STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555186	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Square Post Acute Care	1032 N. Lincoln Street Stockton, CA 95203

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47368 Based on observation, interview, and record review, the facility failed to ensure Resident 119 was treated with dignity for a census of 57 when staff did not cover resident's genital area with a sheet while he was sleeping in bed. These failures had the potential to negatively impact Resident 119's psychosocial well-being. Findings: During a concurrent observation and interview on 12/16/24, at 10:02 a.m., in Resident 119's room, with Certified Nursing Assistant (CNA) 2, CNA 2 confirmed Resident 119 was not covered with a sheet and Resident 119's genitals were exposed while he was in bed sleeping. CNA 2 stated we have to cover it .his private part. CNA 2 further stated the expectation was for residents' private parts to be covered. CNA 2 explained the risk included a loss of dignity and feelings of shame. During an interview on 12/16/24, at 11:52 a.m., the Assistant Director of Nursing (ADON) stated residents should be covered with a sheet when they were in bed for dignity. The ADON further stated, To prevent having residents exposed like that, staff should make rounds to make sure everyone is decent, if the gown is too small offer something bigger. The ADON explained the risk for not covering residents private areas were a loss of dignity and it could embarrass them. During an interview on 12/17/24, at 2:22 p.m., Resident 119 stated he did not like to wear any undergarments because it was easier for him to use the bathroom. Review of the facility policy titled, Quality of Life - Dignity, revised 2/20, indicated, .Staff promote, maintain and protect resident privacy, including bodily privacy .

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 50598 Based on observation, interview, and record review, the facility failed to maintain a resident's rights to privacy of personal and medical records when residents' meal tickets were discarded in the facility kitchen garbage bin for the 57 residents who ate facility prepared meals. This failure had the potential for unauthorized access of residents' personal and medical records. Findings: During an observation on 12/15/24, at 9:45 AM, with the Dietary Aide (DA) 1 in the dishwashing area, DA 1 was observed throwing uneaten food, used napkins, and residents' meal tickets left on the meal trays into the garbage bin. DA 1 confirmed the observation. During a concurrent observation and interview on 12/16/24, at 8:52 AM, with the Dietary Service Supervisor (DSS) in the dishwashing area, the DSS confirmed that DA 1 threw the residents' meal tickets into the garbage bin. The DSS also confirmed that multiple residents' meal tickets were returned with their meal trays to the kitchen. The DSS stated although this did not meet the facility's expectations, they currently did not have a process in place to dispose of the meal tickets other than throwing them away in the trash bin. A review of the facility's meal ticket indicated the meal ticket contained residents' information such as the resident's complete name, resident's unit, room, and bed number, resident's diet order, resident's allergies, resident's food notes and alerts, resident's standing food order, resident's likes and dislikes, and the date and type of meal. During an interview on 12/17/24, at 12:16 PM, with the Registered Dietician (RD), the RD stated she was aware of the practice of throwing the tray cards in the garbage. The RD stated throwing the tray cards in the trash did not meet her expectations. The RD further stated the residents' meal tickets should have been shredded after the resident finished eating to avoid violating HIPPA (Health Insurance Portability and Accountability Act- a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed), and if the meal ticket was returned in the kitchen, the kitchen staff should shred them. During an interview on 12/18/24, at 2:59 PM, with the Director of Nursing (DON), the DON stated the tray tickets were a part of the resident's medical record and should not be thrown in the trash bin. The DON further stated the proper disposal of the tray tickets would be in the shredder. The DON stated throwing the tray tickets in the trash bin placed the residents at risk for having their private information stolen and that this practice did not meet her expectations. A review of a facility provided document titled, HEALTH INFORMATION RECORD MANUAL, dated 11/10/20, indicated, .Residents information, both automated and manual as well as applicants for admission or related health information pertaining to a resident is protected by law and must be secured against loss, destruction, and unauthorized access or use . (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility provided document titled, Confidentiality of Information and Personal Privacy Policy, Dated 10/17, indicated, .The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 51285 Based on interview, and record review, the facility failed to submit a new Level I PASRR (Preadmission Screening and Resident Review- a screening for mental illness and treatment to ensure the facility coordinates with the appropriate State-designated authority to ensure that individuals with a mental disorder, intellectual disability or a related condition receives care and services appropriate to their needs) for 1 of 18 sampled residents (Resident 2) when, a level II Mental Health Evaluation was not completed for Resident 2 due to Resident 2 being on isolation as a health or safety precaution which required the facility to submit a new Level I screening for Resident 2. This failure had the potential to place Resident 2 at risk for not receiving the necessary care or services. Findings: During a review of Resident 2's ADMISSION RECORD, indicated that Resident 2 was admitted to the facility in 2022 with a diagnosis of schizophrenia (a mental disorder characterized by disruptions in thought process, perceptions, emotional responsiveness, and social interactions). A review of Resident 2's PASRR dated 9/26/22, indicated, .Positive Level I Screening Indicates a Level II Mental Health Evaluation is Required .The Level I Screening identifies if an individual has a suspected Mental Illness (MI) .Result: Positive for suspected MI Level II Mental Health Evaluation Referral: Required . During a concurrent interview and record review on 12/17/24, at 3:15 p.m., with the Assistant Director of Nursing (ADON) Resident 2's PASRR dated 10/6/22 was reviewed. The PASRR indicated, .UNABLE TO COMPLETE LEVEL II EVALUATION .After reviewing the Positive Level I Screening and speaking with staff, a Level II Mental Health Evaluation was not scheduled for the following reason: The individual was isolated as a health or safety precautions. The case is now closed. To reopen, please submit a new Level 1 Screening . The ADON stated that Resident 2 had a diagnosis of schizophrenia which resulted in the positive Level I PASRR on 9/26/22 and Resident 2 required a Level II PASRR. The ADON confirmed the Level II evaluation was not completed for Resident 2 and Resident 2 required a new Level I screening. The ADON further stated Resident 2's behavior could worsen if not treated properly. During a concurrent interview and record review on 12/17/24, at 1:45 p.m., with the Director of Nursing (DON), Resident 2's PASRR dated 10/6/22 was reviewed. The DON confirmed a new Level I Mental Health Screening was not completed. The DON stated there was a potential to miss the behavior monitoring, missing the proper treatment of Resident 2, and a risk of putting Resident 2 and the facility at risk when a resident did not receive proper care. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint concurrent interview and record review on 12/17/24, at 2:15 p.m., with the Administrator (ADM) and the DON, the facility's undated policy and procedure (P&P) titled, Preadmission Screening & Resident Review (PASARR), was reviewed. The P&P indicated, .The facility will obtain/complete a Preadmission Screening and Resident Review (PASARR) timely: a. Filed in the electronic or manual health record according to the time frames required for all recipients initially entering a nursing facility to determine if they have a Mental or have Intellectual [A neurodevelopmental condition that limits a person's intellectual functioning and adaptive skills including learning, problem solving, judgment, and adaptive functioning such communication and social participation] or Developmental Disabilities [Is a diverse group of chronic conditions, comprising mental or physical impairments that causes individuals difficulties in certain areas of life, especially in language, mobility, learning, self-help and independent living] . The DON and the ADM acknowledged a new Level 1 screening should have been completed to reflect Resident 1's mental health diagnosis. The DON and the ADM stated the policy was not followed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50778 Based on interview, and record review, the facility failed to ensure 1 of 18 sampled residents (Resident 269) received quality care when staff administered rapid-acting insulin to Resident 269 (Lispro-medication which starts to lower blood sugar within 10-15 minutes) on 12/17/24 based on a medication order that did not include parameters (a fixed limit that establishes how something must be done) defining when to hold/not administer the insulin; and staff did not notify the physician when Resident 269 did not eat her scheduled meal after the rapid-acting insulin was administered. These failures led to Resident 269 experiencing a hypoglycemic event (when the body's blood sugar level drops too low for the body to function properly) with a blood glucose (BG) of 36 (a BG below 70 is considered low BG; hypoglycemic) and needing emergent medical treatment. Findings: Review of Resident 269's ADMISSION RECORD, indicated Resident 269 was initially admitted to the facility with diagnoses including but not limited to type 2 diabetes mellitus (DM- inability for the body to regulate blood sugar/glucose) with diabetic chronic kidney disease (diabetes damages the kidneys over time, making it difficult for them to filter waste). During an interview on 12/17/24, at 1:45 PM, with Resident 269's Responsible Party (RP), the RP stated a licensed nurse (LN) administered ten units of rapid-acting insulin when Resident 269's BG was 129 (normal BG is between 70-100). The RP further stated she told the LN that Resident 269 did not take insulin at home. The RP stated she left the facility and upon return, observed a certified nurse assistant (CNA) removing blankets from Resident 269 because Resident 269 was sweating. The RP requested Resident 269's BG level be checked. The BG level reading was 36. The RP stated emergency action was required to get the BG level to a normal reading. During a review of Resident 269's physician medication orders, dated 12/15/24, indicated .Insulin Lispro . Inject 10 unit[s] subcutaneously [an injection under the skin] before meals . During a review of Resident 269's Medication Administration Record (MAR) dated 12/1/24 - 12/31/24, the MAR indicated Resident 269 was administered 10 units of Insulin Lispro for a BG of 129 at 12:15 PM on 12/17/24. The order did not contain hold parameters. Review of Resident 269's Care Plan dated 12/15/24, the care plan indicated, .POTENTIAL FOR HYPOGLYCEMIA .MONITOR FOR COMPLIANCE WITH DIET . During a review of Resident 269's NUTRITION - Amount Eaten documentation dated 12/2024, the amount eaten indicated, .RR . (resident refused) the lunchtime meal on 12/17/24. Review of Resident 269's Progress Notes, dated 12/17/24, at 2:36 PM, indicated, .Glucagon Emergency Kit [medication used to treat low BG] 1 MG [milligram, a unit of measurement] .Inject 1 mg intramuscularly [into the muscle] as needed for Blood glucose less than 70 .Resident observed to be sleepy and sweaty, blood glucose reading of 36 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 269's Medication Administration Record (MAR) dated 12/1/24 - 12/31/24, indicated, Glucagon Emergency Kit 1 MG . was administered on 12/17/24 for blood glucose level of 36. Review of Resident 269's Progress Notes dated 12/17/24 at 3:18 PM indicated, .PRN [as needed] Administration was: Effective .Blood Glucose reading of 123 . Review of Resident 269's SBAR [Situation Background Assessment Recommendations] Communication Form, and Progress Note, both dated 12/17/24, indicated, .change in condition . Resident observed to be sleepy and noted to be sweating, blood sugar taken with reading of 36. Resident given 8oz [ounces, a unit of measurement] of orange juice with 4 packets of sugar and 1 dose of glucagon. MD [medical doctor] notified with new orders to D/C [discontinue] standard order of 10 units with meals and start Humalog [fast acting insulin] on low dose sliding scale [refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges] .Orders noted and carried out. Follow-up blood glucose taken with reading of 123. Daughter remains at bedside . Review of Resident 269's physician medication orders dated 12/17/24, at 3:31 PM, indicated .Insulin Lispro . Inject 10 unit subcutaneously before meals .DISCONTINUE . During an interview on 12/18/24, at 8:15 AM, with Licensed Nurse (LN) 4, LN 4 stated if BG results were outside parameters, she would not give the dose. LN 4 further stated if an insulin order did not include hold parameters she would call and clarify the order with the physician. LN 4 stated the process for concerns with an insulin order was to contact the physician. LN 4 further stated the risk of giving insulin before a meal when food was late or when the resident did not eat; was a resident's BG could drop drastically and the resident would become unresponsive. During an interview on 12/18/24, at 2:13 PM, with the Medical Doctor (MD), the MD stated a nurse did not call to clarify the insulin order or to obtain [hold] parameters. During an interview on 12/18/24, at 4:20 PM, with the Director of Nursing, the DON stated there should be hold parameters for insulin orders. The DON further stated if there were no hold parameters in place the risk to the resident was hypoglycemia. The DON stated if a nurse was not sure whether to give an insulin dose, they should call the MD. The DON further stated LN's should look at a resident's [BG] trends to decide to give the dose; they should not blindly follow the order. Review of a facility document titled, Diabetes - Clinical Protocol, revised 12/20, indicated, .Related considerations .Risk of hypoglycemia should be considered in any treatment plan, as it is a significant and high-risk complication of treatment. It may be necessary to accept somewhat higher blood sugars in order to minimize the risk of hypoglycemia .The Physician will order desired parameters for monitoring and reporting information related to blood sugar management .staff will incorporate such parameters into the Medication Administration Record and care plan . During a review of a facility document titled, Insulin Administration, revised 9/14, indicated, .three key characteristics of insulin are .onset of action - how quickly the insulin reaches the bloodstream and begins to lower blood glucose .Peak effects - the time when the insulin is at its maximum effectiveness .Duration of effects - the length of time during which the insulin is effective .Type .Rapid-acting .Onset .10-15 min .Peak . 0.5-3 hrs .Duration .3-6 hrs .

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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. 49823 Based on observation, interview, and record review, the facility failed to ensure safe pharmaceutical services for a census of 57 residents when, narcotic medications (used for pain) were not accurately documented in the Medication Administration Record (MAR, a document listing medications and monitoring parameters) when removed from the Controlled Drug Record (CDR, a paper record that kept track of opioid medication use for accountability) for Resident 55. This failure resulted in the inaccurate documentation of Resident 55's pain medication dosages and had the potential to result in decreased well-being for Resident 55. Findings: A review of Resident 55's ADMISSION RECORD, indicated Resident 55 was admitted with diagnoses which included but were not limited to chronic kidney disease (progressive damage and loss of function in the kidneys), and non-pressure chronic ulcer of right midfoot and heel (an open wound that develops on the skin). A review of Resident 55's Physician Order Summary, indicated that Resident 55 was treated under Hospice Care (also considered as palliative care, a program that provides comfort care and support for people who are terminally ill and have stopped treatment to cure their disease). During a concurrent interview and record review of Resident 55's CDR on 12/17/24, at 3:30 p.m., with Licensed Nurse (LN) 1, the CDR indicated .Morphine Sulfate [narcotic medication prescribed for pain] 100mg [milligrams, unit of measure]/[per] 5ml (20mg/ml [milliliter, a unit of measurement]) solution . LN 1 confirmed there was one bottle of Morphine Sulfate 20mg/ml solution in the medication cart labeled for Resident 55. LN 1 stated that facility LNs gave Resident 55 Morphine Sulfate medication for pain as needed from the Morphine Sulfate 20mg/ml bottle kept in the medication cart. LN 1 stated hospice nurses also brought Morphine Sulfate to the facility to medicate Resident 55 under hospice care as needed. LN 1 stated hospice nurses documented medication that they gave to residents on hospice in the hospice binder. LN 1 was unable to find the hospice binder for Resident 55. During an interview by phone on 12/17/24, at 3:57 p.m., with LN 2 (Resident 55's hospice nurse not employed by the facility), LN 2 stated medications that hospice nurses gave to residents under hospice care came from facility staff. LN 2 stated that facility LNs got the pain medication from the facility medication cart. LN 2 stated that if the prescribed pain medication was not available, the pain medication was sent from the same pharmacy that the facility used. LN 2 stated hospice nurses requested medication from the facility LNs and the facility LNs obtained the requested medications from facility medication cart. LN 2 stated facility LNs documented medication given by hospice nurses to the residents. During a review of Resident 55's Physician Order Summary, on 12/17/24, at 4 p.m., the Physician Order Summary indicated, .Morphine sulfate 20 mg/ml give 0.25ml by mouth every one hour as needed for moderate pain or difficulty breathing and give 0.5ml by mouth every one hour as needed for severe pain or difficulty breathing, order dated 7/16/24 . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 55's Physician Order Summary on 12/17/24, at 4 p.m., the Physician Order Summary, indicated, .Morphine Sulfate oral solution 20mg/5ml give 0.25ml by mouth three times a day for pain management related to non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin; encounter for palliative care [a visit to a resident receiving hospice care] dated 7/29/24 . During a review of Resident 55's Physician Order Summary, on 12/17/24, at 4 p.m., the Physician Order Summary, indicated, .Morphine Sulfate concentrate oral solution 20mg/ml give 0.25ml by mouth every one hour as needed for moderate pain or difficulty breathing related to encounter for palliative care dated 7/31/24 . During a review of Resident 55's Physician Order Summary, on 12/17/24, at 4 p.m., the Physician Order Summary indicated, .Morphine Sulfate concentrate oral solution 20mg/ml give 0.25ml by mouth every one hour as needed for severe pain or shortness of breath related to peripheral vascular disease [a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked] dated 7/31/24 . During a review of Resident 55's Physician Order Summary, on 12/17/24, at 4 p.m., the Physician Order Summary indicated, .Morphine Sulfate oral solution 20mg/5ml give 0.5ml by mouth every one hour as needed for moderate-severe pain/SOB [shortness of breath] related to adult failure to thrive [the body is not able to maintain its normal functioning and is experiencing a significant decline in health and well-being] encounter for palliative care dated 9/23/24 . During a review of Resident 55's CDR on 12/14/24, at 4:05 p.m., the CDR indicated the following dosages of Morphine Sulfate 20mg/ml were documented as removed from the bottle in the medication cart to be given to Resident 55: .Morphine Sulfate 0.25ml three times a day . doses given three times a day on the following dates: 11/3/24 - 11/17/24, 11/19/24 - 11/27/24, 11/29/24, and 12/1/24 - 12/16/24. In addition, Resident 55's CDR indicated the following additional doses of Morphine Sulfate 20mg/ml were documented as removed from the bottle in the medication cart to be given to Resident 55: 11/2/24 at 1700 - 0.25ml, 11/18/24 at 0800 &1300 - 0.25ml, 11/28/24 at 0856 - 0.25ml, 11/30/24 at 1635 - 0.25ml, 11/30/24 at 1300 - 0.5ml, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/4/24 at 1400 - 0.5ml, and 12/9/24 at 1140 - 0.5ml. During a review of Resident 55's MAR, dated 12/24, the MAR indicated, .Morphine Sulfate Oral Solution 20mg/5ml give 0.25ml by mouth three times a day for pain management related to non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin; encounter for palliative care . doses were documented as given on the following dates: 11/1/24 - 11/30/24, and 12/1/24 - 12/16/24. During a review of Resident 55's MAR, dated 12/24, the MAR indicated, .Morphine Sulfate Oral Solution 20mg/5ml give 0.5ml by mouth every one hour as needed for moderate-severe pain/SOB related to adult failure to thrive; encounter for palliative care . doses were documented as given on the following dates: 12/4/24 at 1400 for pain level of 4; and, 12/9/24 at 1139 for pain level of 8. During a concurrent interview and record review on 12/17/24, at 4:15 p.m., with the Director of Nursing (DON), Resident 55's Physician Order Summary, CDR for Morphine Sulfate 100mg/5ml/(20mg/ml), November 2024 MAR, and December 2024 MAR were reviewed. The DON confirmed the active physician's orders for Morphine Sulfate. The DON confirmed that staff documented Resident 55's doses of Morphine Sulfate inaccurately on the November 2024 MAR and the December 2024 MAR. The DON further confirmed that the facility policy was not followed. Review of a facility policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 5/22, indicated, .Procedures .A. Preparation .4. Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered .A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away .A. Check#1: Select the medication - label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. B. Check#2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. C. Check#3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights .5. The medication administration record (MAR) is always employed during medication administration .If the label and the MAR are different .the physician's orders are checked for the correct dosage schedule . Review of a facility P&P titled, Hospice Program, dated 2001, the P&P indicated, .10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs .and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include the following .c. Administering prescribed therapies, including those therapies determined appropriate by the hospice . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an online document medically reviewed by Drugs.com titled, Morphine Oral Solution: Package Insert/Prescribing Info, last reviewed dated 1/3/24 indicated, .Ensure accuracy when prescribing, dispensing, and administering Morphine Sulfate Oral Solution. Dosing errors due to confusion between mg and ml, and other morphine sulfate oral solutions of different concentrations can result in accidental overdose and death . Dosage forms and strengths .Oral Solution: 10mg/5ml (2mg/ml), 20mg/5ml (4mg/ml), 100ml/5ml (20mg/ml) . use extreme caution when measuring the dose . (https://www.drugs.com/pro/morphine-oral-solution.html)

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	555186	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Square Post Acute Care	1032 N. Lincoln Street Stockton, CA 95203

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 43496 Based on interview, and record review, the facility failed to ensure 1 of 18 sampled residents (Resident 56) was free from unnecessary medications when, Resident 56 received an antibiotic (medication used to treat infection) even though Resident 56 did not meet the criteria established for use of an antibiotic medication through the facility's antibiotic stewardship program (a set of efforts to ensure that antibiotics are used appropriately and only when necessary). This failure had the potential to result in unnecessary medication side effects for Resident 56 and had the potential to result in the development of multi-drug resistant organisms (MDRO; germs that have developed the ability to survive antibiotics that were previously used to kill them; decreasing antimicrobial resistance (when antibiotics become ineffective against infection) requires antimicrobial stewardship and infection prevention efforts). Findings: Review of Resident 56's SBAR [Situation Background Assessment Recommendation] Communication Form and progress note . dated 12/7/24, indicated, .[Resident 56] noted with productive cough and complaining of pain on her left ear .[name of family member of Resident 56] was present during assessment and was requesting MD [medical doctor] to ask for antibiotics order. MD notified and ordered [Levofloxacin; a medication to treat an infection] .QD [everyday] for 7 days. Order noted and carried out . During a concurrent interview and record review on 12/16/24, at 2:59 PM, Resident 56's electronic medical record was reviewed with the Nurse Consultant (NC). The NC confirmed Resident 56 started on an antibiotic medication (Levofloxacin) on 12/7/24 with an indication for use for chest congestion and left ear pain. The NC stated the Infection Screening Evaluation [contains Loeb (a set of minimum signs and symptoms that indicate a resident in long-term care likely has an infection and may need antibiotic) and McGeer criteria (a set of definitions typically used to identify infection after an antibiotic is started)] should be completed when a resident was started on an antibiotic medication. The NC confirmed there was no record of an initial Infection Screening Evaluation completed for Resident 56 for the antibiotic ordered on 12/7/24. The NC stated an antibiotic time out should be completed within forty-eight to seventy-two hours after the start of an antibiotic. The NC confirmed Resident 56's Infection Screening Evaluation, dated 12/9/24, indicated .McGeer's Criteria Met: Gastroenteritis [an infection of the stomach and intestines] . but not met for the reason why Resident 56 was ordered an antibiotic. The NC stated the expectation would be for staff to communicate with the medical doctor if the infection screening criteria was not met. The NC confirmed there was no record of communication with the medical doctor to inform the medical doctor that Resident 56 did not meet the infection screening criteria. The NC stated the purpose of completing antibiotic stewardship was to make sure that antibiotics were not overused and that if an antibiotic was prescribed it was for the correct reason. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24, at 10:15 AM, the Pharmacist Consultant (PC) stated had the antibiotic medication for Resident 56 been active when he completed the drug regimen review (an evaluation of a resident's medications to identify and prevent potential issues) he would have recommended that the medication was not needed because Resident 56 did not meet infection criteria to be prescribed an antibiotic. The PC stated the nurse completed the McGeer's criteria for Resident 56 on 12/9/24, but the antibiotic was started on 12/7/24. The PC explained he would expect the criteria to be checked prior to the initiation of the antibiotic. The PC stated Levofloxacin was not typically given for bronchitis unless the resident had a history of bronchitis progressing to pneumonia. The PC stated, in his opinion, it was a little too early to prescribe the Levofloxacin antibiotic medication to Resident 56. The PC stated he would have liked to see more documentation from the medical doctor as to the rational for the antibiotic being prescribed, however the antibiotic therapy was not needed for Resident 56. The PC explained unnecessary antibiotic administration (when no infection was present) could result in development of resistance to antibiotics and unnecessary side effects from the medications. Review of an undated facility policy titled, INFECTION PREVENTION AND CONTROL PROGRAM, in the section ANTIBIOTIC STEWARDSHIP PROGRAM, indicated, .Antibiotic stewardship program includes protocols to monitor antibiotic use and resistance including: Optimizing the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic .Reducing the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use and .Implementing a facility-wide system to monitor the use of antibiotics . Review of a facility policy titled, Antibiotic Stewardship - Orders for Antibiotics, dated 12/16, indicated, .If an antibiotic is indicated, prescribers will provide complete antibiotic orders including .Indications for use . Appropriate indications for use of antibiotics include: a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending) . Review of an online article published by the Agency for Healthcare Research and Quality (AHRQ) titled, 12 Common Nursing Home Situations and Infection Control Guidelines for MRSA [methicillin-resistant Staphylococcus aureus, a type of bacteria that is resistant to several antibiotic], C. Difficile [Clostridioides difficile; a bacteria that causes infection in the longest part of the large intestine], and VRE [Vancomycin-resistant Enterococci; bacteria that are resistant to vancomycin, a medication often used to treat infections] Pocket Cards, dated 5/14, in the section 12 Common Nursing Home Situations in Which Systemic Antibiotics [drugs that, when given, affect the whole body] are Generally Not Indicated, indicated, . Upper respiratory infection (common cold) .Bronchitis [inflammation of the bronchial tubes, the airways that carry air to and from the lungs] or asthma [a chronic inflammatory lung disease that causes the airways to become inflamed and narrow, making it difficult to breathe] in a resident who does not have COPD [Chronic obstructive pulmonary disease; a group of lung diseases that cause ongoing breathing problems] .Infiltrate [a substance in the lungs that is denser than air, such as pus, blood, or protein] on chest x-ray [medical imaging procedure that uses X-rays to create detailed images of the lungs, heart, and rib cage] in the absence of clinically significant symptoms .Suspected or proven influenza [an infection of the nose, throat and lungs] in the absence of a secondary infection (but DO treat influenza with antivirals [medications that help your body fight off viral infections]) . (https://www.ahrq.gov/sites/default/files/wysiwyg/nhguide/4_TK2_T2-Antibiotic_Pocket_Cards.pdf)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49823 Based on observation, interview, and record review, the facility did not ensure residents were free from significant medication errors when Resident 55 received more than the prescribed dose of a narcotic pain medication (a controlled medication that is used for pain that is severe) for more than one month. This failure had the potential for a decreased quality of life and well-being for Resident 55. Findings: A review of Resident 55's ADMISSION RECORD, indicated that Resident 55 was admitted with diagnoses which included but were not limited to chronic kidney disease (progressive damage and loss of function in the kidneys), and non-pressure chronic ulcer of right midfoot and heel (an open wound that develops on the skin). Review of Resident 55's Physician Order Summary, dated 7/16/24, indicated, .Morphine Sulfate [a medication used for severe pain] 20 mg/ml [milligram per milliliter; units of measurement] give 0.25ml by mouth every one hour as needed for moderate pain or difficulty breathing and give 0.5ml by mouth every one hour as needed for severe pain or difficulty breathing, order dated 7/16/24 . Based on the physician order for Morphine Sulfate 20mg/ml, one dose of 0.25ml would provide a 5mg dose of Morphine Sulfate (20mg/ml, 10mg/0.5ml, 5mg/0.25ml), and a 0.5ml dose would provide a 10mg dose of Morphine Sulfate. Review of Resident 55's Physician Order Summary, dated 7/29/24, indicated, .Morphine Sulfate oral solution 20mg/5ml give 0.25ml by mouth three times a day for pain management related to non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin; encounter for palliative care (a visit to a resident receiving hospice care) dated 7/29/24 . Based on the physician order for Morphine Sulfate 20mg/5ml solution, one dose of 0.25ml would provide a 1mg dose of Morphine Sulfate (20mg/5ml, 10mg/2.5ml, 5mg/1. 25ml, 4mg/1ml, 3mg/0.75ml, 2mg/0.5ml, 1mg/0.25ml). Review of Resident 55's Physician Order Summary, dated 7/31/24, indicated, .Morphine Sulfate concentrate oral solution 20mg/ml give 0.25ml by mouth every one hour as needed for moderate pain or difficulty breathing related to encounter for palliative care [a specialized form of medical care that focuses on improving the quality of life for people with serious or life-threatening illnesses] dated 7/31/24 . During a review of Resident 55's Physician Order Summary, dated 7/31/24, indicated, .Morphine Sulfate concentrate oral solution 20mg/ml give 0.25ml by mouth every one hour as needed for severe pain or shortness of breath related to peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked) dated 7/31/24 . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 55's Physician Order Summary, dated 9/23/24, indicated, .Morphine Sulfate oral solution 20mg/5ml give 0.5ml by mouth every one hour as needed for moderate-severe pain/SOB ([shortness of breath] related to adult failure to thrive [the body is not able to maintain its normal functioning and is experiencing a significant decline in health and well-being)] encounter for palliative care dated 9/23/24 . During a review of Resident 55's Controlled Drug Record, (CDR, a paper record that kept track of opioid medication use for accountability) the CDR indicated the following dosages of Morphine Sulfate 20mg/ml were documented as removed from the bottle in the medication cart to be given to Resident 55: .Morphine Sulfate 0.25ml three times a day . doses given three times a day on the following dates: 11/3/24 - 11/17/24, 11/19/24 - 11/27/24, 11/29/24, and 12/1/24 - 12/16/24. In addition, Resident 55's CDR indicated the following additional doses of Morphine Sulfate 20mg/ml were documented as removed from the bottle in the medication cart to be given to Resident 55: 11/2/24 at 1700 - 0.25ml, 11/18/24 at 0800 &1300 - 0.25ml, 11/28/24 at 0856 - 0.25ml, 11/30/24 at 1635 - 0.25ml, 11/30/24 at 1300 - 0.5ml, 12/4/24 at 1400 - 0.5ml, and 12/9/24 at 1140 - 0.5ml. During a review of Resident 55's Medication Administration Record [MAR], dated December 2024, the MAR indicated, .Morphine Sulfate Oral Solution 20mg/5ml give 0.25ml by mouth three times a day for pain management related to non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin; encounter for palliative care . doses were documented as given on the following dates: 11/1/24 - 11/30/24, and 12/1/24 - 12/16/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 55's MAR, dated December 2024, the MAR indicated, .Morphine Sulfate Oral Solution 20mg/5ml give 0.5ml by mouth every one hour as needed for moderate-severe pain/SOB related to adult failure to thrive; encounter for palliative care . doses were documented as given on the following dates: 12/4/24 at 1400 for pain level of 4; and, 12/9/24 at 1139 for pain level of 8. During an concurrent interview and record review on 12/17/24, at 4:15 p.m., with the facility Director of Nursing (DON), Resident 55's Physician Order Summary, CDR for Morphine Sulfate 100mg/5ml/(20mg/ml), November 2024 MAR, and December 2024 MAR were reviewed. The DON confirmed the active physician's orders for Morphine Sulfate. The DON further confirmed that the doses of Morphine Sulfate 20mg/5ml documented as given on Resident 55's November 2024 MAR and December 2024 MAR were less than the doses that were removed from the bottle of Morphine Sulfate oral solution 20mg/ml in the facility's medication cart and administered to Resident 55 as indicated on Resident 55's CDR. The DON acknowledged that the documentation by the staff was in error. The DON stated that the risk was that Resident 55 did not receive the correct dose of pain medication. The DON stated that the LNs were responsible to clarify the physician orders for pain. The DON confirmed that the facility policy was not followed. Review of a facility policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 5/22, the P&P indicated, .Procedures .A. Preparation .4. Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered .A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away .a. Check#1: Select the medication - label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. B. Check#2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. C. Check#3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights .5. The medication administration record (MAR) is always employed during medication administration .If the label and the MAR are different .the physician's orders are checked for the correct dosage schedule . Review of a facility P&P titled, Hospice Program, dated 2001, the P&P indicated, .10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs .and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include the following .c. Administering prescribed therapies, including those therapies determined appropriate by the hospice . Review of an online document medically reviewed by Drugs.com titled, Morphine Oral Solution: Package Insert/Prescribing Info, last reviewed dated 1/3/24 indicated, .Ensure accuracy when prescribing, dispensing, and administering Morphine Sulfate Oral Solution. Dosing errors due to confusion between mg and ml, and other morphine sulfate oral solutions of different concentrations can result in accidental overdose and death . Dosage forms and strengths .Oral Solution: 10mg/5ml (2mg/ml), 20mg/5ml (4mg/ml), 100ml/5ml (20mg/ml) . use extreme caution when measuring the dose . (https://www.drugs.com/pro/morphine-oral-solution.html)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49823 Based on observation, interview, and record review, the facility failed to ensure medications were labeled, stored, and disposed of according to standards of practice for a census of 57 residents when: 1. An opened, unlabeled container of a psyllium fiber supplement (helps to bulk and soften poop, making it easier to pass) was stored in the medication cart; 2. An opened, unlabeled bottle of cough medicine was stored in the medication cart; and, 3. Medications for a discharged resident were stored in the medication cart. These unsafe medication storage practices could contribute to medication errors and unsafe medication use. Findings: During a concurrent observation and interview on 12/17/24, at 10:35 a.m., with Licensed Nurse (LN) 3, the [NAME] Unit Medication Cart Number 2 was observed. Medications for a discharged resident were observed in the medication cart lower left drawer. LN 3 stated the medications for a discharged resident should not be in the medication cart. LN 3 then removed the medications. A large container of psyllium fiber supplement was found in the medication cart opened but not dated with an open date. LN 3 stated the container of psyllium fiber was not being used and should not be in the medication cart. LN 3 removed the psyllium fiber supplement from the medication cart. A bottle of an over-the-counter cough medicine was further observed in the medication cart opened without an open date on the bottle. LN 3 removed the undated bottle of cough medicine from the medication cart. During an interview on 12/17/24, at 2:43 p.m., with the Director of Nursing (DON), the DON stated that when residents were discharged , medications for the discharged resident were removed from the medication cart, locked in a cabinet in the medication storage room, and were destroyed routinely. The DON further stated that discharged residents' medications were placed in the medication destroyer bottles (used for safe, environmentally responsible and secure disposal of medications). The DON stated the risk of having a discharged resident's medications in the medication cart was that the medications could be given to another resident in error. The DON further stated the expectation was for staff to follow the policy for placing open dates on medications in the cart. The DON explained certain medications did not need an open date placed on the container. The DON acknowledged that the facility policy was not followed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility policy and procedure titled, Storage of Medications, dated 5/22, indicated, . Medications .are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .Expiration Dating (Beyond-use dating) .B. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date .D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a date opened sticker on the medication and enter the date opened and the .date of expiration .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50598 Based on observation, interview, and record review, the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 57 residents who ate facility prepared meals when: 1. Expired food was not thrown away; 2. Food was not labeled/dated properly; 3. Non food items were found in the dry food storage room; 4. A coffee water filter was expired; 5. A fan located in the food prep area was not clean; 6. Various tray line pans were stacked and stored wet; 7. The food processor bowel was ready to use wet; and 8. The ice machine was dirty. These failures had the potential to put residents eating facility prepared meals at risk for foodborne illnesses. Findings: 1. During the initial kitchen tour on [DATE], at 8:10 AM, in the reach in refrigerator and dry storage the following items were found ready to serve. The findings were confirmed by the Dietary Service Supervisor (DSS): a. Four out of twelve cases of strawberries (approximately 20 strawberries in each case) were covered in a white fuzzy substance. b. Approximately 20 out of 50 tomatoes were noted to have a black fuzzy substance on them, smashed, leaking juices, integrity broken, and mushy to touch. 2. During the initial kitchen tour on [DATE], at 8:10 AM, the following items were found to be improperly labeled. The findings were confirmed by the DSS: a. One large clear container labeled peaches with the open date of [DATE] and the Used By Date (UBD) of [DATE]. b. One large clear container labeled Red Jell-O opened [DATE] with UBD of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. One large clear container labeled sugar free Strawberry Jell-O open date of [DATE] with UBD of [DATE]. d. Two opened whipped cream piping bags one with an open date of [DATE] and UBD [DATE] and the other with a received date of [DATE] without an open date and UBD. During an interview on [DATE], at 12:02 PM, with the Registered Dietician (RD), the RD stated the quality of the produce may have been overlooked by the assigned person. The RD further stated the findings did not meet the facility's expectations and if served could make the residents sick. A review of a facility provided document titled, Food Service Management, dated 2023, indicated, .Labeling marking refrigerated foods .most commercially processed food are safe until their expiration or use by date . A review of a facility provided document titled, What is food Sanitation? dated 2023, indicated, .Sanitation is largely concerned with the removal and/or effective control of micro-organisms (germs, mold, bacteria etc.) in food and everything that touches food. Micro-organisms are important because they cause certain diseases. For example (food Poisoning) which are transmitted by food or other means . During a review of The Food and Drug Administration (FDA) Food Code 2022, ,d+[DATE].17 (A) (B) (C) (D), the food code indicated, .Discussed required food labeling and dating. It states the day the original container was opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises . (https://www.fda.gov/media/164194/download) 3. During an observation on [DATE], at 8:44 AM, three black folding chairs were folded and stored together. The placement of these chairs was between the can goods rack and another shelf that contained items such as pasta, hot chocolate, and dried mashed potatoes. During a concurrent observation and interview on [DATE], at 10:30 AM, with the DSS, the DSS acknowledged the chairs that remained in the dry storage room. When asked the reasoning for the placement; the DSS was unsure. During an interview on [DATE], at 12:44 PM, with the RD, the RD stated the dry storage room was for the resident's food storage only. The RD further stated the chairs were not supposed to be placed in the dry storage. A review of a facility provided document titled, STORAGE OF FOOD AND SUPPLIES, dated 2018, indicated, .Food storage area shall be used for only food . 4. During an initial observation on [DATE] at 8:50 AM, the water filter for the coffee machine had [DATE] written on the side of it with a thick black marker. During a concurrent observation and interview with the DSS on [DATE], at 10:25 AM, the DSS stated the date written on the filter was the last time the filter was changed. The DSS further stated he was unaware of the frequency of changes needed to manage the filter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE], at 2:55 PM, with the DSS, the DSS stated that he was informed by the service provider that the filter needed to be changed once 80,000 gallons of water had passed through it. The DSS further stated the facility did not have a log or any form of a tracking system in place to monitor the amount of water that passed through the filter to determine the necessary maintenance. The DSS presented with one page from the manufacturer manual for the water filter. The DSS acknowledged the manual indicated the filter needed to be changed every ,d+[DATE] months. The DSS was unsure about the proper maintenance of the filter. During an interview on [DATE], at 1:09 PM, with the RD, the RD stated the water filter not being changed per the manufacturer guidelines could cause improper filtering of the filter and contaminants to enter the water. A review of a facility provided document titled, POLICY AND PROCEDURE .Equipment Maintenance, dated [DATE], indicated, .The Director of Food & Nutrition Services (DFNS) will periodically check all equipment and report items needing to repair to the maintenance department .2. The maintenance department routinely monitors all equipment for proper and safety and performs preventative maintenance . A review of the manufacturer's manual for the water filter titled, Water Filtration Products for Single Cartridge Systems, dated 2020, on page three indicated, .REPLACE FILTER CARTRIDGE every 6 or 12 months, at the rated capacity, or sooner if a noticeable reduction in flow occurs. Failure to replace the filter cartridge at the required time may lead to property damage due to water leakage or flooding. On page four of the manual indicated, .Change the disposable filter cartridge at the recommended interval; the disposable filter cartridge must be replaced every 6 or 12 months or sooner. Failure to replace the disposable filter cartridge at recommended intervals may lead to reduced filter performance and failure of the filter, causing property damage from water leakage or flooding . On page 26 of the manual indicated, .For proper maintenance of your filtration system, routine replacement of filter cartridges is required . 5. During an observation on [DATE], at 8:53 AM, an upright house fan with a thick fuzzy grey substance inside of it rotating from left to right was located on top of the counter in the kitchen preparation area. During a concurrent interview and observation on [DATE] at 10:25 AM, with the DSS, in the kitchen preparation area, the DSS acknowledged the fan and the grey fuzzy substance within it. The DSS stated the fan was usually brought in and utilized during the hot seasons. The DSS indicated the risk of that fan being on in the food preparation area would be particles becoming loose and going into the residents food. During an interview on [DATE], at 12:36 PM, the RD stated the particles could dislodge from the fan and enter the resident's food, make them sick and possibly cause an allergic reaction. The RD stated the condition of the fan did not meet the facility's expectations due to the dirt and debris. A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section ,d+[DATE]. 11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, dated [DATE], indicated, .(C) Non-Food Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . (https://www.fda.gov/media/164194/download) (continued on next page)

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	555186	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. During an observation on the initial kitchen tour on [DATE], at 8:53 AM, seven large and twelve small tray line pans were observed stocked and stored wet. The findings were confirmed by the [NAME] (CK) 1 and the DSS. During an interview on [DATE] at 12:44 PM, with the RD, the RD stated the pans being stacked and stored wet placed them at risk for growing mildew and getting the resident's sick. The RD further stated the pans should be fully dried before they were stored. The RD explained storing while wet did not meet the facility's expectations. 7. During an observation on [DATE], at 9:05 AM, the bowl to the food processor was found with a pool of water inside of it. This was confirmed by CK 1. During an interview on [DATE] at 12:44 PM, with the RD, the RD stated the food processor being ready to use with a pool of water placed inside of it, placed the residents at risk for having their food contaminated. The RD further stated the condition of the food processor did not meet the facility's expectations. A review of US FDA 2022 Food Code, Section ,d+[DATE].11, titled Equipment and Utensils, Air-Drying Required, dated [DATE], indicated, .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils . (https://www.fda.gov/media/164194/download) 8. During an interview and observation on [DATE], at 10:03 AM, with the Maintenance Director (MD), the ice machine was observed to have a black slimy substance, light pink substance, and thick white substances near the ice dispenser. The MD confirmed the findings and stated if the ice machine was dirty that it would cause the residents to have stomach pain. During an interview on [DATE], at 1 PM, with the RD, the RD stated the condition of the ice machine placed the residents at risk for becoming sick and did not meet the facility's expectations. A review of a facility provided document titled, Cleaning Procedure Ice Machine, dated 2023, indicated, .Ice is considered food and is under the dietary regulations. Dietary staff may not actually do the cleaning, but they are to ensure that it is done .clean with an approved ice machine cleaner (for removal of slime, algae, and mineral build up) . A review of US FDA 2022 Food Code, Section ,d+[DATE].17, dated [DATE], indicated, .The potential for mold and algal growth in this area is very likely due to the high moisture environment. Molds and algae that form .are difficult to remove and present a risk of contamination to the ice stored in the bin . (https://www.fda.gov/media/164194/download)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 50598 Based on observation, interview, and record review the facility failed to maintain trash in a closed dumpster for a census of 57 residents. This failure had the potential to lead to insect and rodent infestation. Findings: During a concurrent interview and observation on 12/15/24, at 9:18 AM, with the [NAME] (CK) 1, the trash bin for the facility was overflowing with trash bags and the lid was placed completely behind the bin. When asked why the bins were opened CK 1 stated the trash service placed them that way. During an interview on 12/16/24, at 10:58 AM, with the Dietary Services Supervisor (DSS), when interviewed about the trash bin lids being opened, the DSS stated the trash dumpster lids being opened was not the facility's normal process and it was important for the dumpster lids to be closed to avoid any pests. During an interview on 12/18/24 at 12:55 PM, with the Registered Dietician (RD), the RD stated the expectation was for the dumpster lids to be closed and there should be no garabage overflowing out of the dumpster to ensure no pests gets into the dumpster. The RD stated the risk when trash bins were overflowing or left wide open posed a sanitation issue and developing a rodent and/insect issue. A review of the 2022 Food Code, published by the Food and Drug Administration (FDA), dated 1/18/23, in the Section 5-501.15, 111, and 115, indicated, .Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas .All containers must be maintained in good repair and cleaned as necessary in order to store garbage and refuse under sanitary conditions as well as to prevent the breeding of flies .Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents . (https://www.fda.gov/media/164194/download)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49823 Based on observation, interview, and record review, the facility failed to ensure safe infection prevention practices were used for a census of 57 when: 1. Resident 171 was placed in a room with another resident who tested positive for RSV (Respiratory Syncytial Virus, a virus (germ) that causes infection (invasion and growth of germs in the body) of the lung and the respiratory tract) with no Droplet Isolation Precautions (hand hygiene, wearing a surgical mask, eye protection, and a gown and gloves (if contact with blood/bloody fluids is possible) are used when in contact with a person who has an infection with germs that can be spread to others by coughing, talking, or sneezing) in place on 12/15/24; and, 2. Resident 9 tested positive for RSV on 12/11/24 but was not in Droplet Isolation Precautions on 12/15/24. These failures had the potential to decrease Resident 171's health and well-being and put other residents, staff, and visitors at increased risk for infection. Findings: 1. A review of Resident 171's ADMISSION RECORD indicated that Resident 171 was admitted with diagnoses which included but were not limited to generalized muscle weakness (lack of strength and fatigue). During an observation on 12/15/24 at 8:23 a.m. Resident 171 and Resident 9 were roomates and both residents were in the room. No isolation precaution signs were noted on the residents' room doorframe. During an interview and concurrent observation on 12/16/24 at 12:30 p.m. with Certified Nursing Assistant (CNA) 1 outside Resident 171's room, CNA 1 confirmed that Resident 171 was moved to a different room and was placed on Droplet Isolation Precautions. A Droplet Isolation Precautions sign was posted on Resident 171's room doorframe, and personal protective equipment (PPE; mask, gown, gloves, protective eyewear, or respirators used to prevent the spread of germs) was in a cart near Resident 171's room door. During an interview and concurrent observation with the Infection Preventionist (IP) on 12/16/24 at 3:15 p.m. outside Resident 171's room, the IP stated that Resident 171 was transferred out of the room that he shared with Resident 9 and placed in a private room on Droplet Isolation Precautions. The IP stated that Resident 171's roommate, Resident 9, tested positive for RSV on 12/12/24. The IP stated that Resident 9 should have been on Droplet Isolation Precautions on 12/15/24 but was not. The IP stated that the risk was that Resident 171 was exposed to RSV when Resident 171 was placed in the room with Resident 9. The IP stated that Resident 171 was not tested for RSV as he had no symptoms. The IP stated that the facility policy was not followed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 171's care plan dated 12/17/24, indicated, .Focus: Resident exposed to RSV Resident, at risk for infection and/or changes in condition R/T [related to] RSV date initiated 12/17/24 .Goal: Resident will have no complications related to exposure .Interventions .Monitor for symptoms of RSV: cough, runny nose, sneezing, fever, congestion .Place in Contact/Droplet Precautions . 2. A review of Resident 9's ADMISSION RECORD indicated that Resident 9 was admitted to the facility with diagnoses which included but were not limited to paroxysmal atrial fibrillation (an irregular heartbeat that speeds up and slows down at random and can cause fatigue (tiredness, trouble breathing, and dizziness), dementia (a general term for loss of memory, language, problem- solving and other thinking abilities that are severe enough to interfere with daily life), and diabetes mellitus (a condition that occurs when your blood glucose (sugar) is consistently too high). During an observation and concurrent interview on 12/15/24 at 8:23 a.m. with Resident 9 in his room, Resident 9 stated that he had no concerns with his care at the facility. No isolation precaution signs were noted on the resident's room doorframe. Resident 9 had a roommate, Resident 171. During an interview and concurrent observation on 12/16/24 at 12:32 p.m. with CNA 1 outside of Resident 9's room, CNA 1 confirmed that Resident 9 was placed on Droplet Precautions. A Droplet Precautions isolation sign was posted on Resident 9's room doorframe, and PPE was in a cart near Resident 9's room door. During an interview and concurrent observation with the facility Infection Preventionist (IP) on 12/16/24 at 3:15 p.m. outside Resident 9's room, IP stated that Resident 9 tested positive for RSV on 12/12/24. IP stated that Resident 9 should have been on Droplet Precautions on 12/15/24 but was not. IP stated that the risk was that other residents, staff, and visitors were at risk of exposure to RSV. IP stated that the facility policy was not followed. A review of Resident 9's Lab Results Report on 12/16/24 at 3:30 p.m. indicated, .Misc. send out .Respiratory Panel .collection date 12/6/24 13:40 .received date 12/9/24 08:31 .reported date 12/11/24 20:37 .Respiratory Syncytial Virus detected abnormal . A review of Resident 9's Care Plan on 12/16/24 at 3:30 p.m. indicated, .Focus: Isolation Room for Droplet Precautions date initiated 12/10/24 .Goal .spread of infection will be contained with use of isolation techniques .Interventions .provide nursing and therapy services within the room until cleared from isolation precautions . A review of Resident 9's Physician Order Summary on 12/16/24 at 3:30 p.m. indicated, .Isolation Room for Droplet Precautions discontinued 12/10/24 .Isolation Room Due To RSV Infection active 12/12/24 . A review of Resident 9's Progress Notes on 12/16/24 at 3:30 p.m. indicated, .Effective Date: 12/12/2024 23:22 .Type: Change in Condition .Note Text: Alert and verbally responsive. On observation for RSV . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility policy and procedure (P&P) titled, Isolation - Initiating Transmission-Based Precautions, revised August 2019, the P&P indicated, .Policy Statement: Transmission-Based Precautions (TBP, precautions implemented based upon means of transmission to prevent or control the spread of germs) are initiated when a resident develops signs and symptoms of a transmissible (capable of spreading to other people) infection (contamination with disease-producing germs); arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Transmission-Based Precautions may include .Droplet Precautions .Transmission-Based Precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures .2. Transmission-Based Precautions are utilized when a resident meets the criteria for a transmissible infection AND the resident has risk factors that increase the likelihood of transmission. These may include (but are not limited to): a. Uncontained excretions/secretions; b. Non-compliance with standard precautions (Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids [Blood, urine, spit] must be handled in a manner to prevent transmission of infectious agents [e.g., wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient]); or c. Cognitive deficits that restrict or interfere with the resident's ability to maintain precautions .3. When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee): a. Clearly identifies the type of precautions, the anticipated duration, and the PPE that must be used .d. Determines the appropriate notification on the room entrance door .so that personnel and visitors are aware of the need for and type of precautions . Review of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Viral Respiratory Pathogens Toolkit For Nursing Homes, last reviewed dated 10/28/24 indicated, .Prevent Spread .Residents: Apply appropriate Transmission-Based Precautions for symptomatic residents based on the suspected cause of their infection .symptomatic residents should not be placed in a room with a new roommate unless they have both been confirmed to have the same respiratory infection .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 43496 Based on interview, and record review, the facility did not consistently implement an antibiotic stewardship program (to ensure medications used to treat infections are used only when necessary and appropriate) for a census of 57 residents when, Loeb (a set of minimum signs and symptoms that indicate a resident in long-term care likely has an infection and may need antibiotic) and/or McGeer criteria (a set of definitions used to identify infection after an antibiotic is started) were not consistently used to assess the initiation and/or the appropriateness of continued use of an antibiotic, including accurate documentation of the correct indication for use. This failure had the potential to result in antibiotics being prescribed when not indicated and the development of multi- drug resistant organisms (MDRO; germs that have developed the ability to survive antibiotics that were previously used to kill them; decreasing antimicrobial resistance (when antibiotics become ineffective against infection) requires antimicrobial stewardship and infection prevention efforts). Findings: 1. Review of Resident 122's medication orders, dated 12/14/24, indicated, .Azithromycin [antibiotic medication used to treat infections] .give one time only for productive cough and congestion for 1 Week . Review of Resident 122's medication orders, dated 12/15/24, indicated, .Azithromycin .one time a day for URI [upper respiratory infection; a contagious illness that affects the nose, throat, and sinuses] until 12/22/2024 . Review of Resident 122's PHYSICIAN'S PROGRESS NOTES, dated 12/15/24, indicated, Cough productive . No fever Suspected Bronchitis [lower respiratory infection; inflammation of the bronchial tubes, the airways that carry air to and from the lung] R/O [rule out] pne [pneumonia; lower respiratory infection; a serious lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe] . Review of Resident 122's Infection Screening Evaluation, dated 12/15/24, in the section Infection Analysis, neither the Loeb's criteria or McGeer criteria were marked met to indicate a suspected infection. There was no Infection Screening Evaluation completed on 12/14/24 for Resident 122. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/16/24, at 1:50 PM, the Infection Preventionist (IP) stated the purpose of antibiotic stewardship was to ensure the appropriate use of antibiotics for resident safety and for the prevention of MDRO's. The IP stated she completed the Infection Screening Evaluation, for Resident 122 on 12/15/24, but Resident 122's symptoms did not meet the McGeer's criteria for infection. The IP further stated that she communicated with the doctor to clarify the indication for use of the antibiotic, but not regarding the negative infection screening evaluation. The IP stated the doctor prescribed the antibiotic to Resident 122 for a URI and the antibiotic was prescribed prophylactically (administering a treatment or taking a precaution to prevent a disease or infection before it occurs). The IP stated the purpose of completing the McGeer's criteria for infection was to determine if the antibiotic was appropriate or not. The IP stated there should be evidence of why a resident was on an antibiotic and if the antibiotic was effective. During an interview on 12/16/24, at 2:59 PM, the Nurse Consultant (NC) stated staff should follow-up with the medical doctor if the resident did not meet the McGeer's criteria. The NC stated if the prescribing doctor still had a rational for continuing the antibiotic for the resident even when criteria was not met, the expectation would be for that information to be documented in a resident's medical record. The NC stated the purpose of completing antibiotic stewardship was to make sure that antibiotics were not overused and that if an antibiotic was prescribed it was for the correct reason. 2. Review of Resident 56's SBAR [Situation Background Assessment Recommendation] Communication Form and progress note . dated 12/7/24, indicated, .[Resident 56] noted with productive cough and complaining of pain on her left ear .[name of family member of Resident 56] was present during assessment and was requesting MD [medical doctor] to ask for antibiotics order. MD notified and ordered [Levofloxacin; a medication to treat an infection] .QD [everyday] for 7 days. Order noted and carried out . Review of Resident 56's PHYSCIAN'S PROGRESS NOTE, dated 12/8/24, indicated, c/o [complaint of] cough/cold .URI with early bronchitis . During a concurrent interview and record review on 12/16/24, at 2:59 PM, Resident 56's electronic medical record was reviewed with the Nurse Consultant (NC). The NC confirmed Resident 56 started on an antibiotic medication (Levofloxacin) on 12/7/24 with an indication for use for chest congestion and left ear pain. The NC stated the Infection Screening Evaluation [contains Loeb and McGeer criteria] should be completed when a resident was started on an antibiotic medication. The NC confirmed there was no record of an initial Infection Screening Evaluation completed for Resident 56 for the antibiotic ordered on 12/7/24. The NC stated an antibiotic time out should be completed within forty-eight to seventy-two hours after the start of an antibiotic. The NC confirmed Resident 56's Infection Screening Evaluation, dated 12/9/24, indicated . McGeer's Criteria Met: Gastroenteritis [an infection of the stomach and intestines] . but not met for the reason why Resident 56 was ordered an antibiotic. The NC stated the expectation would be for staff to communicate with the medical doctor if the infection screening criteria was not met. The NC confirmed there was no record of communication with the medical doctor to inform the doctor that Resident 56 did not meet the infection screening criteria. The NC stated the purpose of completing antibiotic stewardship was to make sure that antibiotics were not overused and that if an antibiotic was prescribed it was for the correct reason. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/18/24, at 10:15 AM, the Pharmacist Consultant (PC) stated because the antibiotic had already been completed for Resident 56, he would have ignored it during Resident 56's next drug regimen review (an evaluation of a resident's medications to identify and prevent potential issues) that was done monthly. The PC stated had the medication been active he would have recommended that the medication was not needed because Resident 56 did not meet infection criteria to be prescribed as an antibiotic. The PC stated inappropriate antibiotic orders found would be something that could be shared during antibiotic stewardship meetings, however, the facility had not invited him to attend any. The PC stated the nurse completed the McGeer's criteria on 12/9/24 for Resident 56, but the antibiotic was started on 12/7/24. The PC explained he would expect the criteria (McGeer/Loeb) to be checked prior to the initiation of the antibiotic. The PC explained unnecessary antibiotic administration (when no infection was present) could result in development of resistance to antibiotics and unnecessary side effects from the medications. Review of a facility policy titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, dated 12/16, indicated, .Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship .As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist .The IP .will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics .Therapy may require further review and possible changes if: (1) The organism is not susceptible to antibiotic chosen; (2) The organism is susceptible to narrower spectrum antibiotics .(4) Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics . Review of a facility policy titled, Antibiotic Stewardship - Orders for Antibiotics, dated 12/16, indicated, .If an antibiotic is indicated, prescribers will provide complete antibiotic orders including .Indications for use . Appropriate indications for use of antibiotics include: a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending) . Review of a facility policy titled Infection Prevention and Control Program, dated 2001, in the section Antibiotic Stewardship, indicated, .Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities .Medical criteria and standardized definitions of infections are used to help recognize and manage infections .Antibiotic usage is evaluated and practitioners are provided feedback on reviews . Review of a facility policy titled Antibiotic Stewardship, dated 1/23, indicated, .Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an undated online document published by the Centers for Disease Control and Prevention (CDC) titled, The Core Elements of Antibiotic Stewardship for Nursing Homes, in the section .Broad interventions to improve antibiotic use, indicated, Standardize the practices which should be applied during the care of any resident suspected of an infection or started on an antibiotic. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed in your facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available . In the section titled, Pharmacy interventions to improve antibiotic use, indicated, .Integrate the dispensing and consultant pharmacists into the clinical care team as key partners in supporting antibiotic stewardship in nursing homes. Pharmacists can provide assistance in ensuring antibiotics are ordered appropriately, reviewing culture data, and developing antibiotic monitoring and infection management guidance in collaboration with nursing and clinical leaders . (https://www.cdc.gov/antibiotic-use/media/pdfs/core-elements-antibiotic-stewardship-508.pdf) Review of a document published by the Minnesota Department of Public Health titled Loeb and McGeer Criteria, dated 6/5/19, in the section Loeb Criteria are Designed for Clinical Use, indicated, .Loeb criteria are meant to be a minimum set of signs and symptoms which, when met, indicate that the resident likely has an infection and that an antibiotic might be indicated, even if the infection has not been confirmed by diagnostic testing . In the section titled, McGeer .Criteria are Designed for Surveillance, indicated, .Revised McGeer criteria .are used for retrospectively counting true infections .To meet the criteria for definitive infection, more diagnostic information (e.g., positive laboratory tests) is often necessary .Surveillance criteria are not intended for informing antibiotic initiation because they depend on information that might not be available when that decision must be made. If, instead of Loeb criteria, these McGeer guidelines are used to retrospectively assess antibiotic initiation appropriateness, they should be applied without inclusion of diagnostic criteria (e.g., positive urine culture, chest x-ray) that were not available at the time of antibiotic initiation . (https://www.health.state.mn.us/diseases/antibioticresistance/hcp/asp/ltc/loebmcgeer.pdf)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555186	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Square Post Acute Care	1032 N. Lincoln Street Stockton, CA 95203

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 43496 Based on interview, and record review, the facility failed to provide the influenza vaccine (also known as a flu shot, a safe and effective way to protect against the influenza virus) to 1 of 5 sampled residents (Resident 11) when, there was no documented evidence in Resident 11's medical record that the vaccine had been offered, given, and/or refused. This failure had the potential to result in Resident 11 acquiring, transmitting, or experiencing complications from influenza. Findings: Review of Resident 11's ADMISSION RECORD, indicated Resident 11 was admitted to the facility in 2022 with diagnoses including chronic obstructive pulmonary disease (a disease of the lungs that blocks airflow and makes it difficult to breath) and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Resident 11's admission record listed a conservator (a person appointed to make decisions on behalf of another person who is incapable of fully managing their own affairs due to age or physical or mental limitations) from the county as Resident 11's responsible party (takes on some responsibility for the resident's well-being) and included a phone number and email contact information. During a concurrent interview and record review on 12/16/24, at 2:25 PM, Resident 11's electronic medical record was reviewed with the Infection Preventionist (IP). The IP confirmed there was no record in Resident 11's medical record that Resident 11 was offered and/or received the influenza vaccination for the current flu season (usually occurs in the fall and winter months). The IP stated she had attempted to contact Resident 11's conservator regarding the influenza vaccination but did not receive a call back. The IP confirmed there was no documentation in Resident 11's medical record to indicate that an attempt to obtain consent for administration of the influenza vaccination was made. During an interview on 12/17/24, at 3:17 PM, with the Director of Nursing (DON) and the Nurse Consultant (NC), the NC stated the influenza vaccine was available and offered to residents starting in September of this year (2024). The NC stated the influenza vaccine was offered to all current residents and was documented on the consent form (documentation of communication between residents and healthcare providers that leads to agreement or refusal for medical care) if the vaccine was given or declined (refused). The DON stated the expectation would be for the IP to document in a resident's medical record if an attempt was made to obtain approval from a resident's responsible party to administer the influenza vaccine. The DON further stated if staff was not able to get ahold of a resident's responsible party (or conservator) to obtain consent to administer the vaccine then the expectation would be for staff to continue to try once a week and document the attempts on a progress note in the resident's medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Influenza Vaccine, dated 10/19, indicated, .All residents .who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza .Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents .A resident refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record .