appointments. The DON stated that the Administrator (ADMIN) delegated the social services work to the desk nurse and the MDS nurse about three months ago. The DON stated Social Services was inconsistent in the previous three months to when the ADMIN delegated the social services work to the desk nurse and MDS nurse. The Physician's Transportation Order, dated 2/27/24, and the Ophthalmology Consultation, dated 8/25/23, were reviewed. The DON stated that the wait between the vision exam on 8/25/23 and the date of referral of 2/27/24 is a long time and that Social Services should have followed up on it.

During a review of the facility's job description titled, Social Worker, dated October 2020, under Duties and Responsibilities the job description states that the Social Worker will:

1.Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident.

2.Coordinate social services activities with other members of the interdisciplinary team (IDT).

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859 Based on interview, and record review, the facility failed to consistently document the location of the pain, failed to administer a dental prescription order for a dental rinse, and failed to follow their pain assessment and management policy and procedure for one of seventeen sampled residents (Resident 416). These failures resulted in dental pain. Findings: During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated March 2020, the document indicated The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying cause of pain. Assessing residents pain including location of pain, and management interventions shall address the underlying causes of the resident's pain. A review of Resident 416's record indicated he was admitted on [DATE] with diagnoses including Chronic Pain, Chronic Obstructive Pulmonary Disease (difficulty breathing), Diabetes (high blood sugar), and Dysphagia (difficulty swallowing). A review of Resident 416's Minimum Data Set (a resident assessment tool used to assess residents' functional capabilities and helps nursing home staff identify health problems), dated 1/6/24, Brief Interview for Mental Status screening (BIMS) (a cognitive assessment tool), recorded a score of 14 indicating no cognitive impairment. A review of Resident 614's Progress Notes for the months of December 2023 through March 2024 (4 months) indicated the facility missed 52 of 70 opportunities to document the locations of Resident 416's pain while administering pain medications. This prevented the facility from recognizing Resident 416's tooth pain and responding by getting dental care for Resident 416 in a timely manner. During a review of Resident 416's Hygiene Notes, dated 6/9/23, the record indicated an order for Chlorhexidine (Chlorhexidine is an antiseptic and disinfectant. It helps reduce the number of germs [bacteria] in your mouth or on your skin. It can help with mouth infections, mouth ulcers and gum disease). During a review of Resident 416's Order Summary Report dated 6/1/23 the record indicated Chlorhexidine was not ordered for Resident 416. During a review of Resident 416's Order Summary Report dated 7/1/23 the record indicated Chlorhexidine was not ordered for Resident 416. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 416's Care Plan dated 1/6/24 the record indicated that Resident 416 is at risk for oral health or dental care problems as evidenced by missing, broken, decaying teeth, Resident 416 will not have any discomfort or chewing problems related to broken, loose or carious teeth and nursing staff will Assess for oral lesions, inflammation and bleeding and signs and symptoms of pain during care and report to the Medical Doctor (MD) During an interview with Resident 416 on 4/2/24 at 9:30 am, Resident 416 stated, he had been at the facility for about a year and his teeth needed to be pulled, but no appointment had been made. During an interview with Resident 416 on 4/3/24 at 9:40 am Resident 416 stated he has tooth pain every day. Some days it is a 10, and some days it is a 3 (on the 0-10 pain scale, with 0 being no pain, and 10 being the worst pain). Resident 416 stated his dental issues make him feel like giving up on getting his bad teeth taken care of. During an interview with Licensed Vocational Nurse D (LVN D) on 4/3/24 at 3:09 pm LVN D stated Resident 416 never had an order for Chlorhexidine. During an interview with Resident 416 on 4/4/24 at 9:43 am Resident 416 stated, he has told a dentist, nurses, and others caring for him at the facility about his tooth pain since he was admitted to the facility in December of 2022, but he feels like they don't listen to him. During a concurrent interview and record review with the Director of Nursing (DON), on 4/4/24 at 11:39 am Resident 416's Progress Notes, dated 3/1/24 to 3/28/24, the records indicated facility staff have not documented the location of Resident 416's pain consistently. The DON confirmed the location of Resident 416's pain was not consistently documented and stated he expects the facility's nurses to document the location of pain when assessing pain and giving pain medication. Order Summary Reports for June and July of 2023 were reviewed and indicated Chlorhexidine was not ordered for Resident 416. The DON confirmed Chlorhexidine was never ordered for Resident 416.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859 Based on interview, and record review, the facility failed to ensure social services arranged to provide dental and vision services for one of seventeen sampled residents (Resident 416). This failure resulted in Resident 416 feeling like giving up on getting his dental and vision problems addressed. Findings: Review of records indicated Resident 416 was admitted on [DATE] with diagnoses including Chronic Pain, Chronic Obstructive Pulmonary Disease (difficulty breathing), Diabetes (high blood sugar), and Dysphagia (difficulty swallowing). A review of Brief Interview for Mental Status screening (BIMS) (a cognitive assessment) dated 1/6/24, recorded a score of 14 indicating no cognitive impairment. During an interview with Resident 416 on 4/2/24 at 9:30 am Resident 416 stated, he had been at the facility for about a year and has a cataract in his left eye (a condition in which the eye lens becomes opaque, resulting in blurred vision and the leading cause of blindness in adults) that needs treatment, and his teeth needed to be pulled, but no appointment had been made for either issue. This made Resident 416 feel like giving up on getting his dental and vision problems addressed. During an interview on 4/3/24 at 9:22 am with Minimum Data Set nurse/Social Services/Licensed Vocational Nurse (MDS/SS B) (Minimum Data Set is a resident assessment tool used by MDS nurses to assess residents' functional capabilities and helps nursing home staff identify health problems), MDS/SS B stated she and another nurse, Minimum Data Set nurse/Social Services/Registered Nurse (MDS/SS A) had been helping in Social Services since December 2023. MDS/SS B stated she and MDS/SS A are helping train a new person for social services. During an interview with MDS/SS B on 4/3/24 at 10:29 am, MDS/SS B stated the former social worker's final day was 2/22/24. During a review of Resident 416's Hygiene Notes dated 6/9/23, the record indicated Resident 416 could benefit from oral appliances due to multiple broken or rotting teeth and Resident 416 was interested in doing this. During a review of Resident 416's Dental Notes dated 11/30/23, the record indicated x-rays (images taken of the bones) were completed of Resident 416's mouth to evaluate the degree of damage to his teeth. During an interview with Director of Nursing (DON) on 4/4/24 at 11:39 am the DON stated Social Services usually make dental and vision appointments. The DON stated that the Administrator (ADMIN) delegated the social services work to the desk nurse and the MDS nurse about three months ago. The DON stated that Social Services was inconsistent in the previous three months to when the ADMIN delegated the social services work to the desk nurse and MDS nurse. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regarding Resident 416's vision services, the DON stated the wait between the vision exam on 8/25/23 and the date of referral of 2/27/24 is a long time and Social Services should have followed up on it. The DON confirmed the 11/30/23 dental services for Resident 416 were not followed up on by Social Services as their policy and procedure calls for. During a review of the facility's job description titled, Social Worker, dated October 2020, under Duties and Responsibilities the job description states that the Social Worker will: 1.Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident. 2.Coordinate social services activities with other members of the interdisciplinary team (IDT).

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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. 41567 Based on observation, interview, and record review, the facility failed to ensure safe administration of medications for four (of seven residents) when: 1. Licensed Vocational Nurse (LVN) C failed to check expiration dates on medications administered to Resident 44, a failure that could have resulted in ineffective medication or adverse reactions to expired medications, and; 2. LVN D failed to confirm the identities of Residents 39 and 60 before administering medications, a failure that could have resulted in administration of medications to the wrong residents with the potential for harmful health outcomes, and; 3. Eye drops different from those ordered were found to have been pulled from over-the-counter stock for Resident 38, a failure that could have resulted in harmful health outcomes. Findings: A facility policy titled, Administering Medications, rev. April 2019, was reviewed which indicated that individuals administering medications verify the resident's identity, the medication, the dosage, the time, and the route before giving the resident his/her medications, and that the expiration date on the medication label is checked prior to administration. 1. Resident 44 was admitted to the facility with diagnoses which include essential primary hypertension (an abnormal increase in blood pressure [the force required to pump blood through the arteries], which is not caused by a medical condition) and a history of myocardial infarction (death of heart muscle tissue due to decreased blood flow, usually from an obstruction in a vessel). During a medication pass observation dated 4/3/24 at 8:45 am, LVN C was asked to point out on a medication label what she checks before administering medications. LVN C stated, and pointed to type on the label while stating, I check their name, the medication, the route, the dose, and look at the instruction. She then proceeded to provide the Resident 44 the following medications, and was not observed to check the expiration dates: PreserVision AREDS one capsule by mouth for macular degeneration (a condition that effects central vision and can lead to partial blindness); Cyanocobalamin (a synthetic form of vitamin B12) 1000 micrograms (mcg, a unit of measure) one tablet by mouth for supplement; Vitamin D 25 milligram (mg, a unit of measure) one tablet by mouth for supplement; Senna 8.6 mg, one tablet by mouth for constipation; (continued on next page)

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Memantine HCl 5 mg, one tablet by mouth for dementia with behavioral disturbance (a form of dementia [a condition that affects brain functions such as memory, language, thinking, or behavior] that includes verbal and/or physical aggression and/or wandering);

Zoloft 25 mg 1 tablet by mouth for major depressive disorder (a persistent depressive state) as evidenced by verbalization of sadness.

In an interview on 4/3/24 at 9:30 am, LVN C confirmed she had not checked the expiration dates on the medications.

A review was made of an order summary report for Resident 44 which contained an order dated 3/23/23 for PreserVision AREDS one capsule by mouth two times a day for macular degeneration; an order dated 12/1/23 for cyanocobalamin 1000 mcg one tablet by mouth one time a day for supplement; an order dated 3/11/24 for vitamin D 25 mg one tablet by mouth one time a day for supplement; an order dated 7/12/23 for senna 8.6 mg, one tablet by mouth one time a day for constipation; an order dated 6/15/22 for memantine HCl 5 mg, one tablet by mouth one time a day for dementia with behavioral disturbance; an order dated 1/10/24 for Zoloft 25 mg by mouth one time a day for major depressive disorder as evidenced by verbalization of sadness.

A review was made of a medication administration record (MAR) for Resident 44 in which LVN C documented administering: PreserVision AREDS one capsule by mouth on 4/3/24 at 8:57 am; cyanocobalamin 1000 mcg one tablet by mouth on 4/3/24 at 8:57 am; vitamin D 25 mg one tablet by mouth 4/3/24 at 8:57 am; senna 8.6 mg, one tablet by mouth 4/3/24 at 8:58 am; memantine HCl 5 mg, one tablet by mouth 4/3/24 at 9 am; Zoloft 25 mg by mouth 4/3/24 at 9 am.

During a concurrent interview and record review on 4/4/24 at 1 pm, the Director of Nurses (DON) acknowledged that LVN C had not checked the expiration dates when administering medications and confirmed that expiration dates need to be checked before giving them as expired medications can be ineffective or cause adverse effects.

2. Resident 39 was admitted to the facility with diagnoses which include paraplegia (inability to move the lower legs), adult failure to thrive (a state of decline due to poor nutrition, inactivity, depression and decreasing functional ability), and gastroesophageal reflux disease (GERD, a condition in which acidic stomach contents backflow from the stomach and into the throat).

Resident 60 was admitted to the facility with diagnoses which include diabetes mellitus (a chronic [long-lasting] disorder that affects how the body converts food into energy) and fractures of the lumbosacral spine and pelvis (bones of the lower part of the back and pelvis that were broken, usually due to an accident).

During two medication passes on 4/4/24, the following observations were made:

At 11:14 am, LVN D administered the following three medications to Resident 39, and failed to confirm identity:

- metoclopramide (commonly used for nausea/vomiting for patients with GERD) 10 milligram (mg, a unit of measure) I tablet by mouth.

(continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- simethicone (commonly used for gas/bloating) 80 mg by mouth. - nicotine (commonly used for nicotine addiction) lozenge 1 chewable tablet by mouth. At 11:22 am, LVN D administered the following medication to Resident 60, and failed to confirm identity: - gabapentin (commonly used to treat pain secondary to nerve damage) 100 mg, two capsules by mouth. In an interview immediately after administering medication to Resident 60, LVN D acknowledged he had not checked identity. A review was made of an order summary report for Resident 39 which contained orders dated 12/19/23 for metoclopramide 10 mg 1 tablet by mouth before meals for gastrointestinal (GI) support; simethicone 80 mg by mouth four times a day for GI support; nicotine polacrilex mini mouth/throat lozenge give 1 dose by mouth every 2 hours as needed for smoking cessation. A review was made of a medication administration record (MAR) for Resident 39 in which LVN D documented administering the metoclopramide, simethicone, and nicotine lozenge on 4/4/24 at 11:14 am. A review was made of an order summary report for Resident 60 which contained an order dated 2/26/24 for gabapentin 100 mg give 2 capsules by mouth three times a day for neuropathy (nerve pain). A review was made of a medication administration record (MAR) for Resident 60 in which LVN D documented administering the gabapentin on 4/4/24 at 11:22 am. During an interview dated 4/4/24 at 11:25 am, the DON confirmed nursing should identify resident names before administering medications and listed possible outcomes of failing to do so including that medications may not be given to the right patient. 3. Resident 38 was admitted to the facility with diagnoses which include diabetes mellitus, and heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for nutrients and oxygen). A concurrent observation, and interview, was made during the inspection of medication cart number 4 with Licensed Vocational Nurse (LVN) C on 4/3/24 at 9 am, when it was found that a bottle of Visine dry eye drops was found with the hand-written first and last initials of Resident 38. LVN C stated that the eye drops were over the counter medications that had been pulled from general stock. During a record review of an order summary report for Resident 38 it was found that there was no order for Visine dry eye drops; there was instead an order dated 11/21/23, for Refresh Tears Opthalmic solution (carboxymethylcellulose sodium), instill 2 drops in both eyes every 6 hours as needed for redness/itching, as needed. During a concurrent interview, and record review, dated 4/4/24 at 2:30 pm, the DON confirmed Resident 38 was given the wrong eye drop medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41567 Based on observation, interview, and record review, the facility failed to ensure accurate labeling of medications for two (of seven) residents, when: 1. The label for clonidine (a medication to control blood pressure, which is a measurement of the pressure of blood pushing against the arteries as it is pumped through the body) contained partial instructions, a failure with the potential for the medication being given inappropriately which may lead to a dangerously slow heart rate; and, 2. Eye drop solution Visine dry eye relief taken from general stock and used for Resident 38 was found to have been labeled with the resident's first and last initials, and not her name, a failure with the potential for confusion as to the intended recipients and the potential for cross contamination (the transfer of harmful bacteria from one source to another) which could lead to poor health outcomes. Findings: A facility policy titled, Medication Labeling and Storage, rev. February 2023, was reviewed which indicated that medication labels must include appropriate resident names, instructions and precautions, in addition to prescribed dose, strength, route, and expiration date where applicable. 1. Resident 44 was admitted to the facility with diagnoses which include essential primary hypertension (an abnormal increase in blood pressure [the force required to pump blood through the arteries], which is not caused by a medical condition) and a history of myocardial infarction (death of heart muscle tissue due to decreased blood flow, usually from an obstruction in a vessel). During a medication pass observation dated 4/3/24 at 8:45 am, Licensed Vocational Nurse (LVN) C took a blood pressure reading of 138/78 and a heart rate of 52 for Resident 44. She stated she was going to hold Resident 44's clonidine because the heart rate was less than 60. It was noted that the instructions on the label applied to the medication was incomplete; there was instruction to hold the medication for a systolic (a measurement of the blood pressure in the arteries during a heartbeat) blood pressure (SBP) under 100, but there was no instruction regarding the heart rate. A review was made of an order summary report for Resident 44 which contained an order for clonidine HCl 0.1 milligram (mg, a unit of measure), give one tablet by mouth two times a day related to essential primary hypertension, hold for SBP less than 100 and/or heartrate less than 60. A review was made of a medication administration record (MAR) for Resident 44 in which LVN C documented holding the clonidine. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/4/24 at 8:15 am, the Director of Nurses (DON) stated, the MAR should always match the medication exactly and if a nurse read the instructions on the medication but not the instructions on the MAR, they could give the medication and cause a low heart rate. 2. Resident 38 was admitted to the facility with diagnoses which include diabetes mellitus (a chronic [long-lasting] disorder that affects how the body converts food into energy) and heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for nutrients and oxygen). A concurrent interview, and observation, was conducted on 4/3/24 at 9 am, during an inspection of medication cart number 4 with Licensed Vocational Nurse (LVN) C. An opened container of Visine dry eye drops was found with hand-written first and last initials of Resident 38. LVN C stated that the eye drops were over the counter medications that had been pulled from general stock. During a concurrent interview, and record review, on 4/4/24 at 1 pm, the DON stated, this will get fixed today, and that using only initials on medications could cause the medications to be given to the wrong residents with similar initials.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859 Based on interview, and record review, the facility failed to ensure timely dental services for one of seventeen sampled residents (Resident 416) when he complained of tooth pain. This failure resulted in continued dental pain and in Resident 416 feeling like giving up on getting his bad teeth treated. Findings: A review of Resident 416's record indicated he was admitted on [DATE], with diagnoses including Chronic Pain, Chronic Obstructive Pulmonary Disease (difficulty breathing), Diabetes (high blood sugar), and Dysphagia (difficulty swallowing). A review of Brief Interview for Mental Status screening (BIMS) (a cognitive assessment) dated 1/6/24, recorded a score of 14 indicating no cognitive impairment. During an interview on 4/2/24 at 9:30 am, Resident 416 stated he had been at the facility for about a year and his teeth needed to be pulled, but no appointment had been made. During a review of Resident 416's Hygiene Notes dated 6/9/23, the document indicated Resident 416 could benefit from oral appliances due to multiple broken or rotting teeth and Resident 416 was interested in doing this. The record also indicated Resident 416 was prescribed a Chlorhexidine dental rinse (Chlorhexidine is an antiseptic and disinfectant. It helps reduce the number of germs [bacteria] in your mouth or on your skin. It can help with mouth infections, mouth ulcers and gum disease). During an interview on 4/3/24 at 9:40 am, Resident 416 stated he has tooth pain every day. Some days it is a 10 and some days it is a 3 (on the 0-10 pain scale, with 0 being no pain, and 10 being the worst pain). Resident 416 stated his dental issues make him feel like giving up on getting his bad teeth taken care of. During an interview on 4/3/24 at 9:50 am with Minimum Data Set/Social Services Nurse (MDS/SS B) (Minimum Data Set is a resident assessment tool used by MDS nurses to assess residents' functional capabilities and helps nursing home staff identify health problems), MDS/SS B stated that the dental service sends the results for authorization for further treatment after the dentist and x-ray specialist review the exam and x-rays, and it can take 6-8 weeks. It was 4 months (16 weeks) from the date of the last dental exam on 11/30/23 to the date of the interview with MDS/SS B on 4/3/24. During an interview on 4/3/24 at 10:00 am with the Director of Nursing (DON), the DON confirmed that Social Services (SS) usually coordinates dental care for residents and that the expectation for the time between an exam and follow up on dental issues depends on if there is pain or not. The DON stated they will make appointments right away if the resident is having pain. The DON confirmed Social Services should have followed up on Resident 416's dental consultation to ensure Resident 416 got dental treatment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/24 at 9:43 am Resident 416 stated he has told a dentist, nurses, and others caring for him at the facility about his tooth pain since he was admitted to the facility in December of 2022, but he feels like they don't listen to him. During a review of Resident 416's Dental Notes dated 11/30/23, the document indicated x-rays (images taken of the bones) were completed of Resident 416's mouth to evaluate the degree of damage to his teeth. No further dental records were available after 11/30/23. During an interview with the DON on 4/4/24 at 11:39 am the DON stated that Social Services was responsible for making dental and vision appointments. The DON stated that the Administrator (ADMIN) delegated the social services work to the desk nurse and the MDS nurse about three months ago. The DON stated Social Services was inconsistent in the previous three months to when the ADMIN delegated the Social Services work to the desk nurse and MDS nurse. During a review of the facility's job description titled, Social Worker, dated October 2020, under Duties and Responsibilities the job description states that the Social Worker will: 1.Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident. 2.Coordinate social services activities with other members of the interdisciplinary team (IDT).

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49418 Based on observation, interview, and record review, the facility failed to ensure the competency of the Dietary Services Supervisor (DSS) and maintain a full-time Registered Dietitian (RD). This deficient practice did not ensure there was effective oversight of day-to-day dietetic services operations and had the potential to put all residents at risk for unmet nutritional needs, weight gain/loss, and foodborne illness. Findings: During a review of Dietary Services Manager Coverage, dated 10/1/2023 to 3/31/2024, the record indicated a full-time (40 hours/week) RD started 3/24/2024, with Dietary Manager coverage less than 40 hours/week for 20 of 26 weeks: - Weeks of 10/1/2023 to 10/29/2023: 36 hours (4 days) - Weeks of 11/5/2023 to 11/19/2023: 30 hours (3 days) - Weeks of 12/31/2023 to 1/7/2024: 36 hours (4 days) - Weeks of 1/14/2024 to 2/18/2024: 30 hours (3 days) - Week of 2/25/2024: 16 hours (2 days) - Week of 3/3/2024: 32 hours (4 days) - Weeks of 3/10/2024 to 3/17/2024: 36 hours (5 days) During a review of Sanitation and Food Safety Checklist (a checklist tool for RD use to perform monthly Dietary Services audits), dated 10/17/23, the record indicated: - Healthcare Services Group Dietary Manager (CDSS) was present at the facility to cover the Dietary Manager position while the cook received Certified Dietary Manager credentialing. - The Dietary Manager was working on completing competencies of kitchen staff. - No Registered Dietitian approval signature was present on menu substitutions records from 9/10/23 to 10/17/23 . During a review of Kitchen Observation, dated 10/25/2023, the record indicated the kitchen was audited with observations focused on practices that might indicate potential for foodborne illness with the following results: (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Issues were found with labeling/dates: Items not always labeled consistently with same number of days by staff. - Continued maintenance repair opportunities: under dish machine/sink. - The facility did not have a written policy that honors resident preferences safely. During a review of Facility Inspection Report, Discipline: Dietary, dated 3/29/2024, the record indicated: - No Quality Assurance (QA) was in place to see if residents were consuming physician-ordered nutritional supplements. - The facility did not have a Dining Committee that meets quarterly. - Menu was not followed as posted. Test Tray completed on 3/29/2024 had alternate vegetable. - Cool down log not used accurately. No entry since 3/2/2024. - Test Tray on 3/29/2024 was delivered at safe but not desirable temperatures. - Skill checks on file for all food service workers were not up to date. - Inadequate supply of food based on licensed bed capacity. During a concurrent observation and interview on initial kitchen tour with Registered Dietitian A (RD A) on 4/2/2024 at 08:57 AM, RD A stated she was hired three weeks ago and was here every day (full time). RD A stated the facility's Dietary Services Supervisor (DSS) position was in transition at the present time, and a Corporate DSS (CDSS) was the acting dietary manager while DSS A was on leave. During observation of the walk-in freezer, there was an open cardboard box of dough balls. The plastic bag inside the box containing the dough was open, and the dough was uncovered within the box. RD A acknowledged that the dough should not be exposed but rewrapped in a protective covering (e.g., freezer-safe bag) within the box. During an interview with the Administrator (ADMIN), RD A, and RD B on 4/3/2024 at 3:10 PM, ADMIN confirmed the facility did not hava a qualified DSS and and a full time RD.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49418 Based on observation, interview, and record review, the facility failed to consistently incorporate resident preferences for 8 of 68 sampled residents (Residents 31, 28, 51, 41, 56, 416, and two confidential residents) in personal dietary choices. This failure had the potential for all facility residents to eat less food, leading to the potential for weight loss and unmet nutritional needs. Findings: During a review of Skilled Nursing Facility (SNF) Clinic, Resident Food Preferences, Dietary Services, revised 7/2017, the record indicated: - The dietitian or nursing staff will identify a resident's food preferences within 24 hours after his/her admission. - Staff will interview the resident directly, when possible, to determine current food preferences based on history and life patterns related to food and mealtimes. - The Food Services Department will offer a variety of foods at scheduled meals as well as access to nourishing snacks throughout the day and night. - The facility's Quality Assessment and Performance Improvement (QAPI) Committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc. - Therapeutic diets will be ordered only after the resident or representative agrees with and consents to such a diet. - The resident has the right not to comply with therapeutic diets. - If the resident refuses or is unhappy with their diet, the staff will create a care plan that satisfies the resident. During a review of Facility Inspection Report, dated 3/29/24, the record indicated the facility did not have a Dining Committee. The record also indicated the facility had an inadequate supply of food based on licensed bed capacity. During a review of Resident Council Minutes, dated 3/22/24, the record indicated: - 2 of 13 residents (names not provided) in attendance stated they were receiving dislikes on their meal trays. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2 of 13 residents (names not provided) in attendance stated they had not received butter on their meal trays for three weeks. During a review of Resident Council Concern Response Form, dated 3/22/24, the record indicated 'Investigation/Actions' included a staff in-service training on meal preferences and the difference between margarine and butter. During an interview on 4/2/24 at 9:15 AM, Resident 31 stated she likes Jell-O but that the facility buys pre-made Jell-O that's like rubber. During an interview on 4/2/24 at 10:15 AM, Resident 28 stated he wished his food had more spice in it. During an interview on 4/2/24 at 11:03 AM, Resident 51 stated hot chocolate is served lukewarm. Resident 51 stated, You want your hot chocolate to be hot, not cold. Resident 51 stated snacks are not always available on the weekends, adding, Someone did come and give me candy. That is not acceptable. During an interview on 4/2/24 at 11:24 AM, Resident 41 stated sometimes the facility runs out of snacks, noting, Sometimes they have them, sometimes they don't. Resident 41 stated snacks offered are Jell-O or a fruit cup, only canned sugary fruit and processed food, no fresh fruit. Resident 41 stated, I wish they offered string cheese or crackers. Resident 41 stated he cannot deal with the chicken the way it is cooked. Resident 41 stated residents were made aware a new dietitian had been hired at the facility and stated, Things have changed since she got here, adding, but they can do better. During a concurrent observation and interview with Licensed Vocational Nurse D (LVN D), observed the Nourishment Refrigerator (a mini refrigerator that contains snacks for residents) in the Unit 1 Medication Room which contained 4 blue Jell-O cups, 10 store-bought diced peach/pear cups, and four 6-ounce apple juice boxes. LVN D stated, That's not a lot of options. Sandwiches aren't stocked right now. LVN D stated prepackaged dried snacks (e.g., crackers, chips, cookies) were not readily available on Unit 1, and he would go to the kitchen and request snacks if they were not available in the Nourishment Refrigerator. During an interview with Resident 25 on 4/3/24 at 10:02 AM, Resident 25 stated fruit is typically canned or prepackaged and residents have to ask for fresh fruit if they want anything other than a banana. During a concurrent observation of ordered snack delivery tray and record review of Snack Summary - Week of 4/4/24 on 4/3/24 at 10:30 AM, the record indicated Resident 56 should get Chocolate Pudding, 0.5 cups for the 10:00 AM snack. However, chocolate was crossed out on the label of Resident 56's pudding cup, and vanilla pudding was substituted. During a concurrent observation and interview in the kitchen with COOK A, Registered Dietitian A (RD A), Corporate Dietary Services Supervisor (CDSS), and RD B on 4/3/24 at 10:35 AM: - Observed COOK A making 10 bologna sandwiches. COOK A stated she was making the sandwiches for snacks, noting, I do that when the Activities Director asks. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- RD A stated the kitchen closes at 8:00 PM but the Nourishment Refrigerator has snacks for residents at all hours. - RD A stated, We address [food] issues if they're brought up in Resident Council. RD A stated if there are complaints, we'll fix it and change what we offer. - RD A stated chips and fresh fruit, other than bananas, are not offered but she is working on getting more fresh fruit. - Observed dietary ticket on Resident 416's tray indicating 2 Butter Packets.' Tray contained two 5-gram (unit of measure) packets of Gold-N-Sweet Whipped Spread. RD A stated the facility only ordered margarine for resident food trays. RD A stated the facility stocks large blocks of butter for cooking (observed in the kitchen refrigerator). RD A stated Resident 416's diet was a no-added-salt, diabetic diet. RD A stated, I don't see why they can't have butter. During a review of a Foods Product Specification Sheet for whipped spread dated 2024, ingredients are: - Water, - liquid and hydrogenated (charged with hydrogen, changes liquid into solid) soybean oil, - palm oil, - less than 2% of salt, - vegetable mono & diglycerides, - potassium sorbate (a preservative), - citric acid (increases shelf life), - natural & artificial flavor, - beta carotene (color), and - vitamin A (vitamin supplement) added. During a review of Snacks Available to Residents, (undated), the record indicated food items to include graham crackers, saltine crackers, applesauce, vanilla and chocolate ice cream, vanilla and chocolate pudding, Jell-O, cookies, cereal, chips, bananas, peaches, fruit cocktail, chilled peaches, deli sandwich, and egg salad sandwich. During an interview with ADMIN, RD A, and RD B on 4/3/24 at 3:10 PM, RD A stated, We stock [the Nourishment Refrigerator] based on what we hear from Resident Council. RD A stated she was in the process of interviewing residents now about preferences and added, We're checking preferences weekly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49418 Based on observation, interview, and record review, the facility failed to maintain kitchen equipment in accordance with professional standards for food service safety when: 1. A slimy, brown-pink substance was found inside the holding tray of the facility's icemaker. 2. Dirty dishwasher water from the dishwasher's air gap (directs dirty dishwater from a pipe in the dishwasher to a drain in the floor to prevent it from backing up onto clean dishes) was splashing onto floor tiles next to the drain. 3. A kick plate at the bottom of an oven/stove unit was missing, exposing wires and other internal parts. These failures created safety issues for staff and had the potential to cause avoidable food- or waterborne illness for all 68 facility residents. Findings: 1. During a review of Infection Prevention and Control Program (IPCP), revised 10/2018, the policy indicated an IPCP is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection. The policy indicated an important facet of infection prevention includes following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). During a review of the facility's Sanitation policy, revised 11/2022, the policy indicated ice machines and ice storage containers are to be drained, cleaned, and sanitized per manufacturer's instructions. During a review of the Maintenance Department's Logbook Documentation, dated 3/27/24, the record indicated Director of Maintenance (DM) had sanitized the interior of the ice machine and cleaned and sanitized the ice bin. During a concurrent observation and interview with DM on 4/3/24 at 8:35 AM, DM stated he had recently (last week) sanitized the icemaker, which he does monthly. During observation, a white cloth was wiped over the interior of the ice machine where ice drops into a black container. A slimy, brown-pink substance was present on the white cloth after wiping the container. DM stated that the substance should not be there, and cleaning should be increased to more often than once a month. 2. During a review of Kitchen Observation, dated 10/25/23, the record indicated the kitchen was audited for practices that might indicate potential for foodborne illness with the following results: - Continued maintenance repair opportunities under dish machine. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Willows Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 320 North Crawford Street Willows, CA 95988	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview with Registered Dietitian (RD A) at initial kitchen tour on 4/2/2024 at 8:57 AM, milky, gray-colored water splashed from the dishwasher air-gap pipe partially into the floor drain and partly onto the floor. The water was observed pooling on cracked floor tiles under a metal counter. RD A confirmed water should all flow into the drain and should not contact floor tiles. During an interview with DM on 4/2/24 at 11:24 AM, DM stated he was unaware the dishwasher's air gap was draining onto the floor. DM agreed water should only go into the drain and stated he had just (this morning) fixed the air gap by correcting the direction of all waterflow from the dishwasher pipe to the drain. 3. During an observation on initial kitchen tour on 4/2/24 at 08:57 AM, observed an oven/stove kick plate to be missing. Observed exposed internal wires, gas lines, and other parts which would be covered by the kick plate. During a concurrent interview and record review with RD A on 4/4/24 at 9:10 AM, RD A stated Maintenance was aware of the missing kick plate and had ordered the part. RD A produced an invoice dated 4/2/24, which indicated a kick plate had been ordered by DM.

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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** 41567 Based on observation, interview and record review, the facility failed to ensure an infection prevention system was implemented when: 1. Medical supplies were found in dirty condition on the floor, and the sink, soap dispenser and towel dispenser were found in dirty condition, in the medication room. 2. Resident 316 was allowed to store and wash her soiled laundry in a shared bathroom that had the potential to spread infection to one of three Residents (Resident 44). 3. Certified Nursing Assistant (CNA) E failed to do hand hygiene with two of two Residents (Resident 15 and 50) when CNA E assisted Resident 15 to the toilet, wiped her, helped her put on clean pullups(disposable underwear) and then assisted with Resident 50 without doing hand hygiene. These failures had the potential for cross contamination (the transfer of bacteria from one source to another). Findings: 1. A review was made of a facility policy titled, Infection Prevention and Control Program, rev. October 2018, which indicated that the program was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of diseases and infections. During an inspection of the medication room, a concurrent observation, and interview, was conducted with the Director of Nurses (DON) on 4/4/24 8:25 am. Packages of medical supplies were observed on the floor under a cart; upon removal they were found to be two packages of intravenous administration tubing and one package of suction tubing. The sink and soap dispenser were noted to have layers of dust and had dried drips of hardened material; the towel dispenser was also dusty. The DON confirmed that the both the equipment and the products were dirty and could cause cross contamination. 43755 2. A review was made of the facility's undated Policy titled Departmental Laundry and Linen which indicated to consider all soiled linen to be potentially infectious And, that all soiled linen must be placed directly into a covered laundry hamper The policy also indicated not to sort or pre-rinse soiled linens in resident-care areas. A review of Resident 315's face sheet indicated she was readmitted to this facility on 8/28/23 with diagnoses of Lung Disease, Stroke (a medical condition in which poor blood flow to the brain causes cell death) affecting the right non-dominant side (right side was weak) and depression. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 315's Quarterly Material Data Set (MDS, A clinical assessment) dated 3/24/24, indicated Resident 315 scored a 13 on her Brief Interview for Mental Status (BIMS, a cognitive test 1-15) revealing she was cognitively intact. Section GG of the MDS indicated she was able to wheel herself around in her room with little assistance from staff. A review of Resident 44's face sheet indicated she was admitted to this facility on 6/14/22 with diagnoses of Lung disease, Dementia, Depression and Heart Disease. A review of Resident 44's Quarterly MDS dated [DATE] indicated Resident 44 scored a 10 on the BIM's indicating she was moderately cognitively impaired. Section GG of her MDS indicated she was able to wheel herself around her room independently. During an observation in Resident 316's, and Resident 44's shared bathroom on 4/2/24, at 10:01 am, a basin with black, white and tan clothes piled high above the rim of the basin and touching the plumbing was observed on the floor under the sink. Laundry detergent was also observed on the floor. During a concurrent observation and interview with Environmental Services (ES) C, on 4/2/24, at 10:07 am, Resident 316's and Resident 44's shared bathroom was observed. ES C confirmed that there was soiled laundry in an open basin on the floor of this bathroom. She stated I always see her (Resident 316) doing her laundry in the sink. I do not know why they let her do her laundry here. During an interview with Resident 44 on 4/2/24, at 11:01 am, Resident 44 stated she used the same bathroom as Resident 316 and that Resident 316 kept her soiled laundry in there and washed them in the sink. During an interview with Resident 316 on 4/2/24, at 11:20 am, Resident 316 confirmed that her soiled laundry was stored in an open basin on the floor under the sink in the bathroom. She stated she washed her under garments, nylons, shirts and blouses in the sink and hung them up to dry. During an interview with ES D on 4/2/24, at 11:30 am, ES D confirmed that she knew Resident 316 had done her own laundry in her bathroom. ES D was unsure of infection control policies concerning this practice. During an interview with the Infection Preventionist (IP) on 4/3/24, at 2:11 pm, the IP confirmed that Resident 316 did her laundry in a shared sink and that there was always a chance of cross contamination. The IP stated Resident 316 should be storing her soiled clothes in her own room and not in a shared bathroom. 3. A review was made of the facility's policy titled Handwashing/Hand Hygiene revised August 2019, which indicated the facility considered hand hygiene the primary means to prevent the spread of infections. The policy interpretation indicated that the use of alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: Before and after direct contact with residents; Before moving from a contaminated body site to a clean body site during resident care; and after removing gloves. A review of Resident 15's face sheet indicated she was admitted to this facility on 7/31/23 with the diagnoses of Diabetes (disease with sustained high blood sugar in the blood), lung disease, repeated falls and schizophrenia (mental disorder). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 15's MDS Quarterly MDS dated [DATE], indicated Resident 15 scored a 10 on the BIM's indicating she was moderately cognitively impaired. Section GG documented she required full assistance with toileting (cleaning and wiping herself after using the bathroom). A review of Resident 50's face sheet indicated she was admitted to this facility on 5/26/23 with diagnoses of Lung Disease, Heart Disease, Stroke, and Dementia. A review of Resident 50's Quarterly MDS dated [DATE], indicated she was severely cognitively impaired and was dependent with toileting. During an observation on 4/3/24, at 9:19 am, in Resident 15's room, CNA E was observed assisting Resident 15 to the toilet. With goves on CNA E: *Walked Resident 15 to the bathroom. *Took off Resident 15's soiled brief (a type of disposable underware that catches urine) and put it in a bag. *Wiped and cleaned Resident 15 after she urinated. *Took off her gloves. Without doing hand hygiene CNA E: *Helped Resident 15 walk back to the bed. *Obtained a clean pullup from Resident 15's closet. *Put the pullup on Resident 15. *Touched the bedside control and adjusted the bed and covers for the Resident 15. *Went over to the other resident in the room (Resident 50) and pulled back the covers to see if her brief was soiled. *Confirmed the brief was not soiled and pulled the covers up over the shoulders and around the face of Resident 50. CNA E left the room, walked down the hall to throw away the bag with the brief in it then did hand hygiene by using an alcohol-based hand rub. During an interview on 4/3/24, at 9:30 am, CNA E confirmed that she had not done hand hygiene after wiping and cleaning Resident 15, taking her gloves off or after she went from one resident to another, and she should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/24, at 9:46 am, the IP confirmed CNA E should have done hand hygiene after removing her gloves and before going from one resident to another to prevent cross contamination.