STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555211	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to ensure one of 19 final sampled residents (Resident 20) received a timely Level II Mental Health Evaluation for suspected mental illness. * Resident 20's initial Level 1 PASRR screening conducted on 3/20/23, was positive for mental illness and required a Level II mental health evaluation. However, Resident 20 was not available for her Level II mental health evaluation, as Resident 20 was on isolation as a health/safety precaution. When Resident 20 was no longer isolated, the facility failed to submit another Level 1 PASRR screening (as indicated on Resident 20's Unable to Complete Level II Evaluation report dated 4/10/23). Approximately one year after Resident 20's initial Level 1 PASRR screening was conducted (3/20/23), the facility then conducted another Level 1 PASRR screening (on 3/29/24) which again required Resident 20 to receive a Level II mental health evaluation, which Resident 20 received on 4/2/24. After Resident 20 received her Level II evaluation on 4/2/24, Resident 20 was then issued her individualized recommended special services report on 4/3/24. This failure to ensure Resident 20 received her timely Level II Mental Health Evaluation posed the risk for the facility failing to incorporate recommendations from Resident 20's PASARR Level II determination and evaluation report into Resident 20's resident assessment, care planning, and transition of care. Findings: Medical record review for Resident 20 was initiated on 5/20/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Level 1 PASRR screening dated 3/20/23, showed Resident 20's Level 1 screening was positive for suspected mental illness and a Level II mental health evaluation referral was required. Review of Resident 20's Unable to Complete Level II Evaluation dated 4/10/23, showed after (the evaluator) reviewed the positive Level 1 screening and spoke to (facility) staff, a Level II Mental Health Evaluation was not scheduled for the following reason: Resident 20 was isolated as a health or safety precaution. The document showed The case is now closed. To reopen, please submit a new Level 1 screening. (continued on next page)

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

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further Review of Resident 20's medical record showed the facility conducted another Level 1 PASRR screening on 3/29/24 (approximately a year after the initial Level 1 screening) which again showed Resident 20 was positive for suspected mental illness and required a Level II Mental Health Evaluation Referral. Resident 20 then received a Level II Evaluation on 4/2/24, and as a result of Resident 20's Level II evaluation, Resident 20 received a determination report dated 4/3/24, which showed recommended specialized services to address Resident 20's mental health needs. Recommended specialized services for Resident 20 included medication education and training, mental health rehabilitation activities, supportive services, psychotherapy, neuropsychology consultation, psychiatry consultation, pharmacy consultation, and safety monitors. On 5/21/24 at 1553 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 20's initial positive Level 1 screening for suspected mental illness conducted on 3/20/23, showed a Level II mental health evaluation referral was required, however, the Level II mental health evaluation was not performed due to Resident 20 being isolated as a health or safety precaution. The DON verified the facility failed to conduct another Level 1 PASRR screening for over a year (conducted on 3/29/24) and as a result Resident 20 did not receive her Level II Mental Health Evaluation and her accompanying determination report/recommended specialized services, until 4/3/24 (a year after).

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to ensure three of 19 final sampled residents (Residents 37, 16, and 51) attained and maintained their highest practicable well-being. * The facility failed to coordinate the care of Resident 37 with the contracted hospice. The hospice calendar and the sign-in/out forms did not show complete skilled nursing and CHHA visits were provided as per the physician's orders. In addition, the nursing clinical notes, and hospice aide notes were not updated. These failures had the potential for the residents to not receive appropriate hospice care and services. * The facility failed to ensure Resident 16's medication order for Lantus solution (Insulin glargine, a long-acting, synthetic insulin, work by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy) was administered per physician's order. This failure posed risk for Resident 16 to have hyperglycemic episode and to receive unnecessary short acting insulin dose. * The facility failed to ensure the fall risk assessment was done after Resident 51 had an unwitnessed fall on 4/20/24, and transferred to the acute care hospital for evaluation. This failure posed the risk of not receiving immediate care as needed base on the evaluation. Findings: 1. Review of the facility's P&P titled Hospice Program dated 7/2017 showed the hospice services are available to the residents at the end of life. The facility has the responsibility to meet the resident's personal care and nursing needs on coordination with the hospice representative and ensure the level of care provided appropriately based on the individual needs. Review of the Hospice Agreement for Nursing Facility and Inpatient Services between the facility and Hospice Provider A signed 4/2/24, showed the facility shall prepare and maintain complete and detailed records concerning each hospice resident receiving facility services under this agreement in accordance with prudent record-keeping procedures and as a required by applicable federal and state laws and regulations. Medical record review for Resident 37 was initiated on 5/21/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's Order Summary Report dated 4/29/24, showed the following physician's order dated 4/9/24: - to admit Resident 37 for hospice services provided by Hospice Provider A. - for CHHA (Certified Home Health Aide) two times per week for hygiene care. - for SNF (Skilled Nursing Facility) visits one to three times per week for symptom control. (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 37's Hospice Initial Certification of Terminal Illness dated 4/9/24, showed the current benefit period from 4/9/24 to 7/8/24. Review of Resident 37's Personalized Visit Schedule calendar from Hospice Provider A showed the scheduled days were for RN visits once a week and CHHA visits two times per week. However, further review of the calendar showed there were no RN visits and no CHHA visits marked or initialed on the weeks of 4/28/24 to 5/11/24. Review of Resident 37's Focus Visit Flow Sheet from Hospice Provider A dated 5/9/24 to 5/21/24, showed the dates, vital signs, signature of licensed nurses, and notes for Resident 37. However, further review of the documents failed to show Resident 37 was visited by the Hospice provider staff since the resident was admitted to hospice services on 4/9/24. On 5/21/24 at 1409 hours, an interview and concurrent medical record review for Resident 37 was conducted with LVN 1. LVN 1 verified Resident 37 was on a hospice services. LVN 1 verified the above findings. On 5/22/24 at 1052 hours, an interview and concurrent medical record review for Resident 37 was conducted with the Social Services Director for the SNF. The Social Services Director for the SNF verified Resident 37 was on a hospice care. The Social Services Director for the SNF stated she was responsible to communicate with the resident family about social needs and spiritual needs of the resident. On 5/22/24 at 1102 hours, an interview and concurrent medical record review for Resident 37 was conducted with the DON. The DON verified Resident 37 was on hospice services. The DON stated she was responsible for communicating with the hospice resident's needs to the hospice provider. The DON verified the nursing clinical notes and hospice aide notes were incomplete and not updated. The DON verified there were missing skilled nursing and CHHA visits. Cross reference to F849. 48853 2. Medical record review for Resident 16 was initiated on 5/21/24. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's Physician Order Summary Report showed an order dated 8/11/23, for Lantus solution 5 units to be administered subcutaneously two times a day. Review of Resident 16's MAR for May 2024 showed the Lantus solution 5 units dose for 5/17/24 at 0700 hours was not administered or blank. Further review of the MAR failed to show documentation if the medication was held for any reason. On 5/22/24 at 1130 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated Lantus was expected to be administered as ordered by the physician. The DON verified the physician's order for Lantus, and the insulin was not administered as ordered. 49780 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility P&P titled Falls - Clinical Protocol revised March 2018 showed the staff and practitioner will review each resident's risk factors for falling and document in the medical record. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. On 5/21/24 at 0914 hours, an observation and concurrent interview was conducted with Resident 51. Resident 51 stated she had an unwitnessed fall in April 2024 where she fell while asleep. Resident 51 stated the facility transferred her to the acute care hospital for evaluation, but she had no injuries. Resident 51 also stated she ambulated with the walker daily and was able to do all her ADLs by herself. Medical record review for Resident 51 was initiated on 5/21/24. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's H&P examination dated 8/25/23, showed Resident 51 had no capacity to understand and make decision. Review of Resident 51's Fall & Skin Risk Summary dated 1/31/24, showed Resident 51's total risk score was 14 (score of 32 or greater should be considered at risk for falls and/or skin breakdown and should have a careplan addressing the risk). The summary also showed Resident 51 ambulated with assistance and required physical assistance (1-2 persons). Review of Resident 51's Progress notes dated 3/21 to 4/21/24 and Interdisciplinary Team Conference dated 4/22/24, showed Resident 51 had an unwitnessed fall on 4/20/24, in her room and was transferred to the acute care hospital for further evaluation due to the anticoagulant use. On 5/23/24 at 1053 hours, an interview and concurrent medical record review was conducted with LVN 3 for Resident 51. LVN 3 stated the nurses needed to complete a head-to-toe assessment, check the resident's extremities and mental status, complete the Fall & Skin Risk Summary, update the care plan, and document the change of condition after a fall incident. LVN 3 was asked about Resident 51's unwitnessed fall on 4/20/24. LVN 3 reviewed Resident 51's medical record and stated there were documentations in the resident's medical record about the fall on 4/20/24 but verified there was no Fall & Skin Risk Summary done after the fall. LVN 3 verified the last Fall & Skin Risk Summary was done on 1/31/24. LVN 3 stated the nurse should have done the Fall & Skin Risk Summary after the fall. On 5/23/24 at 0926 hours, an interview was conducted with the DON. The DON stated when a fall occurs, the licensed nurses need to assess the resident, call the doctor and the resident's family, do the SBAR (Situation, Background, Assessment, Recommendation) documentation, update the care plan interventions, complete a fall risk, and neuro check assessment. The DON verified there was no fall risk assessment done after Resident 51's unwitnessed fall on 4/20/24. The DON stated the nurse should have completed the Fall & Skin Risk Summary after the fall.

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, and medical record review, the facility failed to ensure one of one final sampled resident reviewed for respiratory care (Resident 37) was provided with the appropriate respiratory care when: * The facility failed to ensure Resident 31's oxygen tubing was not touching the floor. In addition, the facility failed to formulate a plan of care for the use of oxygen therapy. This failure had the potential to affect the respiratory health and well-being of the resident in the facility. Findings: During the initial facility tour on 5/20/24 at 0955 hours, Resident 37 was observed wearing a nasal cannula attached to an oxygen machine with a setting of two liters per minute. The nasal cannula oxygen tubing was observed on the floor. An observation and concurrent interview with LVN 2 who was also in Resident 37's room was conducted. LVN 2 verified the oxygen tubing was on the floor. LVN 2 stated the oxygen tubing should have been placed on a clear plastic bag with label. Medical record review for Resident 37 was initiated on 5/21/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's MDS dated [DATE], showed Resident 37 had severe cognitive impairment. Review of Resident 37's Order Summary dated 4/29/24, showed a physician's order dated 4/9/24, to administer oxygen via nasal cannula at 2 liters/min as needed for comfort. Review of Resident 37's plan of care failed to show a care plan addressing Resident 37's use of oxygen therapy. On 5/23/24 at 1044 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one final sampled residents reviewed for the use of side rails (Resident 20) remained free from accident hazards due to the use of elevated side rails. * The facility failed to attempt alternatives prior to the use of elevate side rails for Resident 20. This failure had the potential to place the resident at risk for entrapment and serious injury. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Bed Safety and Bed Rails revised 8/2022 showed prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rail. The interdisciplinary evaluation includes: an evaluation of the alternative to bed rails that were attempted and how these alternatives failed to meet the resident's needs. Medical record review for Resident 20 was initiated on 5/20/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Order Summary Report showed an order dated 4/10/23, for upper left side rail up only during ADL's, changing resident, and repositioning to promote independence. Review of Resident 20's care plan problem titled limited physical mobility revised 4/24/23, showed Resident 20 had limited physical mobility related to generalized muscle weakness and clinical obesity. Review of Resident 20's care plan problem titled impaired cognition initiated 3/20/23, showed Resident 20 had impaired thought processes related to dementia. Review of Resident 20's care plan problem titled high risk for falls revised 5/22/24, showed Resident 20 was at high risk for falls related to confusion, gait/balance problems, and a lack of awareness of safety needs. On 5/22/24 at 1450 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 20 utilized an elevated side rail during the ADL care and to reposition herself. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 20's medical record failed to show documented evidence the alternatives were attempted prior to the use of the elevated side rail. On 5/22/24 at 1238 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the findings and stated an alternatives were not attempted prior to the use of an elevated side rail for Resident 20.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39453 Based on interview and facility document review, the facility failed to have an RN on duty for at least eight consecutive hours a day. This failure has the potential for the residents' clinical needs not being met either directly by the RN or indirectly by the licensed nurses for whom the RN was responsible for overseeing resident care. Findings: On 5/22/24 at 1524 hours, an interview and concurrent facility document review was conducted with the IP. When asked about the facility direct care staffing, the IP stated the DSD who was responsible for the nursing staffing was on leave, so she had to take over. On 5/22/24 at 1549 hours, an interview and concurrent facility document review was conducted with the Social Worker. The Social Worker for the SNF stated she was responsible for reporting and submitting the staffing report. The Social Worker for the SNF stated she keeps the CMS PBJ Staffing Report and the Nursing Sign-in sheets. Review of the facility's document titled Nursing Sign-in sheets for October through December 2023 for the SNF showed the following: - On 10/14/23, did not show an RN signed in; - On 10/17/23, for 0700 to 1500 hours shift, RN 1 signed in, and the sign-in sheet showed a handwritten note showing 8.00; - On 10/19/23, did not show an RN signed in; - On 10/20/23, for 0700 to 1500 hours shift, RN 1 signed in, and the sign-in sheet showed a handwritten note showing 8.00; - On 10/24/23, for 0700 to 1500 hours shift, RN 1 signed in, and the sign-in sheet showed a handwritten note showing 8.00; - On 10/25/23, for 0700 to 1500 hours shift, RN 1 signed in, and the sign-in sheet showed a handwritten note showing 8.00; - On 10/28/23, for 0700 to 1500 hours shift, RN 1 signed in, and the sign-in sheet showed a handwritten note showing 8.00; - On 10/31/23, did not show an RN signed in; - On 11/3/23, for 0700 to 1500 hours shift, RN 1 signed in, and the sign-in sheet showed a handwritten note showing 8.00; (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 11/11/23, did not show an RN signed in; - On 11/20/24, for 0700 to 1500 hours shift, RN 1 signed in, and the sign-in sheet showed a handwritten note showing 8.00; and - On 11/25/23, did not show an RN signed in. Review of the facility's document titled Invoice showed the following: - On 10/17/23, RN 1 worked from 0830 to 1615 hours, a total of 7.25 hours; - On 10/20/23, RN 1 worked from 0730 to 1545 hours, a total of 7.75 hours - On 10/24/23, RN 1 worked from 0830 to 1600 hours, a total of seven hours; - On 10/25/23, RN 1 worked from 0845 to 1600 hours, a total of 6.75 hours: - On 10/28/23, RN 1 worked from 0850 to 1500 hours, a total of 6.17 hours; and - On 11/3/23, RN 1 worked from 0825 to 1625 hours, a total of 7.33 hours. Review of the facility's document titled Employee Time Cards showed the following: - On 10/14/23, RN 2 worked from 2300 to 2400, a total of one hour; - On 10/19/23, RN 2 worked from 2400 to 0711 hours, a total of 7.18 hours; - On 10/31/23, RN 2 worked from 2400 to 0727 hours, a total of 7.45 hours; and - On 11/25/23, RN 2 worked from 2400 to 0704 hours, a total of 7.07 hours. The Social Worker verified the above findings. The Social Worker for the SNF verified the number of hours marked in the Nursing Sign-in sheets did not match the actual hours worked by the RNs. The Social Worker for SNF stated the facility did not have a SNF DON at the time. The Social Worker for the SNF stated she only submitted the staffing report and did not review the actual RN hours worked. The Social Worker for the SNF stated the Receptionist entered the number of hours worked by the staff in the Nursing Sign-In sheet. On 5/23/24 at 0910 hours, an interview and concurrent facility document review was conducted with the receptionist. The receptionist verified he put in the number of hours worked by the staff in the Nursing Sign-In sheets. When asked where he got the information of the number of hours worked by the staff, the receptionist stated he got an automated email from the Administrator or the owner showing the staff hours. When asked about the number of hours marked in the Nursing Sign-in sheet and the actual hours worked by RN 1, the receptionist verified the hours did not match. The receptionist verified he wrote 8 hours for RN 1 because he was told by the DSD or DON to place eight hours on her name because all RNs got automatic eight hours. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 0933 hours, an interview was conducted with the Administrator. The Administrator stated the facility did not have an RN staffing waiver. The Administrator was informed of the findings. The Administrator stated the RN on duty could work for six hours. The Administrator stated the facility did have RN on duty on those dates and stated the TRC DON was on duty at the time since the facility was less than 120 bed capacity.

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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. 49644 Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to meet the need of the residents. * The facility failed to ensure the quantities documented for the discontinued controlled medications matched the quantities of the medication bubble pack and/or bottle. In addition, the facility failed to document one discontinued controlled medication on the Discontinued Controlled Drug Log sheet. * The facility failed to ensure the two discontinued controlled medications were documented on the Discontinued Controlled Drug Log sheet for the TRC. These failures had the potential for drug diversion (illegal distribution or abuse of prescription drugs). Findings: Review of the facility's P&P titled Discarding and Destroying of Medications revised 10/2014 showed the medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. The medication disposition record will contain the following information: resident's name, date medication disposed, name and strength of the medication, name of the dispensing pharmacy, quantity disposed, method of disposition, reason for disposition, and signature of witnesses. 1. On 5/22/24 at 0916 hours, an observation, facility document review, and concurrent interview was conducted with the SNF DON. The SNF DON was observed counting the discontinued controlled medications and comparing the quantity to the Discontinued Controlled Drug Log sheet. The Discontinued Controlled Drug Log sheets showed the following: - dated 5/12/24, Resident 52's lorazepam (antianxiety medication) 0.5 mg tablet with 18 tablets documented under the quantity column, but the bubble pack (a package used to dispense medication) had 19 tablets. - dated 5/12/24, Resident 37's alprazolam (antianxiety medication) 0.25 mg tablet with 26 tablets documented under the quantity column, but the bubble pack had 27 tablets. - dated 10/26/23, Resident 797's morphine sulfate (narcotic to treat pain) 100 mg/5 ml with 9.75 ml documented under the quantity column, but the bottle contained 29.75 ml. Further review of the Discontinued Controlled Drug Log sheets failed to show Resident 798's lorazepam 1 mg tablet bubble pack with four tablets was documented on the Discontinued Controlled Drug Log sheet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SNF DON stated she reconciled the above medications with a licensed nurse. The SNF DON verified the above findings. The SNF DON stated she wrote the wrong quantities because she was not wearing her eyeglasses. On 5/23/24 at 1551 hours, an interview was conducted with the Administrator and the SNF DON. The Administrator and the SNF DON were informed and acknowledged the above findings. 2. On 5/22/24 at 0916 hours, an observation, facility document review, and concurrent interview was conducted with the TRC DON. The TRC DON was observed counting the discontinued controlled medications and comparing the quantity to the Discontinued Controlled Drug Log sheet for the TRC. The Discontinued Controlled Drug Log sheet failed to show the following discontinued controlled medications were documented: - Resident 4's clonazepam (antianxiety) 0.5 mg bubble pack with one tablet remaining. - Resident 799's lorazepam 1 mg tablet bubble pack with 26 tablets remaining. The TRC DON verified the above findings and stated she forgot to add the two controlled medications to the Discontinued Controlled Drug Log sheet. On 5/23/24 at 1601 hours, an interview was conducted with the Administrator and TRC DON. The Administrator and TRC DON were informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview and medical record review, the facility failed to ensure one of five final sampled residents reviewed for unnecessary medications (Resident 18) were properly monitored for the medications. * Resident 18 was administered Norvasc (amlodipine besylate, a medication used to treat high blood pressure) when Resident 18's pulse was below the parameter prescribed by the physician. This failure had the potential to negatively impact the resident's well-being. Findings: Medical record review for Resident 18 was initiated on 5/21/24. Resident 18 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 1/18/24, showed Resident 18 had no capacity to understand and make decision. Review of Resident 18's Physician Order Summary Report dated 5/22/24, showed a physician's order dated 2/8/24, to administer Norvasc 5 mg by mouth in the morning and hold for the systolic blood pressure below 90 mmHg, diastolic pressure less than 60 mmHg, and pulse rate less than 60 beats per minute. Review of Resident 18's MAR for May 2024 showed Resident 18 was administered Norvasc when the resident's pulse rate was 56 beats per minute on 5/10/24 at 0700 hours. On 5/22/24 at 1151 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified the Norvasc was administered to Resident 18 when the resident's pulse rate was below the parameter prescribed by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50003 Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of six final sampled residents reviewed for the use of psychotropic medications (Residents 3, 18, and 54) were free from the unnecessary psychotropic medications. * The facility failed to ensure Residents 3 and 54 were properly monitored for orthostatic blood pressures (measure the blood pressure while laying down or sitting and again upon standing up) as ordered by the physician for the use of the Seroquel (antipsychotic medications). * The facility failed to ensure Resident 18's episodes of behavior for the use of Abilify (antipsychotic medication), Seroquel (antipsychotic medication), Zyprexa (antipsychotic medication), Lithium carbonate (antipsychotic medication), Buspar (antianxiety medication), and Prozac (antidepressant medication) were summarized on the monthly basis to serve as reference for the gradual dose reduction. The monthly behavior summary was not completed related to Resident 18's use of the psychotropic (any drug that affects behavior, mood, thoughts, or perception) medication. These failures had the potential for the residents to experience adverse consequences from the psychotropic medication. Findings: Review of the facility's P&P titled Antipsychotic Medication Use revised December 2016 showed the nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician including orthostatic hypotension (low blood pressure). Review of the facility's P&P titled Behavioral Assessment, Intervention and Monitoring revised 12/2016 showed the nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior and cognition, including: onset, duration, intensity and frequency of behavioral symptoms. 1a. Medical record review for Resident 54 was initiated on 5/22/24. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's H&P examination dated 3/1/23, showed the resident with history of Alzheimer's/dementia and had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders dated: -3/25/24, to administer quetiapine (antipsychotic mediation) 25 mg by mouth in the afternoon for dementia with behavioral disturbances m/b resistive to care, striking out, screaming and yelling. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/25/24, to administer quetiapine (antipsychotic mediation) 75 mg by mouth two times a day for dementia with behavioral disturbances m/b resistive to care, striking out, screaming and yelling. -3/25/24, to monitor for the orthostatic hypotensive blood pressures (lying/sitting position) every day shift for Wednesday. Review of the MAR for May 2024 showed the quetiapine medication was given daily as ordered from 5/1 to 5/22/24. Further review of the MAR failed to show orthostatic blood pressure readings were completed as follow: - On 5/8/24, the blood pressure readings were 120 mmHg for the sitting position and 123 mmHg for the lying position. - On 5/15/24, the blood pressure readings were 120 mmHg for the sitting position and 123 mmHg for the lying position. b. Medical record review for Resident 3 was initiated on 5/21/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 8/21/23, showed the resident with history of dementia and had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders dated: - 5/10/24, to administer risperidone (antipsychotic mediation) 1 mg by mouth one time a day for psychosis m/b resistive to care/scratching at staff. - 5/10/24 to monitor for orthostatic hypotensive blood pressure (lying/sitting position) once a shift every Wednesday. Review of Resident 3's MAR for May 2024 showed the risperidone medication was given daily as ordered from 5/10 to 5/21/24. Further review of the MAR failed to show the orthostatic blood pressure readings were completed as follows: - On 5/15/24, the blood pressure readings were 124 mmHg for the sitting position and 122 mmHg for the lying position. On 5/22/24 at 0950 hours, an interview and concurrent medical record review was conducted for Residents 3 and 54 with LVN 1. LVN 1 reviewed the medical record for Residents 3 and 54 and verified the licensed nurses were not checking of orthostatic hypotension accurately because only the systolic blood pressure reading was recorded. LVN 1 stated the monitoring of the blood pressures were important and should have been accurate because the prescribed medications can cause hypotension to the residents. On 5/23/24 at 0954 hours, an interview was conducted with the SNF DON for Residents 3 and 54. The SNF DON was informed and verified of the above findings. The SNF DON further stated the expectations for the licensed nurses to monitor the resident's vital signs accurately and if there were issues with recording them in the system then she would be notified. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48853 3. Medical record review for Resident 18 was initiated on 5/21/24. Resident 18 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 1/18/24, showed Resident 18 had no capacity to understand and make decision. Review of Resident 18's Physician Order Summary Report ranges from 1/11 to 5/31/24, showed the following physician's orders: - dated 1/31/24, to administer Abilify (aripiprazole, is used to treat the symptoms of psychotic conditions) 10 mg tablet by mouth at bedtime for psychotic ideation, delusional thoughts related to schizoaffective (is a mental health disorder that is marked by a combination of schizophrenia symptoms such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) disorder, bipolar (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) type. - dated 4/10/24, to administer Seroquel (Quetiapine Fumarate, a medication used to treat certain mental or mood disorders) 400 mg tablet by mouth at bedtime for psychotic ideation, delusional thoughts related to schizoaffective disorder, bipolar type. - dated 1/11/24, to administer lithium carbonate (a medication used to treat manic episodes of bipolar disorder) 600 mg tablet by mouth at bedtime for labile moods related to schizoaffective disorder, bipolar type. - dated 3/20/24, to administer Prozac (fluoxetine hcl, is an antidepressant medication) 60 mg tablet by mouth one time a day for depressed mood related to schizoaffective disorder, bipolar type. - dated 2/28/24, to administer buspirone hcl (Buspar, an antianxiety medication) 15 mg tablet by mouth three times a day for anxiety related to schizoaffective disorder, bipolar type. Review of Resident 18's Psychotropic Summary Sheet forms for use of the above medications showed: - Abilify 10 mg at bedtime for behavior manifestation of psychotic ideation and delusional thoughts; the monthly summary was last completed for 3/1 to 3/31/24. - Seroquel 200 mg at bedtime for behavior manifestation of psychotic ideation m/b guarded and watchful behavior; the monthly summary was last completed for 3/1 to 3/31/24. - Lithium 600 mg at bedtime for behavior manifestation labile moods related to schizoaffective disorder, bipolar type m/b easily agitated, irritable, aggressive, hostile, and yelling; the monthly summary was last completed for 3/1 to 3/31/24. - Prozac 20 mg daily for behavior manifestation depressed mood; the monthly summary was last completed for 3/1 to 3/31/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Buspar 10 mg three times a day for behavior manifestation anxiety time period; the monthly summary was last completed for 3/1 to 3/31/24. On 5/21/24 at 1000 hours, an interview was conducted with LPT 1. LPT 1 stated the behavior monitoring were documented daily in the behavior monitoring sheets and every month the behavior manifested by the resident were tallied monthly in the Psychotropic Summary Sheet. On 5/22/24 at 1608 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated the Monthly Psychotropic Summary Sheet forms should be updated every month to assess the behaviors exhibited by the residents. Review of Resident 18's Monthly Psychotropic Summary forms with the DON failed to show monthly summary was completed for the month of April 2024 for the following medications Abilify, Seroquel, lithium carbonate, Buspar, and Prozac.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were safely and securely stored. * The facility failed to ensure Resident 32's insulin pen was properly labeled. * The facility failed to ensure the safe storage of the insulin pen for Resident 32. * The facility failed to ensure the staff reported to the licensed nurse when Resident 53's medicated patch came off. * The facility failed to ensure Medication room [ROOM NUMBER] did not have expired containers of Sani-Hands sanitizing wipes. * The facility failed to ensure the SNF Medication Cart 2 was secured and locked. These failures had the potential to result in unsafe medication administration, and posed the risk of unauthorized access to the medications and undermining the efficacy of the sanitizing wipes. Findings: Review of the facility's P&P titled Storage of Medications revised ,d+[DATE] showed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 1a. On [DATE] at 0817 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 32's Basaglar KwikPen Solution (medication to control high blood sugar) Pen-injector label had a gray stain, and it was hard to read the label. LVN 4 stated the label for Resident 32's Basaglar KwikPen Solution Pen-injector needed to be changed so it would be fully readable. Medical record review for Resident 32 was initiated on [DATE]. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 32's H&P examination dated [DATE], showed Resident 32 had no capacity to understand and make decisions. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 32's Order Summary Report dated [DATE], showed a physician's order dated [DATE], to administer Basaglar KwikPen Solution Pen-injector 100 unit/ml, inject 10 unit subcutaneously every 12 hours for diabetes mellitus (a disorder in which the amount of sugar in the blood is elevated). b. On [DATE] at 0813 hours, an observation was conducted with LVN 4. LVN 4 was observed leaving the insulin pen injector near the foot of Resident 32's bed while she went to the restroom to wash the piston irrigation syringe for Resident 32. LVN 4 was observed looking down while rinsing the piston irrigation syringe. On [DATE] at 0817 hours, an interview was conducted with LVN 4. LVN 4 stated she could see the insulin pen injector from Resident 32's restroom mirror. However, LVN 4 verified she looked down while rinsing the piston irrigation syringe for Resident 32. 2. On [DATE] at 0827 hours, a medication administration observation for Resident 53 was conducted with LVN 3. Resident 53 was observed without the Exelon patch. LVN 3 verified the above finding. Medical record review for Resident 53 was initiated on [DATE]. Resident 53 was admitted to the facility on [DATE]. Review of Resident 53's H&P examination dated [DATE], showed Resident 53 had no capacity to understand and make decisions. Review of Resident 53's Order Summary Report dated ,d+[DATE], showed a physician's order dated [DATE], to apply Exelon (indicated for the treatment of mild to moderate dementia) patch 24-hour 4.6 mg/24 hours transdermally one time a day for dementia (general term for memory loss and mental changes that are severe enough to interfere with daily life). Follow 14-day site rotation for application and remove per schedule. On [DATE] at 1418 hours, an interview was conducted CNA 1. CNA 1 stated the Exelon patch on Resident 53's left shoulder fell off while she was cleaning the resident. CNA 1 stated she threw Resident 53's Exelon patch in the trash can. CNA 1 verified she did not report the above incident to her supervisor. CNA 1 stated she did not report the incident to her supervisor because she was busy. 3. On [DATE] at 1237 hours, an inspection of Medication room [ROOM NUMBER] was conducted with the Medical Record Assistant the following was observed: - Four containers of Sani-Hands sanitizing wipes had expired on ,d+[DATE]. The Medical Record Assistant verified the observation and stated the expired containers of Sani-Hands sanitizing wipes should have not been stored in Medication room [ROOM NUMBER]. On [DATE] at 1551 hours, an interview was conducted with the Administrator and SNF DON. The Administrator and SNF DON were informed and acknowledged the above findings. 39453 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an observation on [DATE] at 1620 hours, the SNF medication cart (Med Cart 2) was observed parked in the hallway, in front of the nursing station, and facing the lobby. The medication cart was observed unlocked and unattended. Staff was observed passing by the medication cart and there were residents observed in the lobby. On [DATE] at 1627 hours, during a concurrent observation and interview with LVN 4, LVN 4 verified the medication cart was not locked with medications inside. LVN 4 further stated the medication cart should not be left unlocked and unattended.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the laboratory test for one of the 19 final sampled residents (Resident 18) was completed as ordered by the physician. * The facility failed to ensure TSH blood test was completed for Resident 18 as ordered by the physician. This failure posed the risk for undetected blood test abnormality which could significantly impact the resident's well-being. Findings: Review of the facility's P&P titled Lab and Diagnostic Test Results - Clinical Protocol revised September 2012 showed the physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. Medical record review for Resident 18 was initiated on 5/21/24. Resident 18 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 1/18/24, showed Resident 18 had no capacity to understand and make decision. Review of Resident 18's Order Summary Report dated 5/22/24, showed a physician's order on 1/11/24, for TSH laboratory test to be completed every three months. Review of Resident 18's medical record failed to show the laboratory blood test result for the TSH level for the resident was due in April 2024. On 5/22/24 at 1221 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified the laboratory blood test order for the TSH level was to be completed every three months. The DON verified Resident 18's medical record failed to show the laboratory blood test result of the TSH for Resident 18.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the heavy-duty blender used for the puree preparation was air dried prior to use. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the ice machine utilized for the residents and staff was maintained in a sanitary condition. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were in good conditions. * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. These failures had the potential to cause foodborne illnesses for the residents in the facility. Findings: Review of the facility's Resident Assessment Report (CMS-802) dated 5/20/24, showed 90 of 95 residents residing in the facility received food prepared in the kitchen. 1. Review of the facility's P&P titled Dishwashing dated 2023 showed the dishes are to be air dried in racks before stacking and storing. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. During the puree preparation observation on 5/22/24 at 1035 hours, a concurrent observation and interview was conducted with the Dietary Supervisor. A heavy-duty blender was observed washed in the dishwashing machine and was still wet and with visible water was dried using a paper towel by Cook 2. The Dietary Supervisor verified the above findings and stated it was supposed to be air dried to prevent contaminants from getting into the blender. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled Hoods, Filters, and Vents dated 2023 showed the hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. During the initial kitchen tour on 5/20/24 at 0920 hours, a concurrent observation and interview was conducted with the Dietary Supervisor. Blackish dirt residue was observed on the kitchen hood. A sticker placed on the side of the hood showed the hood was last serviced by an outside company on 12/7/23. The Dietary Supervisor verified the findings and stated the dietary staff were supposed to clean the hood every three weeks and an outside company serviced and cleaned the hood every three months. On 5/23/24 at 1553 hours, a follow up interview was conducted with the Dietary Supervisor. The Dietary Supervisor stated there should not be any build up of combustible residue on the hood. 3. Review of the facility's P&P titled Sanitation dated 2023 showed the Maintenance Department will assist the Food and Nutrition Services as necessary in maintaining equipment and in doing janitorial duties which the Food and Nutrition Services employees cannot do and maintain maintenance records on all equipment. Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. According to the USDA Food Code 2017, Section 4-601.11, the equipment food-contact surfaces and utensils shall be clean to sight and touch. On 5/20/24 at 0941 hours, an observation, interview, and concurrent facility record review was conducted with the Dietary Supervisor. The Dietary Supervisor stated the facility had one ice machine for the residents used located in the residents' large dining room. The Dietary Supervisor stated the Maintenance Department was in charge of the cleaning and maintenance of the ice machine. Review of the Ice Machine Cleaning log showed the interior cleaning of the ice machine was last done by the dietary staff on 4/28/24 and the ice machine system was last cleaned and sanitized by the maintenance staff on 1/5/24. A sticker placed on the side of the ice machine showed the ice machine was last serviced by an outside company on 3/27/24. Observation of the inside of the ice machine bin was made with the Dietary Supervisor and the Maintenance Supervisor. The ice bin was observed full of ice. Inside the ice bin back panel located directly above the ice bin, a yellowish/ blackish residue was observed. The Maintenance Supervisor stated he was uncertain what the yellow/ black residue was. The Maintenance Supervisor verified the findings and stated the ice on the ice bin needs to be dumped and the ice is not safe to be used for the residents. 4. Review of the facility's P&P titled Sanitation dated 2023 showed separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. During the initial kitchen tour on 5/20/24 at 0920 hours, a concurrent observation and interview was conducted with the Dietary Supervisor. The green, red, yellow, and white cutting boards were observed with deep groves, heavily marred with knife marks. The Dietary Supervisor acknowledged the findings and stated it should have been replaced to prevent the bacteria from getting into the cutting boards. 5. Review of the facility's P&P titled Sanitation dated 2023, showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 5/20/24 at 0920 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The following were observed and verified by the Dietary Supervisor: - Four white rubber spatulas with red handles were cracked, chipped at the edges, and at the center of the rubber part of the spatula. The Dietary Supervisor stated it was not safe to use because it can potentially break off and get mixed into the food. - One stainless spatula with black handle partially melted and worn off which resembled burnt mark. The Dietary Supervisor stated the spatula should have been replaced. - One stainless slotted spatula with white handle partially melted and worn off which resembled burnt mark. The Dietary Supervisor stated the spatula should have been replaced. - One basting brush with white handle was observed with a frayed bristle, and handle partially melted which resembled burnt mark. The Dietary Supervisor stated the basting brush should have been replaced. 6. Review of the facility's P&P titled Dishwashing dated 2023, showed gross food particles shall be removed by careful scraping and pre-rinsing in running water. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 5/20/24 at 0920 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The following were observed and verified by the Dietary Supervisor: - Three scoops with gray handles used for tray line were observed dirty with dry, crusted food residue and dry water spots. The Dietary Supervisor stated the scoops should have been washed after used. - Three scoops with black handles used for tray line were observed dirty with dry, crusted food residue and dry water spots. The Dietary Supervisor stated the scoops should have been washed after used. - Three scoops with green handles used for tray line were observed dirty with dry, crusted food residue and dry water spots. The Dietary Supervisor stated the scoops should have been washed after used. - Two scoops with cream handles used for tray line were observed dirty with dry, crusted food residue and dry water spots. The Dietary Supervisor stated the scoops should have been washed after used. - One scoop with blue handle used for tray line were observed dirty with dry, crusted food residue and dry water spots. The Dietary Supervisor stated the scoop should have been washed after used. - One black peeler was observed with dry, crusted food residue. The Dietary Supervisor stated the peeler should have been washed after used.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 37726 Based on observation and interview, the facility failed to ensure the garbage was properly stored in three of three garbage dumpsters. This failure of the facility to ensure the garbage was contained and covered had the potential to attract pest/rodents that carried disease. Findings: According to the 2022 FDA (Food and Drug Administration) Food Code, outside garbage 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. On 5/20/24 at 1439 hours, an observation of the facility's outside garbage dumpsters was conducted. Three of three garbage dumpsters were observed with the lids propped open by garbage, preventing the lids from fully closing. On 5/20/24 at 1502 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the facility's three garbage dumpsters were observed with the lids propped open with garbage, preventing the lids from fully closing.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurately maintained for two of 19 final sampled residents (Residents 20 and 40). * Resident 40 was transferred to the acute care hospital. Resident 40's medical record failed to show documentation for Resident 40's change of condition which required a transfer to the acute care hospital. * Resident 20's POLST failed to show documentation as to whether Resident 20 had formulated an advance directive. These failures had the potential for the residents' care needs not being met as the medical record was incomplete. Findings: 1. Medical record review for Resident 40 was initiated on 5/20/24. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's physician's order dated 5/22/24 1918 hours, showed an order to send Resident 40 out to Acute Care Hospital 1. Further review of Resident 40's medical record failed to show documentation specific to Resident 40's change of condition which required Resident 40 to be transferred to Acute Care Hospital 1. On 5/23/24 at 1140 hours, a telephone interview was conducted with LVN 5. LVN 5 verified she was assigned to care for Resident 40 at the time Resident 40 was transferred to Acute Care Hospital 1 (on 5/22/24 at 1918 hours). LVN 5 stated Resident 40 exhibited shortness of breath and LVN 5 then transferred Resident 40 to Acute Care Hospital 1. LVN 5 verified she did not document Resident 40's change of condition (shortness of breath) in Resident 40's medical record. LVN 5 stated she would return to the facility today to document Resident 40's change of condition (which required transfer to Acute Care Hospital on 5/22/24) in Resident 40's medical record. 2. Medical record review for Resident 20 was initiated on 5/20/24. Resident 20 was admitted to the facility on [DATE]. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 5/2017 showed the nurse will record in the resident's medical record information relative to the changes in a resident's medical/mental condition or status. On 5/21/24 at 1600 hours, an interview and concurrent medical record review was conducted with the DON. Review of Resident 20's POLST, Section D (advance directive) dated 3/21/23, failed to show documentation as to whether Resident 20 had formulated an advance directive. The DON verified the findings and stated she would ensure the section was completed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure a designated IDT member was appointed to coordinate care between the facility and hospice agency for one of one final sampled resident reviewed for hospice services (Resident 37). This failure had the potential to put the resident on hospice services at risk of uncoordinated medical care between the facility and the hospice agency. Findings: Medical record review for Resident 37 was initiated on 5/21/24. Resident 37 was admitted to the facility on [DATE], with a physician's order to be admitted to Hospice A's services. Review of the facility's P&P titled Hospice Program dated 7/2017 showed the facility has a designated hospice coordinator to collaborate with hospice representatives and coordinating facility staff participation in the hospice care planning process. However, the designated hospice coordinator information was blank. Review of Resident 37's Hospice Service Agreement between the facility and Hospice A failed to show a designated member of the facility's IDT responsible for coordinating Resident 37's care with Hospice A. On 5/21/24 at 1409 hours, an interview and concurrent medical record review for Resident 37 was conducted with LVN 1. LVN 1 verified Resident 37 was on a hospice services. LVN 1 was asked about the hospice coordinator of the facility. LVN 1 stated there was no specific facility staff who was assigned to coordinate to the hospice provider. LVN 1 further stated usually the Social Service Director, DON, and Administrator did the coordination of care. On 5/22/24 at 1052 hours, an interview and concurrent medical record review for Resident 37 was conducted with the Social Services Director for the SNF. The Social Services Director for the SNF verified Resident 37 was on a hospice care. The Social Services Director for the SNF stated there was no hospice coordinator designated in the facility. On 5/22/24 at 1052 hours, an interview and concurrent hospice contract review was conducted with the DON. Review of the contract between Hospice A caring for Resident 37 and the facility failed to show who the facility IDT member was to coordinate the services with the hospice agency. The DON was asked if there was a care conference conducted with Resident 37's family member, IDT of the facity, and the Hospice Provider A, the DON verified there was no care conference held with the hospice provider representative. The DON acknowledged the findings. Cross Reference to F 684, example # 1.

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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. 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program designed to help prevent the development and transmission of diseases and infections. * The facility failed to implement their infection control surveillance program for the months of January through March 2024. The facility failed to conduct an accurate infection surveillance as per the McGeer's Criteria (a set of criteria used in long term care facilities to identify if residents' symptoms meet the criteria of a true infection). This failure posed the risk for not identifying infections and controlling the transmission of communicable disease to other residents throughout the facility. * The facility failed to ensure the infection control practices were maintained in the facility's laundry room area. This failure had the potential for cross-contamination. * The facility failed to ensure the staff (LVNs 3 and 4) performed hand hygiene during the medication administration per facility's P&P. This failure had the potential for the spread of infection. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program revised 10/2018 showed an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Surveillance section showed process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infection) are used as measures of the IPCP effectiveness. Standard criteria are used to distinguish community-acquired from facility-acquired infections. On 5/22/24 at 1422 hours, an interview and concurrent medical record review, facility document review, and facility P&P review was conducted with the IP. The IP was asked to review and explain the facility's infection control surveillance program. The IP stated she was responsible for conducting surveillance of the residents' infections within the facility. The IP stated the facility utilized the McGeer's Criteria to define infection surveillance activities. The IP stated the licensed nurses completed the Monthly Antimicrobial/ Infection Control Surveillance forms for each resident who had a change of condition and presented signs and symptoms of infection, and then used the data to determine if the infections met the McGeer's Criteria. The IP stated she reviewed these forms daily, and used the data for the monthly and quarterly infection surveillance reports. a. Review of the Monthly Antimicrobial/ Infection Control Surveillance for January through March 2024 failed to show infections were classified as CAI or HAIs, and the antibiotic use were inaccurately documented as having met McGeer's criteria. For example: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For Resident 72, the surveillance form dated January 2024 did not show whether the infection was classified as CAI or HAI. The form also showed the resident's antibiotic use met the McGeer's criteria. However, review of the Infection Criteria Checklist for Resident 72 showed the McGeer's criteria for UTI in resident without catheter were not met. - For Resident 29, the surveillance form dated March 2024 showed the infection was classified as HAI, and met McGeer's criteria. However, review of the Infection Criteria Checklist for Resident 29 showed the McGeer's criteria for cellulitis/ soft tissue/ wound were not met. - For Resident 62, the surveillance form dated March 2024 showed the infection was classified as CAI, and met McGeer's criteria. However, review of the Infection Criteria Checklist for Resident 62 showed the McGeer's criteria for UTI in resident without catheter were not met. - For Resident 3, the surveillance form dated March 2024 showed the infection was classified as HAI, and met McGeer's criteria. However, review of the Infection Criteria Checklist for Resident 3 showed the McGeer's criteria for UTI in resident without catheter were not met. - For Resident 54, the surveillance form dated March 2024 showed the infection was classified as HAI, and met McGeer's criteria. However, review of the Infection Criteria Checklist for Resident 54 showed the McGeer's criteria for lower respiratory tract infection were not met. - For Resident 71, the surveillance form dated March 2024 did not show whether the infection was classified as CAI or HAI, and met McGeer's criteria. However, review of the Infection Criteria Checklist for Resident 71 showed the McGeer's criteria for UTI in resident without catheter were not met. b. Review of the Monthly Infection Surveillance Report by Signs and Symptoms for January through March 2024 showed inaccurate reporting of the infections classified as HAI, and antibiotic use that did not meet McGeer's criteria. For example: - For January 2024, none were reported as non-infection (does not meet McGeer's criteria). However, review of the surveillance forms for January 2024 showed two residents on antibiotic use did not meet McGeer's criteria. - For February 2024, none were reported as HAIs. However, review of the surveillance forms for February 2024 showed two residents were classified as HAIs. - For March 2024, none were reported as non-infection (did not meet McGeer's criteria). However, review of the surveillance forms for March 2024 showed five residents on antibiotic use did not meet McGeer's criteria. c. Review of the Quarterly Infection Surveillance Report dated 4/19/24, showed inaccurate reporting of the total infection tracked and the number of non-infections. For example: - For March 2024, the report showed six infections were tracked, and none were reported with non-infection. However, review of the surveillance forms for March 2024 showed five residents on antibiotic use did not meet McGeer's criteria. The IP verified the above findings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled Laundry and Bedding, Soiled revised 10/2018 showed soiled clean linens are protected from dust and soiling during transport and storage to ensure cleanliness. Clean linens are stored separately, away from soiled linens, at all times. On 5/21/24 at 0811 hours, a laundry area inspection was conducted with the Laundry Supervisor. The following were observed: - Two bags containing slings and socks were observed on top of the dirty linen cart in the dirty laundry area; - Blankets were observed on the floor, on top of flattened boxes, inside the clean linen storage area; - Crates containing residents' shoes and clothing were stored on the floor inside the clean resident clothing storage area; and - A bottle of lotion was stored with folded pillow cases in the clean laundry area. The Laundry Supervisor verified the above findings. 35346 3a. Review of facility's P&P titled Hand Hygiene dated 2001 showed an indication for hand hygiene included after contact with contaminated surfaces. On 05/21/24 at 0819 hours, a medication administration observation was conducted with LVN 4. While LVN 4 was preparing the medications for Resident 32, LVN 4 was observed touching the trash bin's lid, trash bag, and then touching Resident 32's insulin pen injector without performing hand hygiene after touching the trash bin lid and trash bag. LVN 4 was observed touching the trash bin lid, the trash bag, and then touching items in the medication cart, without performing hand hygiene after touching the trash bin lid and trash bag, a total of four times. The findings were verified with LVN 4. b. Review of facility's P&P titled Hand Hygiene dated 2001 showed personnel with direct-care responsibilities should maintain short, natural fingernails, and the fingernails should not extend past the fingertips. Further review of this P&P showed hand hygiene should be performed after touching a resident. On 05/21/24 at 0909 hours, a medication administration observation was conducted with LVN 3. While LVN 3 was preparing the medications for Resident 53, LVN 3 was observed to have fingernails extending about one half inch beyond her fingertips. LVN 3 was observed leaving the trash bin lid located to one side of her medication cart, open. Also, LVN 3 was observed applying Resident 53's patch, touching the resident, and then administering oral medications to Resident 53 without doing hand hygiene in between. LVN 3 verified the findings. When asked about having the LVN's long fingernails, LVN 3 acknowledged she was not supposed to have long fingernails.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to offer PCV 15/PCV 20 (PCV 15 protects against two additional serotypes and PCV 20 protects against seven additional serotypes involved in cases of invasive pneumococcal disease (IPD) and pneumonia) immunizations for 11 of 19 final sampled residents (Residents 10, 16, 27, 29, 32, 37, 39, 40, 51, 52, and 54) and 47 nonsampled residents (Residents 1, 2, 3, 4, 6, 7, 8, 9, 13, 19, 21, 24, 25, 30, 33, 34, 36, 38, 41, 42, 43, 44, 45, 49, 50, 53, 56, 57, 58, 59, 60, 61, 62, 64, 65, 66, 67, 68, 70, 71, 73, 79, 83, 89, 448, and 449) reviewed for pneumococcal vaccination (a vaccine given to protect the resident from pneumococcal disease) in accordance with the CDC's recommendations. This failure increased the residents' risk for being inadequately vaccinated for the pneumococcal disease and its associated complications. Findings: According to https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html, Pneumococcal Vaccination: Summary of Who and When to Vaccinate, there are two types of pneumococcal vaccines recommended in the United States: - Pneumococcal conjugate vaccines (PCVs, specifically PCV15 and PCV20); and - Pneumococcal polysaccharide vaccine (PPSV23, use for protected adults and children older than 2 years of age against invasive disease caused by the 23 capsular serotypes contained in the vaccine). Further review of the CDC's guidelines for pneumococcal vaccination showed the following: -For adults 19 through [AGE] years with any of these conditions or risk factors (alcoholism or cigarette smoking, cerebrospinal fluid leak, chronic heart disease, chronic liver disease, chronic lung disease, cochlear implant, decreased immune function from disease or drugs such as immunocompromising conditions, and diabetes mellitus) or immunocompromising conditions (chronic renal failure or nephrotic syndrome, congenital or acquired asplenia or splenic dysfunction, congenital or acquired immunodeficiency, diseases or conditions treated with immunosuppressive drugs or radiation therapy, HIV infection, or sickle cell disease or other hemoglobinopathies) who had never received any pneumococcal vaccine, regardless of risk conditions, give one dose of PCV15 or PCV20. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. The minimum interval (eight weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then completed; -For adults 19 through [AGE] years who had only received PPSV23 regardless of risk condition, give one dose of PCV15 or PCV20 at least one year after the most recent PPSV23 vaccination. Regardless of vaccine given, an additional dose of PPSV 23 is not recommended since they already received it. Their vaccines are then completed; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For adults [AGE] years or older who had never received any pneumococcal vaccine regardless of risk conditions, give one dose of PCV15 or PCV20. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. The minimum interval (eight weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then completed; and -For adults [AGE] years or older who had only received PPSV23 regardless of risk condition, give one dose of PCV15 or PCV20 at least one year after the most recent PPSV23 vaccination. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they already received it. Their vaccines are then completed. Review of the facility's P&P titled Pneumococcal Vaccine revised 8/2016 showed the following: -All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections; -Prior to or upon admission, the residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated; -Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission; -Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record; and -Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. On 5/22/24 at 1134 hours, an interview and concurrent medical record review and facility P&P review was conducted with the IP. When asked about the residents' pneumococcal immunizations, the IP stated the pneumococcal vaccine was always offered upon admission. When asked what type of pneumococcal vaccine was offered to the residents, the IP stated the type of vaccines offered and administered depends on what the physician had ordered. The IP stated she asked the resident, if alert and oriented, or the family members of their recent pneumococcal vaccination, but the resident or the family members often did not know their pneumococcal vaccination information. The IP stated she started running the residents' immunization report from CAIR (California Immunization Registry) to track the residents' immunizations, four months ago. The IP stated she then input the CAIR report to the residents' immunization report to their medical records. The IP showed the residents' Immunization Reports but did not show record of the residents' pneumococcal vaccination. On 5/23/24 at 1338 hours, a follow-up interview and concurrent medical record review and facility P&P review was conducted with the IP. The IP showed the residents' Immunization Reports with a handwritten note on the pneumococcal vaccine type and the date when the vaccine was received. Review of the Immunization Report dated 5/22/24, for the SNF residents showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555211	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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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 - Some	- Resident 38 did not receive any pneumococcal vaccine; - Resident 62 received PCV13 on 10/17/17; - Resident 29 received PPSV23 on 11/26/19; - Resident 53 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 1/2018; - Resident 58 received PPSV23 on 9/3/22; - Resident 59 received PPSV23 on 6/4/21; - Resident 56 received PCV13 on 10/19/23; - Resident 3 received PPSV23 on 1/4/17; - Resident 57 received PPSV 23 on 4/22/21; - Resident 9 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 1/1/18; - Resident 61 received PPSV23 on 8/24/21; - Resident 25 received PCV7 on 5/19/15, and 7/14/15; - Resident 37 did not receive any pneumococcal vaccine; - Resident 30 received PPSV23 on 12/26/14; - Resident 34 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 10/1/18; - Resident 21 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 7/9/09; - Resident 79 received PPSV23 on 12/15/20; - Resident 6 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 10/20/16; - Resident 448 received PCV13 on 9/21/16, and 7/5/18; - Resident 51 received PPSV23 on 5/22/20; - Resident 24 received PPSV23 on 2/14/19; - Resident 83 did not receive any pneumococcal vaccine; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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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 - Some	- Resident 32 received PPSV23 on 9/10/15; - Resident 449 received PPSV23 on 7/1/17; - Resident 71 received PCV13 on 9/24/20, and PPSV23 on 10/7/21 and 9/1/22; - Resident 54 received PPSV23 on 4/13/21; - Resident 52 received PPSV23 on 5/11/21; - Resident 42 received PCV13 on 10/2/15; - Resident 36 received PPSV23 on 10/15/12 and 8/3/16; - Resident 50 received PCV13 on 11/14/21; - Resident 64 received PPSV23 on 2/15/22; - Resident 7 received PCV13 on 2/27/17; - Resident 40 received PPSV23 on 2/6/18; - Resident 60 received PPSV23 on 8/25/21; - Resident 66 received PPSV23 on 3/14/22; - Resident 41 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 8/8/16; - Resident 10 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 12/17/19; and - Resident 43 received PPSV23 on 5/12/10, and PCV13 on 9/3/15 Review of the Immunization Report dated 5/22/24, for the TRC residents showed the following: - Resident 68 received PPSV23 on 3/7/23; - Resident 45 received PPSV23 on 1/9/20; - Resident 27 received PPSV23 on 4/6/21; - Resident 70 received PCV15 on 4/7/24; - Resident 19 received PPSV23 on 1/27/22; - Resident 2 received PPSV23 on 8/22/20; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555211	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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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 - Some	- Resident 13 received PPSV23 on 3/9/21; - Resident 1 received PPSV 10/7/22; - Resident 49 received PPSV23 on 12/18/18; - Resident 44 received PPSV23 on 11/11/20 - Resident 4 received PPSV23 on 2/13/23 - Resident 33 received PPSV23 on 12/23/21; - Resident 8 received pneumococcal vaccine (but did not identify the pneumococcal vaccine type) on 10/13/21; - Resident 65 received PPSV23 on 3/9/22; - Resident 76 received PPSV on 5/10/23; - Resident 67 received PPSV23 on 10/8/21 - Resident 39 received PPSV23 on 10/24/22; - Resident 16 received PPSV23 on 6/19/19; - Resident 73 received PPSV23 on 2/10/23; and - Resident 89 received PPSV23 on 10/24/22; Review of the residents' medical records failed to show the PCV15 or PCV20 vaccines were offered to those who had never received any pneumococcal vaccines. Further review of the residents' medical records failed to show the PCV15 or PCV20 vaccines were offered a year after to those residents who received PPSV23 as per the CDC guidelines. The IP verified the above findings. When asked if she offered a dose of the PCV15 or PCV20 to those who had never received any pneumococcal vaccine, the IP stated she only offered what was ordered by the physician. When asked if she offered a dose of PPSV23 a year after to those residents who received PCV15, the IP answered no. When asked if she offered PCV15 or PCV20 a year after to those residents who received PPSV23, the IP answered no. The IP stated she was not aware of the current pneumococcal vaccines as per the CDC guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555211	A. Building B. Wing	05/23/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep all essential equipment working safely. 35346 Based on observation and interview, the facility failed to ensure one of one of one medication storage room refrigerator (freezer compartment) was free of ice buildup. This failure posed the risk of the refrigerator not being kept in safe, operating condition. Findings: On 5/21/24 at 0936 hours, a medication storage room inspection was conducted with LVN 1. The medication storage refrigerator was observed with e-kits, vaccines, and insulins. The freezer compartment of the medication storage refrigerator was observed with ice buildup. An ice pack used for the facility's residents was observed inside the freezer compartment. LVN 1 verified the findings and stated it was the nursing staff's responsibility to inform the maintenance when there was an ice buildup. LVN 1 verified the staff did not report the ice buildup to the maintenance staff.