STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555245	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Park Post-Acute	2586 Buthmann Ave Tracy, CA 95376

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50018 Based on observation, interview, and record review, the facility failed to ensure a homelike environment was provided for 2 of 23 sampled residents (Resident 382 and Resident 3) when: 1. Resident 382's floor tiles were replaced with a rubber strip; and, 2. Resident 3 had broken blinds in her room. This failure had the potential to negatively impact Resident 382 and Resident 3's feelings of well-being in the facility. Findings: 1. During an interview on 10/2/24, at 3:59 PM, with Resident 382's Responsible Party (RP) 1, RP 1 stated she was afraid of tripping over the black part on the floor. RP 1 further stated that she had tripped over the black rubber strip a couple times in the past. RP 1 explained Resident 382's room was the only room on the unit that had the black rubber strip located right at the doorway entrance. RP 1 stated that she did not like the way the rubber strip looked and considered it to be a hazard. During concurrent observation and interview at 10/2/24, at 4:10 PM, with the Maintenance Director (DOM), the DOM confirmed no other doorways in the North Station had black rubber strips in the entrance like Resident 382's room. The DOM stated the black rubber strip had been there for at least a year due to the broken and uneven tiles beneath the strip on the floor. During an interview on 10/3/24, at 4:15 PM, with Certified Nurse Assistant (CNA) 2, CNA 2 stated the black rubber strip had been there for a long time. CNA 2 further stated that she had to pay attention to the black rubber strip, or someone could fall and get hurt. CNA 2 stated the floor needed to be more even because wheelchairs got stuck on the black rubber strip. During a concurrent observation and interview on 10/3/24, at 4:20 PM, with the Administrator (ADM) outside of Resident 382's doorway, the ADM confirmed that a black rubber strip was on the floor covering up three tiles. The ADM stated this was not uniform with the rest of the resident rooms and was likely done to replace broken or missing tiles. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER North Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2586 Buthmann Ave Tracy, CA 95376	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/4/24, at 9:30 AM, with the Director of Nursing (DON), outside of Resident 382's doorway, the DON stated she was not aware of the black rubber strip in the doorway of Resident 382's room. The DON further stated she was surprised to see the floor in that manner. The DON stated the flooring should be uniform in a homelike environment. During a review of the facility policy titled, Quality of Life - Homelike Environment, revised 5/2017, indicated, . The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary, and orderly environment .d. personalized furniture and room arrangements . During a review of the facility policy titled, Maintenance Service, revised 12/2009, indicated, .Maintaining the building in good repair and free from hazards . 2. During a concurrent observation and interview on 10/1/24, at 9:33 AM, with the DOM, the DOM confirmed Resident 3 had a section of missing blinds on her window. During an interview on 10/2/24, at 3:05 PM, with Resident 3, Resident 3 stated she would like the blinds in her room replaced. Resident 3 stated her blinds looked kind of shaggy, and stated her blinds had been broken for a quite a while. During an interview on 10/3/24, at 3:55 PM, with the DSD, the DSD stated the blinds in the resident rooms should be well-fitting and fixed appropriately. The DSD further stated the blinds should not be broken and that it would not create a homelike environment. During an interview on 10/4/24, at 9:21 AM, with the DON, the DON stated each resident room should have blinds on the windows. The DON further stated she did not want broken blinds in the resident rooms. The DON stated that blinds should be well-fitting. During a review of the facility policy titled, Resident Rights, revised 8/2022, indicated, .a dignified existence . privacy and confidentiality . During a review of an undated facility policy titled, Windows and Blinds, indicated, .Blinds or curtains must be operational and free from damage .Staff must ensure that blinds or curtains are properly adjusted to maintain residents' privacy, especially in shared rooms during personal care .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50925 Based on interview, and record review, the facility failed to develop baseline care plans (captures key resident needs and must be developed within 48 hours of admission) for 2 of 23 sampled residents (Resident 545 and Resident 596) when: 1. A baseline care plan was not developed for Resident 545's right groin redness, left groin redness and perirectal (affecting the skin around the rectum) area redness within 48 hours of Resident 545's admission; and, 2. A diabetic (blood sugar disease) baseline care plan was not developed for Resident 596's plan of care to address management, treatment, and monitoring of her diagnosis of diabetes and multiple diabetic medications including insulin (a drug given as shot to treat blood sugar) and oral antidiabetic medications. These failures had the potential to result in Resident 545's identified skin issues to worsen and care needs not being met and resulted in a lack of healthcare information necessary to provide effective and person-centered care for Resident 596 which contributed to Resident 596 experiencing a fall as a result of low blood sugar, hospitalization , and subsequent adverse events, including new onset seizures (unusual brain activity/brief, involuntary muscle jerks or twitches), and potentially resulted in not being assessed or treated immediately after the fall. Findings: 1. Review of Resident 545's ADMISSION RECORD, indicated Resident 545 was admitted on [DATE], with multiple diagnoses including but not limited to Enterocolitis due to clostridium difficile (C. Diff; a bacterial infection that causes inflammation of the colon and diarrhea), dementia (loss of the ability to think, remember and reason), generalized muscle weakness, and need for assistance with personal care. During a concurrent interview and record review on 10/4/24, at 2:30 PM, Resident 545's medical record was reviewed with the Director of Nursing (DON). The DON confirmed Resident 545's Admission/Readmission Screen and Baseline Care Plan 4.2, dated 9/25/24, indicated that Resident 545 had left groin redness, right groin redness, and perirectal redness on admission. The DON reviewed Resident 545's care plans which indicated, .Altered skin integrity r/t [related to] right groin redness .Altered skin integrity r/t left groin redness . Altered skin integrity r/t perirectal redness . and confirmed these were all initiated on 10/3/24 (eight days after admission). The DON confirmed Resident 545's baseline care plans should have been initiated within 48 hours of admission. The DON stated the risk for not having care plans initiated for residents included the risk of treatment not being effective, inability to determine if the skin issue deteriorated, or if there was a need to change interventions. 50161 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 596's ADMISSION RECORD, indicated Resident 596 was initially admitted to the facility on [DATE], with a diagnosis of diabetes, among other diagnoses. Review of Resident 596's admission orders from Hospital B, dated 9/12/24, indicated the following orders, . Diabetes Orders .Finger stick blood glucose [FSBG, a way to measure blood sugar level] qAC [before meals] and qHS [before bedtime] .Notify Physician for Change in Condition .Fingerstick Blood Sugar: Notify provider if two BG [blood glucose] results are <70 [less than] or > 400 [greater than] in a 24-hour timeframe and/or change in condition; if no condition change, notify provider on the next business day. Notify provider of .any hypoglycemic event . Further review of Resident 596's facility clinical record revealed these batch orders (the combination of several orders into one) were not carried out upon her admission to the facility on [DATE]. During an interview on 10/4/24, at 1:31 p.m., LN 4 stated she was the admitting nurse for Resident 596 when she first came to the facility on [DATE]. LN 4 further stated Resident 596 was diabetic. LN 4 stated she did not enter the batch order for hypoglycemia (low BG) and hyperglycemia (HIGH BG) protocols and treatment when Resident 596 was first admitted . LN 4 further stated she did not initiate the care plan and stated the care plan was important because it directed the care nursing staff should be providing to the diabetic resident. Review of Resident 596's Admission Readmission Screen and Baseline Care Plan 4.2, dated 9/12/24, indicated Resident 596 was admitted from the hospital with a diagnosis of septic shock (severe blood infection) and was alert and orientated and verbally appropriate. Review of Resident 596's Baseline Care Plan Summary, dated 9/13/24, the record did not indicate a diabetic diagnosis nor mention of any of Resident 596's medications for treatment of her diabetes. Review of Resident 596's clinical progress note titled, Change of Condition, dated 9/20/24, indicated Resident 596 was found lying on the floor with blood coming from her mouth and was then transferred to the hospital via ambulance. Further review of the document did not indicate any nursing interventions to assess her blood glucose level for hypoglycemia. During a telephone interview on 10/4/24, at 12:24 p.m., with Licensed Nurse (LN) 1, LN 1 stated she was Resident 596's LN on 9/20/24 and stated around 2 a.m. the certified nurse assistant (CNA) called for her and she found Resident 596 on the floor, next to her bed, and there was blood coming from her mouth. LN 1 further stated Resident 596 was alert but not orientated and was not acting normal. LN 1 stated Resident 596 was very lethargic (weak/tired), and she checked her blood pressure, oxygen saturation [amount of oxygen in blood], and immediately called 911 for EMS (police/fire/ambulance). LN 1 further stated she was aware Resident 596 was diabetic, but did not take Resident 596's BG. Review of Resident 596's Hospital A's emergency department note, dated 9/20/24, the note indicated, . presents from nursing home for found down on ground with concerns of hypoglycemia found to have glucose of less than 20 [normal blood sugar is 80-120 mg/dL] by EMS .Patient had facial trauma with some blood noticed on her oropharynx [mouth] .Became more awake and alert, however remains nonverbal on route after glucose [sugar] given .Mental status change . Review of Resident 596's Hospital B's discharge summary, dated 9/26/24, indicated, .Patient reportedly had seizure episode twice .Per neurology (doctor who diagnoses, treats, and manages disorders of the brain, spinal cord and nerves) .seizures were triggered by severe hypoglycemia . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/24, at 10:41 a.m., Family Member (FM) 1 stated Resident 596 had never experienced that low of a blood sugar before. FM 1 further stated she spoke with LN 4 on 9/23/24 and was told that Resident 569 had a seizure at the facility, and the facility staff were not checking her BG. During a concurrent interview and record review on 10/4/24, at 2:30 p.m., with the Director of Nurses (DON), Resident 596's clinical record was reviewed. The DON stated care plans were important to create a pathway of care for the resident. The DON explained care plans listed how to monitor treatments related to the problem, and to determine if treatment was effective for the resident. The DON stated the components of a care plan included a focus, goal, and interventions, and directed the care of the resident for the staff. The DON further stated care plans were person centered and should include frequent checks for the residents. The DON confirmed there was no diabetic care plan for Resident 596 and stated Resident 569 should have had a diabetic baseline care plan. The DON explained the baseline care plan directed the initial plan of care until the comprehensive care plan (an ongoing, long term plan of care) could be completed. Review of a facility Policy and Procedure (P&P) titled, Care Plans - Baseline, dated 2001, indicated, .A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission .To assure that the resident's immediate care needs are met and maintained .The Interdisciplinary Team [a group of health care professionals with different areas of expertise who work together to achieve a common goal] will review the healthcare practitioner's orders .medications . initial goals based on admission order .physician orders .The baseline care plan will be used until the staff can conduct the comprehensive assessment [comprehensive care plan] .

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F 0684 Level of Harm - 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** 50161 Based on interview, and record review, the facility failed to ensure one of twenty-three sampled residents (Resident 596) received quality care when, Resident 596, who was diabetic (inability for the body to regulate blood sugar/glucose levels) and received insulin (injectable medication used to control/regulate blood sugar/glucose levels) and oral anti-diabetic medications; 1. Experienced injuries from an unwitnessed fall resulting from low blood sugar levels on 9/20/24, 2. Exhibited signs of confusion and altered level of consciousness (a change in a person's state of awareness) and a licensed nurse did not implement emergent nursing interventions to assess Resident 596's blood glucose (BG) level on 9/20/24, 3. A licensed nurse did not inform Emergency Medical Services (EMS, ambulance/fire/police) of Resident 596's diabetic diagnosis or when she had her last dose of Lantus (Insulin) on 9/20/24; and, 4. Resident 596's Attending Physician (AP) did not ensure she had orders for BG monitoring and testing. These failures led to Resident 596 being treated by EMS for a critically low blood sugar level of 20 (normal blood sugar range is 70-100), being admitted into the intensive care unit (ICU, a special care unit within a hospital for the critically ill), and resulted in Resident 596 having two seizures (a temporary, abnormal burst of electrical activity in the brain that can cause physical changes in behavior). Findings: Review of Resident 596's ADMISSION RECORD, indicated Resident 596 was initially admitted to the facility on [DATE], with diagnoses including but not limited to diabetes. Review of Resident 596's Admission Readmission Screen and Baseline Care Plan 4.2, dated 9/12/24, indicated Resident 596 was admitted from Hospital B and was alert, orientated, and verbally appropriate. Review of Resident 596's skilled nursing facility (SNF) physician orders from Hospital B, dated 9/12/24, indicated .continue all attached orders for 30 days .or until reviewed by SNF Attending Physician .Diabetes Orders .Finger stick blood glucose [BG] [blood test used to determine blood sugar level] qAC [before meals] and qHS [before bedtime] .Notify Physician for Change in Condition .Fingerstick Blood Sugar: Notify provider if two BG results are <70 [less than] or > 400 [greater than] in a 24-hour timeframe and/or change in condition; if no condition change, notify provider on the next business day. Notify provider of .any hypoglycemic event . During a telephone interview on 10/4/24, at 1:31 p.m., LN 4 stated she was the admitting nurse for Resident 596 when she first came to the facility on [DATE]. LN 4 stated she did not put in the portion of the orders which outlined the BG testing/parameters when she entered Resident 596's anti-diabetic medication orders. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident 596's SNF physician orders from Hospital B, dated 9/12/24, indicated Resident 596 was ordered routine intermediate acting insulin (Humulin-an injectable anti-diabetic medication which is between a short acting and long-acting insulin) twice per day (morning and evening), and two oral anti-diabetic medications (Glipizide and Metformin). Attached to the Humulin insulin orders were orders to check Resident 596's BG level. During a concurrent interview and record review on 10/3/24, at 4:16 p.m., LN 3 stated she remembered rounding (looking at residents) with Resident 596's Attending Physician (AP) on 9/13/24. LN 3 stated she remembered the AP changed Resident 596's insulin orders and oral anti-diabetic orders verbally. A review of Resident 596's 9/2024 medication administration record (MAR) with LN 3 indicated Humulin insulin (injectable medication used to control/regulate blood sugar/glucose levels) was changed to Lantus insulin (long acting injectable medication used to control/regulate blood sugar/glucose levels) and when the Humulin insulin order was changed on 9/13/24, there were no more orders for Resident 596's BG to be checked. Further review of the MAR with LN 3 indicated the AP discontinued Resident 596's order for oral Glipizide (oral medication that directs your body to store blood sugar) and doubled the order for oral Metformin (oral medication used to help lower blood sugar levels). LN 3 confirmed the last time Resident 596 had her BG tested was on 9/13/24, one day after admission and no new orders to check Resident 596's BG were written by the AP. LN 3 confirmed she changed Resident 596's orders based on the verbal orders of the AP during rounding. Review of Resident 596's Baseline Care Plan Summary, (a plan of care developed within 48 hours of admission that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) dated 9/13/24, did not indicate a diabetic diagnosis nor mention any of Resident 596's anti-diabetic medications used to treat Resident 596's diagnosis of diabetes. During a concurrent interview and record review on 10/4/24, at 9:41 a.m., the AP stated Resident 596 was admitted to the facility on [DATE] and she came into the facility to evaluate the resident on 9/13/24. The AP stated Resident 596 was on a very high dose of insulin twice per day and she recalled telling Family Member (FM) 1 that Resident 596 could not handle the high doses of insulin, including Humulin. The AP stated her BG was controlled when she was at the hospital, so she decided to change the Humulin to Lantus, and then doubled her dose of Metformin. The AP confirmed she did not write orders for BG monitoring or write orders for a sliding scale (the amount of insulin a person would receive depending on their BG result using a scale ordered by the physician). The AP stated it was a system failure. The AP stated Resident 596 was underweight and continued to receive insulin without BG monitoring and this led to the resident having a fall and a change of condition in the facility. The AP confirmed she should have written orders for Resident 596 regarding hypoglycemia (blood sugar level drops too low) and hyperglycemia (blood sugar levels are too high) management, and parameters including a sliding scale (indicates how much insulin to take before each meal dependent on the blood sugar level), and when to inform the physician as part of diabetic management. The AP stated it might have been an oversight on her part. The AP stated she should have gone over Resident 596's orders more carefully. When asked what the risk to Resident 596 was, the AP stated the risk would be death, seizures, or a hypoglycemic event. Review of Resident 596's clinical progress note titled, Change of Condition, dated 9/20/24, indicated Resident 596 was found lying on the floor with blood coming from her mouth and was transferred to Hospital A via ambulance. Further review of the progress note did not indicate emergent nursing interventions were implemented to assess Resident 596's BG level after the fall. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 596's Hospital A's emergency department note, dated 9/20/24, indicated, .presents from nursing home for found down on ground with concerns of hypoglycemia found to have glucose of less than 20 [normal BG is 70-100] by EMS [can include police/fire/ambulance] given D10 [sugar water given through a vein for treatment of hypoglycemia] .Patient had facial trauma with some blood noticed on her oropharynx [the middle section of the throat, located behind the mouth] .Became more awake and alert, however remains non-verbal on route after glucose given .diabetes on Lantus as well as metformin .unclear if she has been having recent episodes of hypoglycemia .Patient herself is nonverbal unable to get history from patient . Unable to perform ROS [review of symptoms]: Mental status change . Review of Resident 596's Hospital A transfer summary, dated 9/21/24, indicated, .presents with severe hypoglycemia in 20's noted at nursing home with patient found on ground seizing [seizure] per report and oral trauma and abrasion to right knee and left foot . Resident 596 was initially transferred to Hospital A after her fall and was then transferred to Hospital B for further care and treatment. Review of Resident 596's Hospital B transfer summary, dated 9/26/24, indicated, .presented to [Hospital A] on 9/20 due to a ground-level fall at nursing facility. Patient was noticed to be hypoglycemic by EMS with a glucose less than 20 .Patient reportedly had seizure episode twice and was started on Keppra [medication used to treat seizures] .MRI [Magnetic resonance imaging, medical imaging test that produces detailed images of almost every internal structure in the human body] of brain was suggestive of signal abnormality [abnormal electrical activity in the brain] .new onset seizures and involuntary movements .jerks of the right upper extremity .Per neurology [medical specialty that focuses on the diagnosis and treatment of disorders of the brain, spinal cord, and nerves] who evaluated the patient .seizures were triggered by severe hypoglycemia .Reason for Hospital Admission .seizures due to hypoglycemia . During an interview on 10/4/24, at 12:24 p.m., Licensed Nurse (LN) 1 stated she was Resident 596's LN on 9/20/24 and stated around 2 a.m. the certified nurse assistant (CNA) called for her and she found Resident 596 on the floor, next to her bed and there was blood coming from her mouth. LN 1 stated Resident 596 was alert but not acting normal. LN 1 stated Resident 596 was very lethargic (tired/weak). LN 1 stated she checked Resident 596's blood pressure, oxygen level, and immediately called 911 for EMS. LN 1 confirmed she was aware Resident 596 was diabetic but did not take Resident 596's BG level after the fall. LN 1 stated she did not inform the EMS team who arrived that Resident 596 was diabetic or taking insulin. LN 1 stated it would have been important to inform EMS of Resident 596's diabetic status as they would have been able to treat her more immediately. LN 1 stated when she had a new resident, she would review their orders, but she did not get a chance to look at Resident 596's medical history or her orders during her shift on 9/20/24. LN 1 explained it was important to review the clinical record of the resident she was providing nursing care to so she knew about the patient to provide appropriate care. LN 1 stated she could have given Resident 596 glucagon IM (intramuscular; an emergency medicine used to treat severe hypoglycemia administered into a muscle) to treat her hypoglycemia if her BG level was known. LN 1 stated it was important to follow hypoglycemia protocol because this would have helped treat Resident 596's low BG level and would have prevented further decline of the resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/2/24, at 10:41 a.m., FM 1 stated Resident 596 came into the facility following a Urinary Tract Infection (UTI, an infection of the urinary system) and was receiving physical therapy to help her with her strength and was set to be released from the facility on 9/24/24. FM 1 stated she received a phone call on 9/20/24 around 2:30 a.m. from Resident 596's nurse who told her Resident 596 had a seizure and was being rushed to the hospital. FM 1 stated the hospital told her Resident 596's blood glucose was below 20. FM 1 stated Resident 596 had never experienced that low of a BG level. FM 1 stated she spoke with LN 4 on 9/23/24 and she told her Resident 569 had a seizure at the facility, and facility staff had not been checking her blood sugars. FM 1 stated Resident 596 had never experienced low blood sugar and had never experienced a seizure prior to this. FM 1 stated Resident 596 still had slight tremors to her right arm and hand and could not open her mouth completely. Review of a facility Policy & Procedure (P&P) titled, Admission Criteria, dated 3/2019, indicated, .Prior to or at the time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident, including orders covering at least .medication orders, including (as necessary) a medical condition or problem associated with each medication; and .routine care orders to maintain or improve the resident's function until the physician and care planning team conduct a comprehensive assessment and develop a more detailed interdisciplinary care plan .Residents are admitted to this facility as long as their needs can be treated adequately by the facility. Examples of condition that can be treated adequately in this facility include .diabetes . Review of a facility P&P titled, Specific Medication Administration Procedures, dated 4/2008, indicated a goal of .to administer medications in a safe and effective manner . Review of a facility P&P titled Nursing Care of the Resident with Diabetes Mellitus, revised 12/29/18, indicated, .The purposes of this guideline are to: 1. Review the most common and serious conditions and complications associated with diabetes .3. Prevent recurrent hyperglycemia/hypoglycemia .4. Recognize, manage, and document the treatment of complications commonly associated with diabetes .Hypoglycemia . Signs and symptoms of hypoglycemia usually have a sudden onset and may include the following . weakness, dizziness, or faintness .irritability or bizarre changes in behavior .numbness of the tongue and lips/thick speech .(More severe) stupor [unable to act or think normally], unconsciousness and/or convulsions [rapid, involuntary muscle contractions that cause uncontrollable shaking and arm/leg movement] .(More severe) coma [a deep state of prolonged unconsciousness in which a person cannot be awakened, fails to respond normally to painful stimuli, light, or sound] .Glucose Monitoring .1. The management of individuals with diabetes mellitus should follow relevant protocols and guidelines .2. The physician will order the frequency of glucose monitoring .Management of HYPOGLYCEMIA .For unresponsive residents with hypoglycemia (Blood glucose .70 .or less than the physician ordered parameter) .Immediately administer 1 mg [milligram; a unit of measurement] glucagon IM [intramuscular] .and notify MD [Medical Doctor] for further orders. If pt. [patient] remains unresponsive; call 911 (in accordance with patient's advance directives [a legal documents that provide instructions for medical care and go into effect if you cannot communicate your own]) and notify MD; Monitor vital signs; hold diabetic medications & notify MD; monitor vital signs; hold all diabetic medications .

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F 0710

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50161

Based on interview, and record review, the attending physician (AP) failed to provide orders for routine blood glucose (sugar) monitoring and provide adequate physician oversight and management for diabetic (blood sugar disease) care for one of twenty-three sampled residents (Resident 596) when, Resident 596 who was diabetic and received multiple medications to treat her diabetes did not have orders for routine blood sugar monitoring and did not have orders to manage complications associated with her anti-diabetic medication administration and diabetic diagnosis and care.

This failure contributed to Resident 596 experiencing a fall related to low blood sugar, resulting in hospitalization and transfer to the intensive care unit (a department within a hospital for the critically ill), and subsequent adverse events including new onset seizures (unusual brain activity and involuntary movement).

Findings:

Review of Resident 596's ADMISSION RECORD, indicated Resident 596 was initially admitted to the facility on [DATE], with a diagnosis of diabetes among other diagnoses.

Review of Resident 596's admission orders from Hospital B dated 9/12/24, indicated, .Diabetes Orders . Finger stick blood glucose [FSBG] qAC [before meals] and qHS [before bedtime] .Notify Physician for Change in Condition .Fingerstick Blood Sugar: Notify provider if two BG results are <70 [less than] or > 400 [greater than] in a 24-hour timeframe and/or change in condition .Notify provider of .any hypoglycemic [low blood sugar] event . Further review of Resident 596's clinical record indicated these admitting orders were not carried out upon her admission to the facility on [DATE].

Review of Resident 596's Order Summary Report, (document which includes all medication, tests, and non-medication orders) dated 9/13/24, the report did not include orders for FSBG before meals or before bedtime, orders for when to notify the physician for change in condition, nor did it include orders for parameters for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar), and an order for physician notification for Resident 596.

Review of Resident 596's Order Summary Report, dated 9/13/24, signed by the Attending Physician (AP), indicated handwritten orders as follows:

.Active Orders As Of .9/12/24 .I have approved these orders for [Resident 596] .Physician .[AP name] . Signature .[AP name] .Date .9/13/24 .

1. start Lantus [long acting injectable insulin/antidiabetic medication] insulin - 25 units [measure of dosage] subcut [subcutaneous, inject under the skin] at bedtime .

2. [increase] metformin [oral medication to treat to diabetes] .1 gm po BID [gm is gram a unit of measure, po by mouth, BID means twice a day] .

3. stop glipizide[oral diabetic medication to treat diabetes] .[AP signature] .9/13/24 .

(continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the record indicated Resident 596's summary of all medical orders entered by facility's nursing staff onto the Order Summary Report, were reviewed and approved by the AP. Further review of the Order Summary Report, indicated the AP did not include orders to stop Resident 596's NPH insulin (intermediate-acting insulin) and did not include orders for FSBG monitoring. The AP did not order diabetic emergency medication administration for reversal of low or high blood sugars. The AP did not order parameters to monitor and guide the nursing staff on use of high-risk medications such as insulin, or orders for nursing staff to monitor the resident for signs and symptoms of very low or very high blood sugar, or orders for when to notify the physician. Review of Resident 596's clinical record titled, Physician Admission Progress Note, written by the AP, dated 9/13/24, and faxed to the facility four days later on 9/16/24, the document indicated Resident 596 was to have a sliding scale (FSBG determines the amount of insulin received) for insulin administration and NPH was to be discontinued, however there were no orders written in the clinical record for staff to follow. The progress note did not include FSBG checks, did not include orders for hypoglycemia or hyperglycemia management, or parameters of when to notify the physician regarding her diabetic management, nor were there orders for emergency medications to treat a hypoglycemic or hyperglycemic event. During a review of Resident 596's Medication Administration Record, (MAR, a document listing all medications and tests administered/carried out by nursing staff) dated 9/24, indicated Resident 596 was receiving multiple diabetic medications including insulin and oral anti-diabetic medication. The record indicated Resident 596 did not have orders for blood glucose monitoring, no orders for emergency diabetic medications to treat hypoglycemia, no parameters or a sliding scale for her insulin administration, and no instructions on when to notify the physician regarding her blood glucose management including hypoglycemic or hyperglycemic events. Further review of Resident's 596's MAR indicated the nursing staff recorded two FSBG measurements in the first 24 hour of admission, while administering NPH insulin and glipizide (an oral antidiabetic drug), as follows: 9/12/24, BG was 301 mg/dL at 8 p.m., and on 9/13/24 BG was 232 mg/dL at 7 a.m. The record did not indicate if the AP reviewed the first 24-hour BG records when she visited the resident in the facility. The record indicated blood sugar measurements were discontinued after the AP visit. During a concurrent interview and record review, with Licensed Nurse (LN) 3, on 10/3/24, at 4:16 p.m., LN 3 stated she was the nurse who managed the care of Resident 596 in the facility. LN 3 stated the workflow was for the admission nurse to go over admitting orders and ensured they were inputted accurately in the computer system. LN 3 stated she remembered rounding (checking on residents) with Resident 596's AP during her initial visit when the AP changed the insulin and diabetic orders. LN 3 stated she put the new orders in the computer system and stopped the NPH insulin although there was no written order to do so. LN 3 stated the FSBS orders were discontinued when the NPH order was stopped. LN 3 stated no orders for emergency rescue medication and treatment of low and high blood sugar were processed or entered in the computer system during Resident 596's stay at the facility. Review of Resident 596's MAR (9/24), indicated Resident 596 received seven doses of Lantus 100 units/mL (unit of measure), inject 25 units subcutaneously at bedtime on 9/13/24/, 9/14/24, 9/15/24, 9/16/24, 9/17/24, 9/18/24, and 9/19/24. Further review of Resident 596's clinical record did not include entries for FSBG associated with the medication administration. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 596's clinical progress note titled, Change of Condition, dated 9/20/24, indicated the resident was found lying on the floor with blood coming from her mouth and was then transferred to the hospital via ambulance. Further review of the document did not indicate any nursing intervention to assess Resident 596's blood glucose level or treatment. Review of Resident 596's Hospital A's emergency department note, dated 9/20/24, indicated, .presents from nursing home for found down on ground with concerns of hypoglycemia found to have glucose of less than 20 [normal blood sugar is 80-120] by EMS [emergency medical services] .Patient had facial trauma with some blood noticed on her oropharynx [mouth] .Became more awake and alert, however remains nonverbal on route after glucose [sugar] given .type 2 diabetes on Lantus [long-acting insulin] as well as metformin . unclear if she has been having recent episodes of hypoglycemia .Patient herself is nonverbal unable to get history from patient .Unable to perform ROS [review of symptoms]: Mental status change . Review of Resident 596's Hospital B (transferred to this hospital from Hospital A for further care and treatment) discharge summary, dated 9/26/24, indicated, .presented to [Hospital A] on 9/20 due to a ground-level fall at nursing facility. Patient was noticed to be hypoglycemic by EMS with a glucose less than 20 Patient reportedly had seizure episode twice and was started on Keppra [medication used to treat seizures] .MRI [Magnetic resonance imaging, medical imaging test that produces detailed images of almost every internal structure in the human body] of brain was suggestive of signal abnormality .Seizure x2 [two times] .new onset .jerks of the right upper extremity. Neurology [brain physician] evaluated the patient. Per neurology .seizures were triggered by severe hypoglycemia . During a concurrent interview and record review on 10/4/24, at 9:41 a.m., with the AP, the AP stated Resident 596 was admitted on [DATE] and she came into the facility to evaluate the resident on 9/13/24. The AP stated she would come into the facility to review the medications and check if there were any problems with the resident. The AP stated her expectation of LN's were to follow the orders from the hospital until the facility doctor comes into the facility. The AP stated she recalled seeing Resident 596, and acknowledged she was very thin and weighed about 100 lbs. (pounds- a unit of weight). The AP stated Resident 596 was on a very high dose of insulin twice per day. The AP reviewed her clinical charting notes and her admission orders and confirmed she did not write an order to stop the NPH. The AP confirmed Resident 596's diabetes was not well controlled and had unstable blood sugars. The AP stated Resident 596 should have had a sliding scale combined with a short acting insulin (an insulin that works right away) for better BG control. The AP confirmed there was no order for short acting insulin and confirmed there was no orders for BG monitoring or testing. The AP stated her notes from her visit on 9/13/24, for Resident 596, were faxed to the facility four days later, on 9/16/24. The AP stated staff may have not read her notes. The AP confirmed that LN's could not have implemented new orders for a resident unless they were written or confirmed by the medical doctor. The AP stated she assumed the orders for management of high and low blood sugar did not require an order as it was standard protocol at another facility she worked at. The AP stated she should have gone over Resident 596's orders more carefully as this resident did experience a fall, low blood sugar, and seizures. The AP stated she was ultimately the responsible person for the medical care provided to a resident. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the facility's Medical Director (MD), on 10/4/24, at 1:13 p.m., the MD stated BG checks for diabetic residents on insulin should have been at least ordered twice a day, in the morning and before bed. The MD stated the resident should have been tested more often if there were signs and symptoms of hypoglycemia or hyperglycemia. The MD stated all residents who receive insulin in the facility should have emergency medication orders to treat hypoglycemia. Duirng a concurrent interview and record review on 10/4/24, at 2:30 p.m., the Director of Nurses (DON) stated there was no policy that diabetic residents should have had a standard or standing order for blood glucose monitoring. The DON stated her expectation was that all diabetic residents should have orders and/or guidelines for nursing staff to treat hypoglycemia and hyperglycemia. The DON stated the facility needed a doctor's order to administer emergency medication for treatment of a low blood sugar. The DON stated Resident 596 was at risk for blood sugar irregularities without FSBG checks. The DON stated Resident 596 experienced a fall in the facility, perhaps as a result of low blood sugar, and later found out her blood sugar was extremely low when emergency medical services arrived and checked her blood sugar. Review of a facility policy and procedure (P & P) titled, Admission Criteria, dated March 2019, indicated, .Our Facility admits only residents whose medical and nursing care needs can be met .Prior to or at the time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident, including orders covering at least .medication orders, including (as necessary) a medical condition or problem associated with each medication; and .routine care orders to maintain or improve the resident's function until the physician and care planning team conduct a comprehensive assessment and develop a more detailed interdisciplinary care plan .Residents are admitted to this facility as long as their needs can be treated adequately by the facility. Examples of condition that can be treated adequately in this facility include .diabetes . Review of a facility P&P titled, Nursing Care of the Resident with Diabetes Mellitus, revised 12/29/18, the policy under Glucose Monitoring indicated, .The physician will order the frequency of glucose monitoring. The policy further indicated, management of hypoglycemia and hyperglycemia per physician ordered parameters.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. 40903 Based on interview, and record review, the facility failed to ensure the safe use of insulin (a high-risk injectable medication used to treat diabetes, a blood sugar disease) for two residents with diabetes (Resident 1 and Resident 596) out of a sample of 23 residents, when: 1. Resident 1's order for insulin did not include parameters with instruction when blood sugar was high, and ongoing high blood sugar levels were not treated or reported to the medical doctor; and, 2. Resident 596's diabetic medication and insulin use was not monitored by blood sugar measurement. These failures may have contributed to unsafe insulin and antidiabetic drug use and subsequent adverse events. Findings: 1. During a review of Resident 1's electronic medical record (EMR) titled, Diagnosis, the record indicated diagnoses of diabetes, heart, and kidney disease while under hospice care (comfort care) via primary care Medical Doctor (MD). During a review of Resident 1's EMR titled, Medication Administration Record, (or MAR, a document which lists medications and treatments administered based on doctor's order) for 9/2024 and 10/2024, the record indicated Resident 1 was given two types of insulin with four times per day blood sugar monitoring as follows: i. HumaLOG .[Insulin Lispro, a short acting insulin]; Inject 3 unit subcutaneously [injection under the skin, unit is how insulin dose is measured] before meals for DM [diabetes]; Hold Humalog insulin if blood sugar less than 70 [normal blood sugar number is between 80-120]; Start date: 9/30/24. ii. Lantus . [Insulin Glargine, a long-acting insulin]; Inject 20 unit subcutaneously at bedtime for DM Hold if BS [Blood Sugar] less than 70; Start Date: 6/8/24. Further review of insulin orders indicated there was no parameter to address high blood sugar numbers and the order did not address when or at what point the physician should have been contacted. Review of Resident 1's blood sugar numbers documented in the EMR for September 2024 and the first 3 days of October 2024, indicated high blood sugar numbers as follows: I. September 2024- 9 PM blood sugar recordings indicated 19 times when the blood sugar was above 300 and 8 times when it was above 400 with no additional treatments or interventions. II. September 2024- 5 PM blood sugar recordings indicated 18 times when the blood sugar was above 300 and 9 times above 400 with no additional interventions. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. September 2024- 12 noon blood sugar recordings indicated 13 times the blood sugar was above 300 and no additional interventions. IV. October 2024- 5 blood sugars were recoded above 300 in the first three days of October with no additional interventions. Review of Resident 1's EMR titled, Progress Notes, with date range of 9/3/24 to 10/3/24, did not show any nursing documentation to address high blood sugar numbers or notification of the MD. Review of MD 1's progress notes titled, Office Visit, dated 9/24/24, under assessment and plan for diabetes indicated, .monitor FSBG [Finger Stick Blood Sugar-when finger is poked to get blood to measure blood sugar level]; Continue current meds [Medications]. The doctor's monthly note did not address Resident 1's current trends and high blood sugar numbers. Review of Resident 1's plan of care (a nursing care plan on how to monitor resident's medical condition) for diabetes, last revised on 8/26/24, indicated, observe/report sign and symptoms of hyperglycemia [high blood sugar] .to MD promptly .Check blood sugar via finger stick as ordered. Notify MD if blood sugar less than 70 or more than 400. During an interview on 10/4/24, at 9:02 AM, with Licensed Nurse (LN) 7 at the North station, LN 7 stated she had cared for Resident 1 for a while. LN 7 further stated MD 1 followed him. LN 7 stated the insulin order did not have a sliding scale (to give insulin based on the blood sugar number) to address variation in the blood sugar. LN 7 further stated the order in the MAR did not have parameters to notify the doctor and acknowledged high blood sugar numbers in the evenings. During a telephone interview on 10/4/24, at 12:59 PM, with MD 1, MD 1 stated he was not aware of Resident 1's blood sugar was in the 300 to 400 range. MD 1 could not recall if he addressed the high blood sugar numbers in his monthly notes. MD 1 stated he needed to address the blood sugar control in the setting of the hospice care when multiple high-risk medications continued to be given per his orders. During an interview on 10/4/24, at 3:35 PM, with the Director of Nursing (DON), in her office, the DON stated the nursing staff should have called the doctor to get parameters to address the high and low blood sugar. The DON stated the physician should have reviewed the trend in blood glucose and guided the nurses on how to monitor or when to call the provider. Review of the facility's policy titled, Nursing Care of the Resident With Diabetes Mellitus, dated 12/2019, the policy under Purpose indicated, The purpose of this guideline are to: 1. Review the most common and serious conditions and complications associated with diabetes .3. Prevent recurrent hyperglycemia/hypoglycemia [High and Low blood sugar complications]; 4. Recognize, manage, and document the treatment of complications commonly associated with diabetes . The policy under, Management of HYPERGLYCEMIA indicated, If Blood glucose is 400 mg/dL [mg/dL is milligram per Deciliter, a measure of blood sugar value] and above, or more than the MD physician ordered parameter: Administer insulin as ordered and call physician. Review of a facility policy titled, Specific Medication Administration Procedures, dated 4/2008, the policy indicated the goal to administer medications in a safe and effective manner.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 50598 Based on interview, and record review, the facility failed to ensure an anti-anxiety medication was administered correctly for 1 of 23 sampled residents (Resident 61) when Resident 61 received a lower dose of anxiety medication 18 times in May of 2024 and once in September of 2024. This failure had the potential for Resident 61 to experience increased anxiety and emotional distress. Findings: Review of Resident 61's physician orders indicated, Lorazepam [or Ativan-an anxiety medication] oral tablet 1 mg [mg-milligram is a unit of measure]; Give 1 tablet by mouth every 6 hours for agitation with behaviors; Start Date: 4/29/24. During a comparative review of Resident 61's Controlled Drug Record (CDR, a paper record that keeps track of controlled medications and is used for accountability) and the MAR (a record of medications ordered and administered) for May 2024 and September 2024, the MAR documentation did not match the removal from the CDR when Ativan 0.5 mg was removed by nursing staff as follows: 5/3/24- two times Ativan 0.5mg given and documented as Ativan 1 mg given, 5/4/24- three times Ativan 0.5mg given and documented as Ativan 1 mg given, 5/5/24- four times Ativan 0.5mg given and documented as Ativan 1 mg given, 5/6/24- five times Ativan 0.5mg given and documented as Ativan 1 mg given, 5/7/24- two times Ativan 0.5mg given and documented as Ativan 1 mg given, 5/9/24- two times Ativan 0.5mg given and documented as Ativan 1 mg given, 9/10/24- one time Ativan 0.5mg given and documented as Ativan 1 mg given, The MAR documentation sheet for Ativan indicated the nursing staff documented the Ativan 0.5 mg administration under the higher dose of Ativan 1 mg on the above dates. During an interview on 10/2/24, at 11:27 AM, with the Director of Nursing (DON), the DON stated Resident 61 did not receive the medication as ordered by physician and Resident 61 received Ativan 0.5mg instead of Ativan 1 mg dose which was half of the dose ordered by the doctor. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, PREPARATION AND GENERAL GUIDELINES; CONTROLLED MEDICATIONS, dated August 2014, indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration 2) Amount administered 3) Signature of the nurse administered the dose on the accountability record the time the medication is removed from the supply. 4) Initials of the nurse administering the dose on the MAR after the medication is administered . A review of the facility's policy and procedure titled, SPECIFIC MEDICATION ADMINSTRATION PROCEDURES, dated 4/2008, indicated To administer medications in a safe and effective manner .read medication label before administering.

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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** 40903 Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in medication carts (a mobile cart storing medications to be administered to residents) for a census of 93 when: 1. Medication Cart #4 at the facility's South station stored an outdated Lantus insulin Pen (blood sugar drug in a pen form) with an open date (the date the insulin was out of refrigerator and was started to be used) of [DATE] and the pharmacy label indicated discard 28 days after opening; and, 2. The treatment cart at the facility's North station stored an opened bottle of Sterile Sodium Chloride [a mixture of salt and water that is free from bacteria which is used to rinse sinuses, clean wounds, flush eyes and more] in the cart. These failed practices may result in residents receiving expired or unusable medications. Findings: 1. During a concurrent interview and inspection of medication cart #4 at facility's North Station, on [DATE], at 11:27 AM, accompanied by Licensed Nurse 5 (LN) 5, the cart stored an insulin Lantus pen that was opened on [DATE] and the label on the pen indicated discard the product 28 days after opening. LN 5 acknowledged the insulin pen was beyond its use date. 2. During a concurrent interview and inspection of the facility's treatment cart at the South station, on [DATE], at 4:38 PM, accompanied by LN 6, the treatment cart contained one opened bottle of a wound care solution (liquid form) called Sterile Sodium Chloride Irrigation (Microbe free salt solution). The container's label indicated sterile .Single use, Discard unused portion. LN 6 acknowledged the finding and stated the bottle should have been tossed out. During an interview on [DATE], at 4:25 PM, with the Director of Nursing (DON), the DON stated the insulin pen should have been discarded after 28 days and single use products should have been tossed out after use. Review of the facility's policy titled, Medication Storage in the Facility, dated ,d+[DATE], the policy indicated, . outdated, contaminated, or deteriorated medications .are immediately removed from stock and disposed of according to procedure for medication disposal .

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NAME OF PROVIDER OR SUPPLIER North Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2586 Buthmann Ave Tracy, CA 95376	

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 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** 40583 Based on observation, interview, and record review, the facility failed to store and distribute food in accordance with professional standards for food service and safety when: 1. Dietary Aide (DA) 1 was not wearing a hair net while in the kitchen, 2. Drinking glasses and food containers were wet nested (stacked wet promoting growth of bacteria), 3. Clean fruit cups, stored under the dishwasher, had water dripping onto them, 4. Expired yogurt was available for resident consumption, 5. Dishwasher water temperature was not in range, 6. Parts per million (PPM - amount of solution in water) of the dishwashing solution was below the accepted standard, 7. Two of three utensil drawers contained a moderate amount of dust and debris, 8. Two dented cans of corn were found in food storage; available for resident consumption, 9. Three fans in the kitchen, including the food prep area, contained a moderate amount of dust and debris; and, 10. There was a moderate amount of dust and debris on the counter above the stove top and on the oven. These failures had the potential of leading to food borne illnesses in the 89 residents receiving facility prepared meals. Findings: 1. During a concurrent observation and interview on [DATE], at 8:32 AM, with the Dietary Services Supervisor (DSS), a Dietary Aide (DA) 1, was observed in the kitchen, not wearing a hairnet. DA 1 stated he should have been wearing a hairnet, so hair did not get into the food. The DSS confirmed DA 1 was not wearing a hairnet. The DSS explained the importance of hairnets was to prevent hair from falling into the food, which could negatively impact food safety. 2. During a concurrent observation and interview on [DATE], at 8:35 AM, with the DSS, the DSS confirmed plastic glasses and food containers were wet nested. During a follow up interview on [DATE], at 9:30 AM, with the DSS, the DSS explained wet nesting could promote bacterial growth and it would not be safe for patients to consume food from dishes that had been wet nested. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility policy titled, Sanitization, revised [DATE], indicated, The food service area shall be maintained in a clean and sanitary manner .All kitchens, kitchen areas and dining areas shall be kept clean . All utensils, counters, shelves and equipment shall be kept clean . 3. During a concurrent observation and interview on [DATE], at 8:35 AM, with the DSS, the DSS confirmed there was water dripping from the dishwasher area onto clean fruit cups. The DSS explained clean fruit cups should not have water dripping on them from the dishwasher above. A review of the facility policy titled, Sanitization, revised [DATE], indicated, The food service area shall be maintained in a clean and sanitary manner .All kitchens, kitchen areas and dining areas shall be kept clean . All utensils, counters, shelves and equipment shall be kept clean . 4. During a concurrent observation and interview on [DATE], at 8:53 AM, with the DSS, in the kitchen walk-in refrigerator, the DSS confirmed there were two containers of yogurt, past their best-by date, available for resident consumption. The DSS explained they should have been discarded and not available for resident consumption. A review of the facility policy titled, Food Receiving and Storage, revised [DATE], indicated, .All refrigerated unopened foods must be consumed by useby or best by date . 5. During a concurrent observation and interview on [DATE], at 8:55 AM, with DA 2, DA 2 stated the dishwasher should be 120 degrees. During a concurrent observation and interview on [DATE], at 9 AM, with the DSS, the DSS stated the dishwasher temperature should be 120 degrees or greater. The DSS confirmed the dishwasher temperature was 110 degrees, 10 degrees below the required 120 degrees. During a follow up interview on [DATE], at 9:30 AM, with the DSS, the DSS explained it was important to make sure the dishes were clean to ensure it was safe for the residents to eat off them. A review of the facility policy titled, Sanitization, revised [DATE], indicated, .Low-Temperature Dishwasher . Wash temperature (120 degrees F [Fahrenheit a unit of measure]) . 6. During a concurrent observation and interview on [DATE], at 8:56 AM, with DA 2, DA 2 tested the PPM of the dishwasher solution, it was 10 PPM and stated it should have been between ,d+[DATE] PPM. During a follow up interview on [DATE], at 9:30 AM, with the DSS, the DSS explained it was important to make sure the dishes were clean to ensure it was safe for the residents to eat off them. A review of the facility policy titled, Sanitization, revised [DATE], indicated, .Low-Temperature Dishwasher (Chemical Sanitization) .Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds . 7. During a concurrent observation and interview on [DATE], at 9 AM, with the DSS, two of three utensil drawers were noted to have a moderate amount of dust and debris. The DSS confirmed there was a moderate amount of dust and debris in the two utensil drawers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview on [DATE], at 9:30 AM, with the DSS, the DSS explained it would not be safe to use the utensils for cooking, they needed to be cleaned for food safety. A review of the facility policy titled, Sanitization, revised [DATE], indicated, The food service area shall be maintained in a clean and sanitary manner .All kitchens, kitchen areas and dining areas shall be kept clean . All utensils, counters, shelves and equipment shall be kept clean . 8. During a concurrent observation and interview on [DATE], at 9 AM, with the DSS, the DSS confirmed there were two dented cans of corn in the food storage area, available for resident consumption. The DSS explained the dented cans should be returned and not available for resident consumption. A review of the facility document titled, Sanitation and Infection Control .Canned and Dry Goods Storage, dated 2023, indicated, .Canned food items should be routinely inspected for damage such as dented, bulging or leaking cans. These items should be set aside in a designated area for return to the vendor or disposed of properly . 9. During a concurrent observation and interview on [DATE], at 9:30 AM, with the DSS, the DSS confirmed three fans in the kitchen, including the food preparation area contained moderate amounts of dust and debris. The DSS explained the dust and debris were a concern for infection prevention and food safety. A review of the facility policy titled, Sanitization, revised [DATE], indicated, The food service area shall be maintained in a clean and sanitary manner .All kitchens, kitchen areas and dining areas shall be kept clean . All utensils, counters, shelves and equipment shall be kept clean . 10. During a concurrent observation and interview on [DATE], at 9:30 AM, with the DSS, the DSS confirmed there was a moderate amount of dust and debris on the counter above the stove top and on top of the oven. The DSS explained the dust and debris could get in residents' food and it would not be safe for the residents to consume the food. A review of the facility policy titled, Sanitization, revised [DATE], indicated, The food service area shall be maintained in a clean and sanitary manner .All kitchens, kitchen areas and dining areas shall be kept clean . All utensils, counters, shelves and equipment shall be kept clean .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 40583 Based on interview, and record review, the facility failed to provide documented evidence of education for immunizations (a process by which a person becomes protected against a disease through vaccination) when: 1. One of four sampled residents' (Resident 14) and one unsampled resident (Resident 23) records did not indicate education was provided for the Influenza (a common, sometimes deadly viral infection of the nose, throat and lungs, also called flu) vaccine; and, 2. One unsampled resident's (Resident 23) record did not indicate education was provided for the Pneumococcal Polysaccharide (PPSV 23 - for prevention of pneumonia; an infection that affects one or both lungs) vaccine. This failure had the potential for Resident 14 and Resident 23 to not be aware or informed of the benefits, risks, and potential side-effects of the vaccinations prior to receiving or declining the vaccination. Findings: 1. During a concurrent record review and interview on 10/4/24, at 8:40 AM, with the Infection Preventionist (IP), Resident 14's Influenza record, dated 9/29/23, was reviewed. The IP acknowledged the box titled, Education Provided to Resident/Family, was not checked and the IP confirmed there was no documented evidence of education provided to Resident 14 regarding the Influenza vaccination he received on 9/29/23. During a concurrent record review and interview on 10/4/24, at 8:40 AM, with the IP, Resident 23's Influenza record, dated 12/13/23, was reviewed. The IP acknowledged the box titled, Education Provided to Resident/Family, was not checked and the IP confirmed there was no documented evidence provided to Resident 23 regarding the risk and benefits of refusing the Influenza Vaccination. A review of the facility policy titled, Influenza Vaccine, revised August 2016, indicated, .Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine .Provision of such education shall be documented in the resident's/employee's medical record .A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record . 2. During a concurrent record review and interview on 10/4/24, at 8:40 AM, with the IP, Resident 23's PPSV 23 record, dated 5/6/21, was reviewed with the IP. The IP acknowledged the box titled, Education Provided to Resident/Family, was not checked and the IP confirmed there was no documented evidence of education provided to Resident 23 regarding the PPSV 23 vaccination she received on 5/6/21. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/24, at 9:25 AM, the Director of Nursing (DON), the DON stated providing education to residents prior to administer or refusal of a vaccination gives the resident sufficient information on the medication they were receiving such as the risks and benefits. The DON explained it gave the resident the opportunity to agree or not agree to recieve the vaccination. A review of the facility policy titled, Pneumococcal Vaccine, revised August 2016, indicated, .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 .Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 40583 Based on interview, and record review, the facility failed to provide documented evidence of education for immunizations when four of four sampled residents' (Resident 14, Resident 17, Resident 20, and Resident 42) and one unsampled resident's (Resident 23) clinical records did not contain documented evidence of education for the COVID-19 vaccination. This failure had the potential for Resident 14, Resident 17, Resident 20, Resident 42, and Resident 23 to not be aware or informed of the benefits, risks, and potential side-effects of the COVID-19 vaccination prior to receiving or declining the vaccination. Findings: During a concurrent interview and record review on 10/4/24, at 8:40 AM, with the Infection Preventionist (IP), the IP acknowledged the box titled, Education Provided to Resident/Family, was not checked, and the IP confirmed the medical records for Resident 14, Resident 17, Resident 20, Resident 42, and Resident 23 did not contain documented evidence of education for the COVID-19 vaccinations risk and benefits to the above residents was provided. During an interview on 10/4/24, at 9:25 AM, with the Director of Nursing (DON), the DON stated providing education to the resident prior to administer or refusal of a vaccination gave the resident sufficient information on the medication they were receiving such as the risks and benefits. The DON explained it gave the resident the opportunity to agree or not agree. A review of the facility policy titled, COVID-19 Vaccination, revised 10/4/23, indicated, .Before the COVID-19 vaccine is offered, the Resident and Staff are provided with education regarding the benefits, risks, and potential side effects associated with the vaccine .The Resident's medical record includes documentation that indicates the following .That the Resident or Resident Representative was offered the COVID-19 vaccine or information on obtaining the COVID-19 vaccine .