STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555164	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Rehabilitation & Nursing Center	900 North Church Street Lodi, CA 95240

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 32096 Based on observation, interview, and record review, the facility failed to ensure one of 26 sampled residents (Resident 72's) dignity was protected when the urine drainage bag was exposed to public view. This failure resulted in Resident 72 feeling embarrassed. Findings: Review of Resident 72's ADMISSION RECORD, indicated the resident was admitted to the facility recently with diagnoses that included prostate gland enlargement that could cause urination difficulty. In a concurrent observation and interview on 8/19/24 at 8:58 a.m. in the resident's room, Resident 72 was in bed with his urine drainage bag hanging at the side of the bed facing toward the hallway. The door of the resident's room was wide open. The urine drainage bag contained yellow urine, was exposed, and visible from the hallway. Infection Preventionist (IP) verified Resident 72's urine drainage bag was exposed and stated it should have been covered with the dignity bag to protect the resident's dignity. In an interview on 8/21/24 at 12:07 p.m. in the Director of Nursing (DON's) room, the DON acknowledged, in the presence of the Assistant DON, the urinary drainage bag should have been covered for Resident 72. In an interview on 8/22/24 at 9:10 a.m. in Resident 72's room, Resident 72 indicated that he wanted his urine bag to be covered with the blue bag [dignity bag]. The resident stated, It's embarrassing without the blue bag.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 29825 Based on observation, interview and record review, the facility failed to accommodate resident needs when call lights were inaccessible for three of 26 sampled residents. A. Resident 479 B. Resident 65 C. Resident 1 This failure prevented the residents from getting help as quickly as possible when experiencing pain, discomfort or for any emergency needs. Findings: A. Resident 479 was admitted to the facility in the summer of 2024 with diagnoses which included multiple fractures, repeated falls and need for assistance with personal care. During a review of Resident 479's Progress Notes [PO], dated 8/14/24, the PO indicated, admitted to [name of hospital] hospital for recurrent ground-level falls. It appears .possibly precipitated by orthostatic hypotension and syncope [a sudden drop in blood pressure when standing up from a seated or lying position] .now admitted to SNF for rehabilitation .Plan .Implement fall prevention strategies . During a review of Resident 479's Care Plan titled, At risk for falls and injuries r/t [related to] .Medications .Hx [history of] repeated falls, dated 8/14/24, the CP indicated, Keep call light within reach . During a review of Resident 479's Minimum Data Set (MDS, an assessment tool), dated 8/19/24, the MDS indicated he was alert and oriented, able to make his needs known. He required partial to moderate assistance with personal hygiene, showering and dressing. During an initial tour observation on 8/19/24 at 9:38 a.m., Resident 479 was observed lying on his back in bed with his call light hooked to the wall, not within reach. He did not answer coherently when spoken to. During a concurrent observation and interview on 8/19/24 at 9:40 a.m. with Licensed Nurse (LN) 9, LN 9 verified the observation and said, It [call light] should be within reach . During an interview on 8/20/24 at 10 a.m. with the Director of Nurses (DON), the DON was asked about her expectations regarding the call light and said, My expectation is that the resident call light should be in reach at all times. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. During a review of Resident 65's Admission Record, he was admitted in the facility on 9/26/20 with diagnoses which included hemiplegia and hemiparesis (hemiplegia is paralysis of one side of the body; hemiparesis is one-sided muscle weakness) following cerebral infarction (brain obstruction) affecting left non-dominant side, acute respiratory failure with hypoxia (lack of oxygen in the body) and pain in right shoulder. During a concurrent observation and interview inside the room of Resident 65 on 8/19/24 at 9 a.m., Resident 65 was lying on his bed, awake, and his call light was found looped and hung by the wall away from his reach. When asked if he could find his call light, Resident 65 responded, I don't know where it's at. Certified Nursing Assistant 1 (CNA 1) confirmed the call light was looped and hung by the wall away from Resident 65's reach. CNA 1 stated, Yes, it should be within his reach so he can call for help anytime. During a review of Resident 65's Care Plan, dated 9/26/20, indicated, Self-Care Deficit As Evidence by: Needs one person max assistance with ADLs [activities of daily living] Related Dementia, CVA [stroke], Weakness. During a review of Resident 65's Care Plan, dated 12/25/23, indicated, The resident has impaired function/dementia or impaired thought processes r/t [related to] vascular Dementia [can cause problems with memory, speech or balance], Hx [history] of BIMS [Brief Interview for Mental Status, evaluates mental impairment] score <13 [indicates cognitive impairment]. C. During a review of Resident 1's Admission Record, he was admitted in the facility on 12/15/17 with diagnoses which included hemiplegia affecting right dominant side and left non dominant side, generalized epilepsy [seizures] and pain in left wrist. During a review of Resident 1's MDS the BIMS indicated Resident 1 was moderately cognitively impaired and Section G indicated he was dependent on staff for assistance with activities of daily living. During a concurrent observation and interview inside the room of Resident 1 on 8/19/24 at 9 a.m., Resident 1 was lying on his bed, awake, partially covered with white linen, and yelled I'm cold, I'm cold. His call light was found on the floor away from his reach. CNA 1 confirmed the call light was on the floor away from Resident 1's reach. CNA 1 stated, Yes, his call light should be near him on his bedside so he can press the button. During an interview on 8/22/24 at 10:30 a.m., with the Assistant Director of Nursing, (ADON), the ADON stated, The location of the call lights should be within reach for all residents and the staff must make sure that they are in place. During a review of Resident 1's Care plan, dated 4/27/20, indicated, Acute Urinary Condition of painful urination. During a review of Resident 1's Care Plan, dated 4/17/19, indicated, Resident at risk for choking/aspiration due to edentulous [lacking teeth]. During a review of Resident 1's Care Plan, dated 12/15/17, indicated, Self-Care Deficit As Evidence by: Needs 1-2 person max to total assistance with ADLs Related to left side hemiplegia. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, implemented 10/22, the P&P indicated, The call system will be accessible to residents while in their bed .within the resident's room.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 32096 Based on observation, interview and record review, the facility failed to implement a care plan for one of 26 sampled residents (Resident 120) when the care plan for fall interventions was not carried out. This failure had the increased potential for injury should Resident 120 fall again. Findings: Review of Resident 120's ADMISSION RECORD, indicated the resident was admitted to the facility recently with diagnoses that included right side paralysis, generalized muscle weakness and other abnormalities of gait and mobility. Review of Resident 120's medical records, a care plan, created on 7/11/24, indicated the resident was identified at risk for falls and injury related to medications, stroke, and a heart problem. The care plan set goals to minimize and manage risk for falls with interventions including fall mats on sides of bed implemented on 8/5/24. Review of Resident 120's medical records, SBAR [Situation, Background, Assessment, Recommendation, a medical communication framework] fall Report of Incident 8hr - V3, created on 8/3/24, indicated the resident had an actual fall, documented, Seen pt [patient] lying on the floor at bedside in left lateral position .Noted to have bleeding to his left side of the head .Pt was sent out to [Name of Hospital] ER [emergency room] for evaluation. In a concurrent observation and interview on 8/21/24 at 9:05 a.m., in Resident 120's room, with Licensed Nurse (LN 1), the resident was observed to be lying in his bed. There were no fall mats at the side of his bed or anywhere in his room. LN 1 verified there was no fall mat in the resident's room and stated, I don't see the fall mat at this moment. LN 1 then checked Resident 120's medical records at the nursing station and verified the resident's care plan for fall risk included the intervention for fall mats at the resident's bedsides. LN 1 stated the fall mats should have been placed at the bedside as care planned. Review of the facility's December 2017 policy and procedure, Care Plan, Comprehensive, stipulated, The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life .

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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. 32096 Based on observation, interview and record review, the facility failed to meet the professional standards of practice of nursing for one of 26 sampled residents (Resident 20) when a medication was not administered as ordered. This failure had the potential for ineffective medication therapy for Resident 20. Findings: Review of Resident 20's medical record, ADMISSION RECORD, indicated the resident was admitted to the facility recently with the diagnoses that included chronic lymphocytic leukemia, a type of cancer of the blood and bone marrow. A medication administration observation was conducted on 8/20/24 at 9:20 a.m. for Resident 20 by Licensed Nurse (LN 2). The medication administration by LN 2 was reconciled with Resident 20's medication orders and noted that the resident had a physician order, dated 4/5/24, for Ferrous Sulfate 325(65 Fe, a mineral) mg (milligram, a unit of measurement) 1 tablet daily that was not administered during the medication administration. In an interview on 8/20/24 at 2:17 p.m., LN 2 verified Resident 20 had the physician order for Ferrous Sulfate and stated it was not administered because the medication was not available. Review of the facility's policy and procedure, revised 4/1/22, stipulated, Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications. Review of the Nursing Practice Act Rules and Regulations indicated, .the practice of nursing .means .Direct and indirect patient care services, including, but not limited to, the administration of medications .ordered by . a physician, as defined by Section 1316.5 of the Health and Safety Code. In an interview on 8/21/24 starting at 12:07 p.m., the Director of Nursing (DON), with the Assistant DON present, acknowledged the ferrous sulfate should have been administered to Resident 20 as ordered during the medication administration.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable.

39489

Based on observation, interview, and record review, the facility failed to ensure nail care was provided for one of 26 sampled residents (Resident 96).

This failure had the potential for Resident 96 to sustain injury, neglected personal grooming and infection.

Findings:

A review of Resident 96's Admission Record indicated Resident 96 was admitted in the facility on 9/22/23, with the diagnosis that included Type 2 Diabetes Mellitus (high blood sugar), gout (painful form of arthritis), sepsis (infection), and muscle weakness.

A review of Resident 96's Minimum Data Set (MDS-tool used to direct care), Brief Interview for Mental Status (BIMS, evaluates mental impairment] Section C - Cognitive Patterns, dated 6/12/24, showed Resident 96's cognition is intact with a score of 15. Section E - Behavior, dated 6/12/24, indicated, Resident 96 did not have a history of rejecting care.

During a concurrent observation and interview on 8/19/24 at 10:10 a.m., with Resident 96 inside his room, Resident 96 was observed with contracted right hand, the skin was dry and peeling, his index, middle and ring fingers were tucked like a closed fist. The nails were long, with brownish/blackish substance underneath the fingernails. The pinkie/fifth digit finger was tucked under the ring finger and Resident 96 was unable to stretch it out. Resident 96 stated, I can't straighten up my fingers, it hurts if I try to. When asked about his pinkie fingernail, Resident 96 confirmed, My fingernail is very long for a year now and it's digging into my skin. I know because I can feel it, and I told the nurses about it, but they just ignored me. Resident 96 further stated some nurses tried to trim his fingernails in the past but gave up and never tried again.

During an interview on 8/21/24 at 2:15 p.m., with License Nurse 4 (LN 4), LN 4 confirmed Resident 96's right hand has been contracted for a long time and he's unable to unfold his fingers. LN 4 stated, I tried to trim his nails, but I can't, because he's contracted and he can't open his fingers,

During an interview on 8/22/24 at 1030 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 96, needed assistance from the staff for his daily care such as trimming his fingernails, but his right hand is contracted, and he is unable to open his fingers. The ADON further stated the expectation from the nurses is to do a full head to toe assessment as part of their nursing assessment and to report/document of their findings such as long fingernails. The ADON further stated, Resident 96's fingernails may injure his right hand because his nails are continuously growing and are not being trimmed.

A review of Resident 96's Order Summary Report, dated 6/13/24, indicated, Carrot-hand contracture of R hand.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 96's Care Plan, [CP] dated 9/24/23, indicated, Self-Care Deficit As Evidence by: Needs assistance with ADLs Related to weakness . CONTRACTURES: The resident has contractures of the RIGHT hand . A review of Resident 96's CP dated 9/23/23, indicated, The resident has Diabetes Mellitus . During a review of the facility's policy and procedure titled, Bath, Bed, dated 2006, indicated, .To inspect the body .Observe condition of skin. Range of motion limitation. ADL function .Wash neck, arms .Dry skin well . Give special care to umbilicus, folds of skin, hands .Care of fingernails and toenails is part of the bath. Be certain nails are clean .Fingernails and toenails of diabetic residents are cut by the licensed nurse or podiatrist . A review of Resident 96's medical record for 2024 had no documentation that the facility consulted with available resources, including a podiatrist to care for Resident 96's nails when they were unable to care for his nails within the facility.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 32096 Based on observation, interview and record review, the facility failed to provide meaningful ongoing activities for one of 26 sampled residents (Resident 120). This failure caused the resident to feel trapped. Findings: Review of Resident 120's ADMISSION RECORD, indicated the resident was admitted to the facility recently with diagnoses that included right sided paralysis, heart and lung problems. In an observation on 8/19/24 at 9:36 a.m. in Resident 120's room, the resident was lying in bed with the TV on. The resident stated his right side of the body was paralyzed and wanted to do something to get it stronger, but showers were pretty much the only time he got out of bed. The resident complained he spent his day watching TV because the facility did not get him up and put him in the wheelchair. Resident 120 stated he liked to attend group activities. There were no books, magazines, crossword puzzles or any other activity materials visible in the room. The resident stated, they come out once in a while and went away when asked if the activities provided room visits. The resident stated, I feel trapped .I feel like I am insignificant to them. Review of the facility provided 2015 policy and procedure, Residents' Rights to Refuse Activities, stipulated, Continuously offer residents a wide range of activity program opportunities so that they may explore potential leisure interests .Continue to invite residents to group programs, offer one-to-one activity contacts and/or offer materials for independent leisure pursuits .Record activity participation or attendance. Review of Resident 120's medical record included a care plan initiated 7/11/24 indicated the resident to spend, .the majority of his free time resting in the comfort of his room involved in independent leisure pursuits . with interventions included, ROOM VISIT CHECK-INS: Activity staff and/or volunteers will offer room visit check-ins for Added socialization Friendly conversation topics may include but are not limited to: Welcome pet visits, Offer materials for independent use, Offer snacks from snack cart. In an interview on 8/22/24 at 9:10 a.m. in the Activity Director's (AD) room, the AD verified Resident 120 did not attend group activities and there was no 1:1 room visit log, or any list of activity materials provided for Resident 120 to pursue independent leisure in his room. The AD stated the activity department visited resident in the morning daily to greet each resident, however, acknowledge it was not considered an activity. The AD stated the facility should have provided meaningful ongoing activities to Resident 120 and indicated watching TV all day long in bed was not a meaningful ongoing activity. The AD stated, We should have gotten him up.

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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. 32096 Based on observation, interview and record review, the facility failed to supply medication for one of 26 sampled residents (Resident 20) when ferrous sulfate, an iron supplement, was not available for administration. This failure resulted in Resident 20 not receiving the mineral supplement for five days. Findings: Review of Resident 20's medical record, ADMISSION RECORD, indicated the resident was admitted to the facility recently with the diagnoses that included chronic lymphocytic leukemia, a type of cancer of the blood and bone marrow. Review of Resident 20's medical record included a physician order, dated 4/5/24, for ferrous sulfate 325(65 Fe, a mineral) mg (milligram, a unit of measurement) 1 tablet every day. During the medication administration observation on 8/20/24 starting at 9:20 a.m., Licensed Nurse (LN 2) did not administer ferrous sulfate. Review of Resident 20's laboratory reports dated 5/14/24 and 5/18/24, indicated the resident's red blood cell counts were low at 3.81 and 3.83 (normal reference range: 3.93-5.22 millions/microLiter, a unit of measurement) respectively and the MPV (Mean Platelet Volume, a blood test that measures the average size of platelets) were also low at 9.0 and 9.1 (normal reference range: 9.4-12.4 femtoLiter, a measue of volume) respectively. Review of Resident 20's August 2024 Medication Administration Record (MAR) indicated the resident did not receive the iron supplement from 8/16/24 to 8/20/24 for five days. In an interview on 8/21/24 at 11:28 a.m., LN 2 stated she did not administer the iron supplement because there was no medication available. LN 2 verified Resident 20 did not receive the medication for five days since 8/16/24, and stated it was the facility policy that LNs are to let the central supply know when the over-the-counter medications were down to two bottles. LN 2 indicated LNs should have informed the central supply before ferrous sulfate ran out. In an interview on 8/21/24 at 12:07 p.m. in the Director of Nursing (DON's) office, the DON, in the presence of Assistant DON (ADON), acknowledged the facility should have supplied the medications as ordered by the physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32096 Based on observation, interview and documentation review, the facility failed to ensure: 1. Expired medical supplies were removed from the medication storage room, and 2. Medication carts were maintained clean and in an orderly manner. These failures had the potential for accidental use of expired supplies and for drug diversion for a census of 124. Findings: 1. During the medication storage room check on [DATE] starting at 2:35 p.m. in the North Station with the Licensed Nurse (LN 4), an expired Mic-Key continuous feed extension set (a feeding tube extension) was stored in the medication room available for use. The expiration date was [DATE]. There were Covid-19/Flu test kits also stored in the bag with the expiration date of [DATE]. LN 4 verified the expiration dates of the medical supplies and stated they should have been discarded. Review of the facility's [DATE] revised policy and procedure, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, stipulated, Facility should ensure that medications and biologicals for expired .stored separately, away from use, until destroyed or returned to the provider. 2. a. During the medication cart check on [DATE] at 3:12 p.m. in the East Nursing Station, with LN 5 and the Assistant Director of Nursing (ADON), two loose pills and a broken pill were observed in the cart. LN 5 verified the loose pills. b. During the first of two medication cart checks on [DATE] at 3:19 p.m. in the South Station, with LN 6 and the ADON, one loose pill, loose white powder and brownish residue were observed in the back of the drawer of the medication cart. LN 6 verified the findings. c. During the second of two medication cart checks on [DATE] at 3:27 p.m. in the South Station, with LN 7 and the ADON, ten loose pills were observed in the cart. LN 7 verified the loose pills. The ADON stated LNs on the cart were responsible for cleaning the cart and indicated the facility expectation was no loose pills to be found in the medication carts. Review of the facility's [DATE] revised policy and procedure, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, stipulated, Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 12:07 p.m. in the Director of Nursing (DON's) office with the ADON, the DON stated the Covid-19 test kits with the expiration date [DATE] in the medication storage room were not expired because the facility found a manufacturer's memo on their website that the company extended the expiration date of the Covid-19 test kits. The DON however, acknowledged the expired biologicals in the medication storage room over 8 to 10 months should have been removed. In an interview on [DATE] at 2:45 p.m. in the DON's office, the ADON clarified that the facility found the manufacturer's memo for the Covid-19 test kits expiration date extension after the medication storage room inspection done on [DATE]. The ADON stated the Covid-19 test kits should have been removed when the medication storage room was cleaned.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29825 Based on observation, interview and record review, the facility failed to follow professional standards for food service safety when Quat (Quaternary Ammonium, a sanitizer) strips (measure the concentration of sanitizer) currently being used were expired. This failure increased the risk for food borne illness for the residents that consumed facility prepared meals in a total facility census of 124. Findings: During an initial tour observation of the kitchen on [DATE] at 8:38 a.m. with the Dietary Manager (DM), DM was asked to check the sanitizer level of the Quat solution used to sanitize surfaces in the kitchen. The bucket was tested at 150 ppm (parts per million, a measurement) and then the DM was asked for the expiration date on the strips. The DM verified the Quat strips expired [DATE]. During a concurrent interview, the DM was asked his expectations regarding the checking of expiratory dates of the sanitizer strips and said, I expect the date should be checked frequently enough that they are not expired. During an interview on [DATE] at 10:43 a.m. with the Registered Dietician (RD), the RD was asked her expectations for checking expiratory dates of the Quat strips (Quaternary Ammonium, test strips used to test sanitizing solution chemical levels) and said, Sanitizer strips [expiration date] should be checked before usage. During a review of the facility policy and procedure (P&P) titled, CHEMICAL SANITIZING, dated ,d+[DATE], the P&P indicated, Ensure equipment and work surfaces are sanitized .For equipment that cannot be put in water, use double strength sanitizer and water .Multi-Quat ,d+[DATE]ppm [parts per million] . There was no instruction to check the date of expiration of the strips. During a review of the facility document titled, Sanitizer Log (SL), dated ,d+[DATE], the SL indicated, Check sanitizer solution with the proper test strip . There were no instructions to check the date of expiration of the test strips.

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NAME OF PROVIDER OR SUPPLIER: Arbor Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 900 North Church Street, Lodi, CA 95240	

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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. 29825 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for of census of 124 residents when: 1. Resident 1's nasal cannula (thin, flexible tube with two prongs that fit into the patient's nostrils and is attached to an oxygen source), and tubing were laying on top of the oxygen condenser (a medical device that takes air from the surroundings, extracts oxygen and filters it into purified oxygen); 2. Hand hygiene was not practiced during the meal service; 3. Resident 72's urinary bag touched the floor; 4. PPE (Personal Protective Equipment) was not donned for Resident 38; and 5. Linen cart was not covered, and Laundry Aide's (LA) uniform touched the clean personal clothes of the residents while hanging them. These deficient practices had the potential to spread infection and disease among residents, staff, and visitors. Findings: 1. Resident 116 was admitted to the facility in the summer of 2024 with diagnoses which included chronic obstructive pulmonary disease (COPD, a lung disease), respiratory failure and shortness of breath. During a review of Resident 116's Minimum Data Set (MDS, an assessment tool), dated 7/9/24, the MDS indicated Resident 116 had moderate memory loss. She required partial/moderate assistance to maintain personal hygiene. During a review of Resident 116's physician order (PO), dated 7/10/24, the PO indicated, Oxygen at 2 LPM [liters per minute, a measurement of volume] via NC [nasal cannula] . During a review of Resident 116's care plan (CP) titled, Acute Respiratory Condition (SOB [shortness of breath]), undated, the CP indicated O2 [oxygen] as ordered . During an initial tour observation on 8/19/24 at 10:14 a.m., Resident 116's nasal cannula was found on top of the oxygen concentrator uncovered. During a concurrent observation and interview on 8/19/24 at 10:19 a.m. with the Director of Nurses (DON), the DON verified the observation and said, The oxygen cannula is not covered. It should be covered . (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 8/22/24 at 7:17 a.m. with the infection Preventionist (IP), the IP was asked what her expectations were for covering nasal cannula when not in use and said, I expect the oxygen tubing to be in a respiratory bag, covered at all times, when not in use. During a review of the facility policy and procedure (P&P), titled procedure-Oxygen Concentrator, undated, the P&P indicated Store tubing/mask in a sanitary manner, such as in a clean plastic bag . 2. a. During the dining observation on 8/19/24 starting at 12:15 p.m. in the main dining hall, Certified Nurse Assistant (CNA 2) was observed to be sitting next to a resident at the table and touching the resident on his back while talking to him. CNA 2 then pulled the resident's wheelchair by the wheel with her bare hand to the table in order for the resident to sit close to and aligned with the table. CNA 2 then resumed serving drinks for other residents and pouring coke for another resident. CNA 2 did not wear gloves or perform hand washing during the process. In an interview on 8/19/24 at 1:14 p.m. in the dining hall, CNA 2 acknowledged she did not wash her hands after pulling the resident's wheelchair and before serving drinks for other residents. CNA 2 acknowledged she should have practiced hand hygiene for infection prevention control. b. During the dining observation on 8/19/24 starting at 12:15 p.m. in the main dining hall, Restorative Nursing Assistant (RNA 1) was observed pushing the drink cart and serving drinks for residents. RNA 1 stopped and stroked a resident's back with her hand who was dozing at the table as she said something to the resident. RNA 1 went back to her cart and continued serving drinks and crackers to other residents. RNA 1 then stopped at one table and poured a drink from the cup on the table to a resident's sippy cup (a training cup that is designed to prevent or reduces spills), closed the lid of the cup and gave the cup back to the resident. RNA 1 did not wash her hands or use hand sanitizer during these processes. In an interview on 8/19/24 at 1:29 p.m., RNA 1 acknowledged she did not wash her hands between the residents and stated she should have washed hands when she touched residents and/or objects or poured the juice in the cup into the resident's sippy cup. In an interview on 8/22/24 at 10:13 a.m. in the DON's office, with the Assistant DON present, the DON stated it was her expectation that staff touched residents then wash hands before taking another resident. The DON stated, They should have washed their hands. 3. Review of Resident 72's ADMISSION RECORD indicated the resident was admitted to the facility recently with diagnoses that included enlarged prostate. Review of Resident 72's medical record included a care plan for the resident being at high risk for urinary tract infection due to indwelling catheter which was initiated on 7/25/24. The care plan included an intervention, Ensure catheter tubing and drainage bag are properly positioned to prevent back-flow or contamination. In a concurrent observation and interview on 8/19/24 at 3:51 p.m. in Resident 72's room, Resident 72 was in bed with his urinary tubing fastened to the side of his bed. The resident's urine bag was laid on the floor with the collected urine in it. The lower half of the urine bag was touching the fall mat and the floor, and the rest of the bag was held upright position. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a concurrent observation and interview on 8/19/24 at 3:51 p.m. in Resident 72's room, Licensed Nurse (LN) 8 verified the resident's urine bag was touching the fall mat and the floor. LN 8 stated the resident's urine bag should float above the floor, not touching the floor as it posed the risk to obtain a bacterial infection. Review of the facility's 2012 policy and procedure, CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI) PREVENTION, stipulated, Keep the collection bag and tubing off the floor. In a concurrent observation and interview on 8/21/24 at 2:47 p.m., in Resident 72's room, the resident was in bed with his urine bag fastened to the bed. Again, the urinary bag was observed to be touching the floor. LN 1 verified the observation and stated the resident urine bag was touching the floor because the resident's bed was low. LN 1 acknowledged the urine bag should not touch the floor for infection control issues. 4. Review of Resident 38's medical record, ADMISSION RECORD indicated that the resident was admitted to the facility in the Spring of 2024 with diagnoses that included diabetes. Her medical record, [Name (#)] indicated she was on enhanced precaution that required gown and gloves when performing high contact tasks due to wound. During the medication administration observation on 8/20/24 starting at 11:42 a.m., LN 3 checked Resident 38's finger stick blood sugar (FSBS) before the lunch tray was served in her shared room. The resident's FSBS results required 2 units of insulin injection according to the sliding scale insulin order by the physician. LN 3 prepared the insulin at the medication cart at the door of the resident's room, went into the room and injected the insulin to the resident's right upper arm. During the process, LN 3 did not wear a protective gown that was required for enhanced precautions. When asked about donning PPE (Personal Protective Equipment) for Resident 38, LN 3 acknowledged he should have worn the gown when he checked the FSBS and administered the insulin. LN 3 stated, I completely forgot about it. 5. a. During a concurrent observation and interview on the South hallway on 8/20/24 at 1:30 p.m., LA 2 pushed a partially covered linen cart that contained clean linens. When asked, LA 2 acknowledged the linen cart was partially covered, and stated, clean linens must be fully covered and protected at all times to promote infection control prevention. b. During a concurrent observation and interview in the laundry room on 8/21/24 at 11:10 a.m., LA's uniform touched the clean personal clothes of the residents while hanging them on the hangers. LA acknowledged she's been in and out of the laundry room and her uniform may have been contaminated and shouldn't touch the clean clothes to prevent cross contamination. During an interview in the laundry room on 8/21/24 at 11:25 a.m., with the Environmental Services Manager (EVS Mgr.), the EVS Mgr. confirmed, LA's uniform should not touch the clean clothes, and all laundry should be handled and transported in a sanitary method to promote infection control. (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 8/21/24 at 2:40 p.m., with the IP, the IP stated, the staff must practice hand hygiene during meal service, after touching a chair and before touching residents' utensils. Linen cart contained clean linens must be fully covered at all times to protect it from dust and soil during transport, to avoid cross contamination, They should cover it all up. The IP further stated, The LA must prevent her uniform from touching the clean clothes because their uniforms are contaminated, infection control must be practiced all the time. During a review of the facility's policy and procedure titled, LAUNDRY MANUAL POLICIES & PROCEDURES, effective 8/14, indicated, .1. Clean linen shall be stored, handled and transported in a manner that prevents cross-contamination .