STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555249	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sea Cliff Healthcare Center	18811 Florida St Huntington Beach, CA 92648

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview and medical record review, the facility failed to ensure the MDS was coded accurately for two of three final sampled residents (Residents 25 and 87) reviewed for nutrition. * The facility failed to ensure the MDS was coded accurately when Resident 25 had a weight loss of more than 5% in a month. * Resident 87's MDS was inaccurately coded to reflect the resident's weight gain. These failures had the potential for the residents to not receive individualized plans of care to address their individual care needs and inaccurate data for quality measures. Findings: 1. Medical record review for the Resident 25 was initiated on 2/11/25. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 25's Admission MDS dated [DATE], showed Resident 25's weight as 153 lbs. Review of Resident 25's Weights and Vitals Summary dated 2/13/25, showed the following weights: - on 11/23/24, a weight of 156.6 lbs; - on 11/25/24, a weight of 153 lbs; - on 12/1/24, a weight of 147.4 lbs; - on 12/9/24, a weight of 147.4 lbs; - on 12/16/24, a weight of 143 lbs; and - on 12/23/24, a weight of 139.6 lbs; (8.76 % weight loss in comparison to the weight of 153 lbs on 11/25/24) (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 25's Discharge Assessment- Return Anticipated MDS dated [DATE], showed Resident 25's weight as 140 lbs. However, the section for Weight Loss, Loss of 5% or more in the last month or loss of 10% or more in last six months showed, No or unknown. On 2/13/25 at 1140 hours, an interview and concurrent medical record review for Resident 25 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings. The MDS Coordinator stated Resident 25 had more than 5% weight loss in a month, so the MDS on 12/24/24, should have been coded yes for the section for Loss of 5% or more in the last month or loss of 10% or more in last six months. The MDS Coordinator stated the dietary department was responsible to complete the MDS assessment of the residents' nutrition in the facility. On 2/14/25 at 0930 hours, an interview and concurrent medical record review for Resident 25 was conducted with the DON. The DON verified and acknowledged above findings. 39683 2. Medical record review for Resident 87 was initiated on 2/11/25. Resident 87 was readmitted to the facility on [DATE]. Review of Resident 87's Weight and Vitals Summary showed the following weights: - on 7/3/24, a weight of 114 lbs. - on 1/1/25, a weight of 130.8 lbs (an increase of 14%). However, review of Resident 87's Quarterly MDS assessment dated [DATE], showed, no or unknown for the section showing if the resident had a weight gain of 5% or more in the last month, or 10% or more in the last six months. The dietary section was signed as completed by the DSS. On 2/12/25 at 1430 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 87's weights and MDS data and verified the MDS assessment on 1/15/25, was incorrectly coded. The MDS Coordinator stated the dietary section was completed by the DSS.

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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 - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of four final sampled residents (Resident 47) reviewed for accidents. * Resident 47's post fall neurological evaluation was missing the hourly neurological assessments after the resident had an unwitnessed fall on 1/18/25. This failure had the potential for a delay in providing care to the resident. Findings: Review of the facility's P&P titled Neurological Evaluation revised 3/28/23, showed a neurological assessment will be done every 15 minutes for one hour, then every 30 minutes for four hours, then every hour for two hours, and then every shift for 72 hours. Medical record review for Resident 47 was initiated on 2/11/25. Resident 47 was readmitted to the facility on [DATE]. Review of Resident 47's Nursing Note dated 1/18/25 at 2010 hours, showed at 2005 hours, Resident 47 had an unwitnessed fall and was found on the floor mat next to the wheelchair. Review of Resident 47's Neurological Assessment Flowsheet initiated on 1/1/8/25 at 2010 hours, showed the neurological assessments should be completed every 15 minutes for one hour, then every 30 minutes for four hours, then every hour for two hours, and then every shift for 72 hours. Review of the flowsheet showed the first hourly assessment was completed on 1/19/25 at 0155 hours; however, there was no second hoursly assessment done at 0255 hours. The next assessment was performed two hours later at 0355 hours. On 2/13/25 at 1605 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for the unwitnessed falls, the post fall neurological assessments should be conducted per the frequency listed on the flowsheet. The DON reviewed Resident 47's Neurological Assessment Flowsheet and verified the scheduled neurological assessment for 1/19/25 at 0255 hours, was not completed. The DON stated it should have been done.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services related to the GT per the facility's P&P for three of three final sampled residents (Residents 87, 111, and 152) reviewed for enteral feeding. * Two of two licensed nurses administered the medications to Residents 111 and 152 by pushing the medications through the GT instead of gravity. * One of two licensed nurses (LVN 4) did not check the tube placement and residual volume before the GT medication administration for Resident 111. * Resident 87's GT placement and residual checks were not performed prior to starting the resident's enteral feeding. These failures had the potential for the residents to develop complications related to the GT care and management, including tube dislodgement, infection of the GT site, delayed nutritional feeding, and trauma. Findings: 1. Review of the facility's P&P titled Enteral Tube Medication Administration Procedures dated 1/28/25, showed the licensed nurse allows medication to flow down tube via gravity and give gentle boosts with the plunger (approximately 1 inch down) if the medication will not flow by gravity. a. Medical record review for Resident 152 was initiated on 2/11/25. Resident 152 was admitted to the facility on [DATE], with a diagnosis of dysphagia (difficulty swallowing), following a cerebral infarction (stroke due to blockage of blood flow to the brain). Review of Resident 152's Order Summary Report showed the following physician's order: - dated 11/13/24, for the enteral feed order, to crush all crushable medications given via feeding tubes; and may slow push to facilitate consumption. On 2/11/25 at 0815 hours, a medication pass observation was conducted with LVN 8. LVN 8 was observed administering six medications, including five medications via GT for Resident 152. Before administering the medications, LVN 8 placed the tip of a 60 ml syringe into a cup of water and withdrew about 15 ml of water by pulling back the plunger of the syringe with her left hand, while holding the GT with her right hand. Then, LVN 8 was observed attaching the syringe to the GT and administering the water by pushing the plunger into the syringe rapidly (over 3-5 seconds) to deliver the water into the GT. LVN 8 was observed using the same method of pushing the plunger into the syringe rapidly when administering each medication. (continued on next page)

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 2/11/25 at 1228 hours, an interview was conducted with LVN 8. LVN 8 stated depending on the medications, some medications could be pushed, and some medications were administered by gravity. LVN 8 also stated she pushed the medications by following the physician's order for the GT medication administrations and showed the physician's order written on 11/13/24, with a direction to crush all crushable medication given via feeding tube. May slow push to facilitate consumption.

b. Medical record review for Resident 111 was initiated on 2/12/25. Resident 111 was admitted to the facility on [DATE], with a diagnosis of dysphagia.

Review of Resident 111's Order Summary Report showed the following physician's order:

- dated 9/6/24, for the enteral feed order, to crush all crushable medications given via feeding tubes; and may slow push to facilitate consumption.

On 2/12/25 at 0814 hours, a medication pass observation was conducted with LVN 4. LVN 4 was observed administering nine medications, including eight medications via the GT for Resident 111. LVN 4 withdrew the prepared medications from the first cup by pulling back the plunger of 60 ml syringe. LVN 4 started administering the first medication by pushing the plunger into the syringe rapidly (over 3-5 seconds) to deliver the medication into the GT. Before administering the second medication, LVN 4 stated he made a mistake and was supposed to use the gravity method to administer medications into the GT. LVN 4 was then observed using the gravity method to administer the remaining seven medications into the GT.

On 2/12/25 at 1110 hours, an interview was conducted with LVN 4. LVN 4 verified he did not use the gravity method when he administered the first medication into the GT.

On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON acknowledged when giving the medications through the GT, the licensed nurse was supposed to administer the medications by pouring the liquid into the syringe and let it go down by the gravity. The DON stated it was okay to push the medications with the syringe and plunger but very slowly and gently for about one inch only, when there was resistance to the flow.

2. Review of the facility's P&P titled Enteral Tube Medication Administration Procedures dated 1/28/25, showed it is the policy of the facility to check tube placement by unclamping tube and inserting a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sound, and aspirate stomach contents with syringe.

Review of Resident 111's Order Summary Report showed the following physician's order:

- dated 9/6/24, for the enteral feed order, to check the tube placement and residuals before giving medications or starting the feeding.

On 2/12/25 at 0814 hours, a medication pass observation was conducted with LVN 4. LVN 4 was observed administering nine medications, including eight medications via the GT for Resident 111, one by one, through the syringe without first checking for the tube placement and assessing the gastric residual volume (the amount of fluid already in the stomach) to determine if it was safe to administer the medications.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 1110 hours, an interview was conducted with LVN 4. LVN 4 verified he did not check the GT placement and residual volume, which were required before starting the medication administration. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON acknowledged when giving the medications through the GT, the licensed nurse should listen to the resident's stomach with a stethoscope for a gurgling sound to verify the GT placement and check for the residual volume prior to administering the medications. 39683 3. Review of the facility's P&P Enteral Feeding Administration revised 5/2020 showed to check the enteral feeding tube placement before initiating the feeding. Medical record review for Resident 87 was initiated on 2/11/25. Resident 87 was readmitted to the facility on [DATE]. Review of Resident 87's Order Summary Report showed the following physician's orders: - dated 8/23/24, to administer Glucerna 1.5 (enteral feeding) at 50 ml/hr for 20 hours, staring at 1300 hours. - dated 8/12/24, to check the tube placement and residuals before starting the tube feeding. - dated 11/13/24, to administer enteral water flush at 40 ml/hr for 20 hours, starting at 1300 hours. On 2/12/25 at 1301 hours, an observation and concurrent interview was conducted with LVN 4 at Resident 87's bedside. LVN 4 was observed starting Resident 87's enteral feeding and water flush. LVN 4 was then observed connecting the enteral feeding tubing and water flush tubing to the resident's GT and starting the enteral feeding and water flush. LVN 4 did not verify the GT placement and/or checked the gastric residuals. As LVN 4 started walking away, LVN 4 was asked if he verified the GT placement and checked the gastric residuals before starting the enteral feeding and water flush. LVN 4 verified he did not and stated he should have. On 2/12/25 at 1340 hours, an interview was conducted with the DON. The DON stated prior to starting an enteral feeding, the nurse should verify the GT placement by injecting 5-10 ml of air bolus into the tubing while using a stethoscope to auscultate and verify the placement. The DON stated a residual check was done to ensure there was not a delay in gastric emptying; and if the residuals was more than 100 ml, the enteral feeding should be held for an hour.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and the facility P&P review, the facility failed to ensure the oxygen was administered as ordered by the physician for one of two final sampled residents (Resident 152) reviewed for oxygen use. This failure had the potential to affect the respiratory health and well-being of Resident 152. Findings: Review of the facility's P&P titled Oxygen Administration revised 2/2023 showed it is the policy of this facility that oxygen therapy was administered by the licensed nurse as ordered by the physician, or as a nursing measure and an emergency measure until the order can be obtained. Medical record review for Resident 152 was initiated on 2/11/25. Resident 152 was admitted to the facility on [DATE]. Review of Resident 152's Order Summary Report showed a physician's order dated 11/13/24, to administer the oxygen at two liters per minutes via nasal cannula continuously to keep the oxygen saturation level more than 90%. Review of Resident 152's MDS dated [DATE], showed Resident 152 was dependent on the staff for his activities of daily life, including repositioning in bed from lying on the back to sitting on the side of the bed, rolling to the left and right sides, and returning to lying on the back. On 2/11/25 at 1048 hours, Resident 152 was observed lying in the bed. The oxygen was observed being on at two liters per minutes and connected to the nasal cannula tubing. However, the nasal cannula tubing was observed hanging on the feeding tube stand, not on Resident 152. On 2/11/25 at 1050 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified the above observation and stated Resident 152 required a continuous oxygen administration. RN 1 further stated the nasal cannula should be on Resident 152's nose and not hanging on the feeding tube stand. RN 1 was then observed placing the nasal cannula on Resident 152's nose. On 2/14/25 at 0930 hours, an interview and medical record review for Resident 152 was conducted with the DON. The DON verified and acknowledged the above findings.

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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. 50610 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the provision of pharmacy services met the needs of the residents in accordance with the facility's P&P when: * The licensed nurse left Resident 152's medications unattended on the resident's bedside table during the medication administration. This failure had the potential for misuse of the medications by the residents, facility staff and/or visitors. * An opened container of the CII E-kit was not replaced timely within 72 hours after being opened. This failure had the potential for the emergency medications to be unavailable when needed. * One tablet of Percocet (narcotic pain medication) was removed from CII E-kit and wasted due to the resident's refusal was not disposed of as per the facility's policy; instead the Percocet medication was kept inside the CII E-kit while waiting for the pharmacy to replace the opened E-kit. This failure had the potential to result in controlled medication abuse, diversion or unauthorized removal from the facility. * A staff discarded the non-scheduled medication wastes into a regular trash bin during the preparation for the medication administration. This failure had the potential for the misuse of the medications and environmental harm. Findings: 1. Review of the facility's P&P titled Administration Process dated 1/28/25, showed the prepared drugs are not left with the resident (unless the resident has asked for, and has had approved the right of self-administration). On 2/11/25 at 0815 hours, a medication administration observation was conducted with LVN 8. LVN 8 was observed administering five medications via GT and an insulin medication via injection for Resident 152. During the medication administration, LVN 8 left the medications on Resident 152's bedside table and walked out of the resident's room to obtain supplies from the medication cart located in the hallway outside the resident's room. The following was observed: - After LVN 8 disconnected the feeding tube from the GT, LVN 8 left the medications at the bedside when she went to get the stethoscope; - Before starting the medication administration, LVN 8 left the medications at the bedside when she went to get a cup of water; and - LVN 8 left the insulin pen at the bedside when she went to get the alcohol swab to clean the insulin injection site. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 1228 hours, an interview was conducted with LVN 8. LVN 8 stated she had to get the supplies from the medication cart because she was not fully prepared for medication administration. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the licensed nurse should be able to always secure the line of vision for the medications, otherwise they should take the medications with them. 2. Review of the facility's P&P titled Emergency Pharmacy Service and Emergency Kits dated 1/28/25, showed the opened kits are replaced 72 hours of opening. On 2/11/25 at 1624 hours, an inspection of Medication Cart 1 and concurrent interview was conducted with LVN 9. Inside the medication cart, a CII E-kit was observed to be sealed with black locks. LVN 9 verified the black lock meant the CII E-kit had been opened by the nursing staff. During an inspection of the CII E-kit, two paper slips were observed inside the E-kit. The paper slips titled Emergency Drug Kit Slip showed the E-kit was opened twice on 2/7/25, as follows: one tablet of Norco (hydrocodone-acetaminophen medication, a potent controlled medication for pain) 5/325 mg was removed and one tablet of Percocet 5/325 mg medication was removed. LVN 9 verified the CII E-kit had not been replaced since 2/7/25, and acknowledged it should have been replaced. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the facility had only one CII E-kit in the building. The DON further explained that once the E-kit was opened, the nursing staff sealed it with black tags and called the pharmacy to request for a replacement. The DON was aware the CII E-kit was not replaced in a timely manner, which should have been replaced within 72 hours in accordance with the facility's P&P. 3. Review of the facility's P&P titled Controlled Drugs dated 1/28/25, showed if a dose is prepared for administration, but is refused or held for any reason, the dose must be destroyed. On 2/11/25 1624 hours, an inspection of the CII E-kit stored Medication Cart 1 and concurrent interview was conducted with LVN 9. One of the Emergency Drug Kit Slips inside the E-kit was observed stapled to a plastic bag containing one tablet of medication. The note on the slip showed a licensed nurse removed one tablet of Percocet 5/325 mg on 2/7/25, but the resident refused the medication and requested for the Norco medication instead, due to an allergy. LVN 9 verified the tablet in the plastic bag was Percocet 5/325 mg. LVN 9 stated the resident refused the Percocet medication and requested for the Norco medication due to an allergy, and the nursing staff stapled the bag with a pill of the Percocet medication onto the slip. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the licensed nurse should have given the refused narcotic or discontinued controlled medication to the DON, so the DON could dispose the controlled medications properly according to the facility's P&P. 4. Review of the facility's P&P titled of General Procedures to Follow for All Medications dated 1/28/25, showed once removed from the package or containers, unused doses should be disposed of according to the facility policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 0814 hours, a medication administration observation was conducted with LVN 4. LVN 4 was observed preparing nine medications, including five solid tablets, two capsules, one vial of solution for inhalation, and one liquid suspension for Resident 111. LVN 4 placed each tablet in a small plastic bag, crushed each medication individually by using a crushing device, and placed the crushed medication into small individual cups. LVN 4 opened the capsule form of medications and placed the contents inside the capsule into a small individual cups. Two cups out of the seven cups prepared by LVN 4 were observed containing very small amount of crushed medications. When asked which medications were in the two cups, LVN 4 stated it was the wastes from the preparation. LVN 4 then grabbed the two cups and wasted them into a regular trash bin attached to the medication cart. When asked the total number of medications due for the morning medication pass, he reviewed Resident 111's MAR and could not identify which medications were left in the remaining five cups and which medications he had to prepare. LVN 4 was observed discarding the remaining five cups containing crushed medications into the regular trash bin and re-prepared seven medications, including five tablets and two capsules. On 2/12/25 at 1110 hours, an interview was conducted with LVN 4. LVN 4 stated he trashed all the cups containing crushed medications into the regular trash bin, but he should have transferred the medications from the cups into a drug disposing bottle. LVN 4 showed the liquid containing drug disposing bottle stored in his cart and stated he should have disposed the wasted medications into the bottle containing a solution so the medication could not be reused. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the licensed nurse should dispose the crushed medication or regular medication into the drug disposal system, which was stored in each of the medication carts.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50610 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate during the medication administration observation was less than 5%. * The facility had a cumulative medication error rate of 20%. Six medication errors occurred out of 30 opportunities during the medication administration for two out of four residents (final sample residents, Residents 111 and 152). This failure resulted in medications not given in accordance with the physician's orders and the facility's P&P, which had the potential for residents not receiving the full therapeutic effects of the medications and worsening of the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Administration Process dated 1/28/25, showed the medications are administered in accordance with written orders of the attending physicians. Review of the facility's P&P titled General Procedures to Follow for All Medications dated 1/28/25, showed in part, .obtain and record any vital signs, as necessary, prior to mediation administration . Medical record review for Resident 152 was initiated on 2/11/25. Review of Resident 152's MAR showed the following physician's orders: - dated 11/13/24, to administer amlodipine besylate (used to treat high blood pressure, lowering blood pressure) 10 mg one tablet via PEG-tube one time a day for HTN, hold for SBP less than 110 mmHg or heart rate less than 60 beats per minute; - dated 11/13/24, to administer carvedilol (used to treat high blood pressure, lowering blood pressure) 25 mg one tablet via PEG-Tube two times a day for HTN, hold for SBP less than 110 mmHg or heart rate less than 60 beats per minute; - dated 2/9/25, to administer aspirin (a drug that reduces pain, fever, inflammation, and blood clotting) 325 mg one chewable tablet via PEG-Tube one time a day for CVA prophylaxis; and - dated 2/9/25, to administer Multivitamin & Mineral Oral Liquid 15 ml via PEG-Tube one time a day for supplement. On 2/11/25 at 0815 hours, a medication administration observation was conducted with LVN 8. Prior to administering the medications, LVN 8 was observed assessing the resident's blood pressure using a stethoscope and a BP cuff but did not measure the resident's HR. After the BP assessment, LVN 8 was observed preparing the following six medications: - amlodipine 10 mg one tablet; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- carvedilol 25 mg one tablet; - aspirin 81 mg chewable one tablet; - multivitamins with mineral one tablet; - escitalopram (antidepressant) 10 mg one tablet; and - Lantus (insulin) Solostar 10 units. LVN 8 was observed placing each tablet in a small plastic pouch, crushed each medication individually by using a crushing device, and transferred the crushed medication into a small individual cups. Then, LVN 8 transferred the contents prepared in the small cups to the individual big cups, added water into each big cup, and stirred the mixture in the cups with unused spoon to dissolve. After LVN 8 finished preparing the medications and checking the GT placement with the residual volume, LVN 8 was observed administering the prepared medications through the resident's GT. On 2/11/25, during the medical record review of Resident 152's MAR post medication administration observation, the following was identified: - The physician's orders required the resident's HR to be checked/monitored/documented in addition to checking/documenting the SBP. The physician's orders for the amlodipine and carvedilol medications showed the two medications should be held when the SBP was less than 110 mmHg or the HR was less than 60 beats per minute. However, LVN 8 did not assess Resident 152's HR prior to administering the amlodipine and carvedilol medications. The HR was documented as 72 on Resident 152's MAR by LVN 8. - LVN 8 administered one chewable tablet of aspirin 81 mg instead of the physician's order for aspirin 325 mg tablet; and - LVN 8 administered one tablet of multivitamins with mineral instead of the physician's order for the liquid form of multivitamins with mineral. On 2/11/25 at 1228 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 stated she did not check Resident 152's HR but documented the HR in the MAR. When asked about the physician's holding parameters for Resident 152's BP medications, LVN 8 stated the BP medications needed to be held if the SBP less than 110 mmHg and the DBP less than 60 mmHg. LVN 8 was asked to check the MAR to verify the physician's order for Resident 152. LVN 8 then verified Resident 152's physician's order instructed both the SBP and HR to be checked and followed before administering the amlodipine and carvedilol medications. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the licensed nurses should read the physician's orders, including the holding parameter instructions. The DON further stated the LVN should have measured the HR in addition to the SBP prior to administering the amlodipine and carvedilol medication. 2. Review of the facility's P&P titled Enteral Tube Medication Administration Procedure dated 1/28/25, showed in part, .Flush the tube with 30 ml of water prior to medication administration .Administer the medication and flush the tube with water .flush the tube with 30 ml of water or as directed . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Administration Process dated 1/28/25, showed in part, .Flush tube before and after medication administration with at least 30 ml or warm water . a. Medical record review for Resident 152 was initiated on 2/11/25. Review of Resident 152's MAR showed the following physician's order: - dated 11/13/24, to flush the GT with 50 ml of water pre and post medication administration via tube. On 2/11/25 at 0815 hours, a medication administration observation was conducted with LVN 8. LVN 8 was observed administering five medications through Resident 152's GT. Prior to administering the first medication, LVN 8 was observed flushing Resident 152's GT with 15 ml of plain water. After the first flushing with the water, LVN 8 proceeded to administer the five prepared medications through Resident 152's GT. However, LVN 8 did not flush the resident's GT with plain water in between the administration of each medications. After administering the fifth medication through Resident 152's GT, LVN 8 was observed rinsing one of the medication cups with water and administered it through Resident 152's GT. LVN 8 did not flush the GT with plain water at the end of the medication administration. On 2/11/25 at 1228 hours, an interview was conducted with LVN 8. LVN 8 verified she flushed Resident 152's GT with 15 ml of water before giving medications. LVN 8 stated the reason why she did not flush the GT with water in between each medication was because each medication contained water, and thought it was okay to give the medications without flushing with water after administering each medication. b. Medical record review for Resident 111 was initiated on 2/12/25. Review of Resident 111's MAR showed the following physician's order: - dated 9/6/24, to flush the tube (GT) with 50 cc (ml) of water pre and post mediation administration via tube. On 2/12/25 at 0814 hours, a medication administration observation was conducted with LVN 4. LVN 4 was observed administering nine medications, including eight medications through Resident 111's GT. LVN 4 was not observed flushing the GT with water prior to administering the first medication, between the first and the second medication administration and after giving the last medication. LVN 4 was observed flushing Resident 111's GT with about 15-30 ml of plain water in between each medication administration after giving the second medication through the eighth medication. On 2/12/25 at 1110 hours, an interview was conducted with LVN 4. LVN 4 verified he did not flush the resident's GT with plain water before and after administering the medications and between the first two medications. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated when administering medications through a GT, the licensed nurse should flush the resident's GT with 30 ml of plain water before and after administering medications and 5-10 ml of plain water between each medication to prevent clogging, with the exact amount depending on the physician's flushing order and instruction.

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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 50610

Based on observation, interview, facility document review, and facility P&P review, the facility failed to store and label the medications in accordance with the manufacturer's instructions and the facility's P&P when:

* An amber bottle of megestrol acetate (appetite stimulant) oral suspension was not properly labeled with

the specific instruction on preparation in Medication Cart 2.

* A bottle of Katerzia (amlodipine, use for treatment of hypertension, to lower blood pressure) oral suspension requiring refrigerated storage condition was stored at a room temperature in Medication Cart 2.

* An opened Levemir insulin vial was stored without an open date in Medication Cart 1.

* Three boxes of expired Tempa-DOT (single-use, disposable clinical thermometer for oral and axillary (armpit) use that measures body temperature, designed to be sanitary and prevent the spread of infection) supplies were stored in Medication Room A.

These failures had the potential for the residents to receive unsafe, ineffective medications and inaccurate medical device.

Findings:

1. Review of the manufacturer's package insert (detailed description of a drug's uses, storage, and more that is available to clinicians) for megestrol acetate oral suspension dated ,d+[DATE] showed, shake container well before using.

On [DATE] at 1553 hours, an observation of Medication Cart 2 and concurrent interview was conducted with LVN 10. The pharmacy label on the provided amber bottle of megestrol acetate oral suspension 40 mg/ml was observed without the specific preparation instruction for the licensed nurses to shake the container well before using. No auxiliary label was observed on the amber bottle which could be used as a reminder for the licensed nurses to shake the container well before use. LVN 10 acknowledged the finding and stated the information of shake well was a special preparation instruction that the licensed nurses needed to know when they prepared the medication before administering it to the residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0856 hours, an interview was conducted with the DON. The DON stated any suspension medications required the proper and adequate shaking to produce a uniform preparation of the medication prior to each administration since the suspension medications had the potential to settle in the bottom of the medication bottle. The DON also stated if the suspension medication was not labeled to shake the bottle, the staff should have contacted the pharmacy to request a replacement of the medication with the appropriate labels. 2. Review of the facility's P&P titled Medication Storage in the Facility dated [DATE], showed medications requiring refrigeration temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Review of the manufacturer's package insert for Katerzia (amlodipine) oral suspension dated ,d+[DATE] showed the Katerzia (amlodipine) oral suspension should be stored refrigerated (2 C to 8 C/36 F to 46 F). Review of the manufacturer's box container in which the bottle of medication was stored showed, Must store refrigerated: 2 C - 8 C (36 F - 46 F). On [DATE] at 1553 hours, an observation of Medication Cart 2 and concurrent interview was conducted with LVN 10. A manufacturer's bottle of Katerzia (amlodipine) oral suspension 1 mg/ml in a manufacturer's box container with attached pharmacy-applied label was observed stored inside Medication Cart 2 at a room temperature, instead of being stored in a refrigerator. LVN 10 acknowledged the finding and stated one of the licensed nurses might have used the medication for the resident and left it in the medication cart. On [DATE] at 0856 hours, an interview was conducted with the DON. The DON was informed of the above findings. The DON stated the medication should be stored in accordance with the manufacturer's storage instruction. The DON also stated after the licensed nurses used the refrigerated medication for the resident, the licensed nurses should bring the medication back to the refrigerator in the medication room. 3. Review of the facility's P&P titled Medications Requiring Notation of Date Opened dated [DATE], showed all the medications requiring an open date will be dated immediately upon opening. Date will be applied using a Date Open label or written directly on the packaging by the charge nurse. To ensure potency, maintain efficacy and avoid cross contaminations, certain medications must be dated when first opened and discarded when the designated expiration time period or the manufacturer's expiration date elapses. The following expiration periods are based on currently accepted standards of practice and/or the manufacturer's recommendation: - Expires 28 days after opening: All insulins. On [DATE] at 1624 hours, an observation of Medication Cart 1 and concurrent interview was conducted with LVN 9. An opened vial of Levemir (insulin medication) 100 units/ml without an open date was observed in Medication Cart 1. LVN 9 verified the finding and stated the insulin vials should be discarded 28 days after the opened date. When asked about the expiration date of the opened Levemir insulin vial, LVN 9 stated she was unable to identify the expiration date of the medication without an open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0856 hours, an interview was conducted with the DON. The DON stated the insulin vials and pens should be dated when opened. The DON further stated the multi-dose vial would expire in 28 days. 4. On [DATE] at 0949 hours, an inspection of Medication Room A and concurrent interview was conducted with the Central Supply Staff. During the inspection of the medications and medical supplies in Medication Room A, three boxes of expired Tempa-DOT were observed. Review of the manufacturer's boxes of the Tempa-DOT showed one box with an expiration date of [DATE], and two boxes with an expiration date of [DATE]. The Central Supply Staff verified the findings and stated the expired supplies should have been removed. On [DATE] at 0856 hours, an interview was conducted with the DON. The DON stated the facility staff working in the central supply room should be checking the expiration date of the medical supplies. The DON further stated if the expired supply delivered to the nursing units for resident use, the licensed nurses who received the supply should check the expiration date prior to using it for the resident. The DON stated the facility staff should dispose of any expired supplies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51423 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed as evidenced by: 1. The frozen meat was not thawed in a safe manner. 2. The food preparation equipment was not clean or in good working condition. 3. The dry bulk food was not stored properly. 4. The meal preparation equipment was not air dried. 5. Two floor drains did not have a backflow prevention. 6. The cleaning equipment was not stored in a sanitary manner. These failures posed the risk for food borne illnesses in highly susceptible resident population of 157 facility residents who received food prepared in the kitchen. Findings: Review of the facility's Matrix dated 2/11/25, showed 157 of 166 residents who resided in the facility consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Thawing of Meats dated 2023 showed thawing of the meat properly can be done by labelling defrosting meat with a pull date (date food put in refrigerator) and use by date. On 2/11/25 at 1022 hours, during the initial kitchen walkthrough and concurrent interview with the DSS in the kitchen, seven bags of thawed raw chicken with a large amount of bloody liquid in a large plastic container dated 2/11 were found in the walk-in refrigerator. The chicken did not have a pull date. The DSS stated the chicken was to be used that day and was put in the refrigerator three days ago. The DSS verified the chicken did not have a date reflecting when the chicken was placed in the walk-in refrigerator. The DSS could not show when the chicken was placed in the walk-in refrigerator. The DSS stated the chicken should have a pull date listed on the container. 2. Review of the facility's P&P titled Sanitization dated 2023 showed all the 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. On 2/11/25 at 1022 hours, during the initial kitchen walkthrough and concurrent interview with the DSS and RD, a frying pan with heavy black residue was observed. The DSS and RD verified the frying pan was unusable and should be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's P&P titled Storage of Food and Supplies dated 2023 showed the dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized. Scoops should not be left in the containers . On 2/11/25 at 1022 hours, during the initial kitchen walkthrough and concurrent interview with the DSS and RD, a plastic scoop was found in the powdered thickener container. The DSS and RD verified the findings. 4. According to the USDA Food Code 2022, Section 4-901.11 (A) Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried . before contact with food. On 2/11/25 at 1022 hours, during the initial kitchen walkthrough and concurrent interview with the DSS and RD, a blender was observed stored wet with the lid on. The DSS and RD verified the findings. 5. According to the USDA Food Code 2022, Section 5-202.13 Backflow Prevention, Air Gap. An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (one inch). On 2/11/25 at 0903 hours, during a kitchen walkthrough and concurrent interview was conducted with the Maintenance Director. The Maintenance Director was asked to check the drainage pipes of the juice machine and walk-in refrigerator. The Maintenance Director verified the juice machine and walk-in refrigerator drainage pipes did not have an air gap for backflow prevention. 6. According to the USDA Food Code 2022 Annex 3, Section 6-501.113 Storing Maintenance Tools. To prevent harborage and breeding conditions for the rodents and insects, the maintenance equipment must be stored in an orderly fashion to permit cleaning of the area. On 02/11/25 at 1022 hours, during the initial kitchen walkthrough and concurrent interview with the DSS, a broom was observed stored on the floor in the utility closet. The DSS verified the broom should be stored off the floor.

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F 0836

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39856

Based on interview and medical record review, the facility failed to ensure the RD completed or reviewed the MDS Nutritional Status assessment and the quarterly nutritional assessment for accuracy for one of 33 final sampled residents (Resident 87). This failure posed the risk for the residents' nutritional needs to not be met in the facility.

Findings:

The California Business and Professions Code (B&P Code) are a set of laws that govern businesses and licensed professions in California. The B&P Code 2586 governs the services of Registered Dietitians. These services include nutritional and dietary assessments.

Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2024 showed under Section K Nutritional Status: the assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately. If the resident is gaining a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.

a. Medical record review for Resident 87 was initiated on 2/11/25. Resident 87 was readmitted to the facility on [DATE].

Review of Resident 87's Quarterly MDS Section K Swallowing/Nutritional Status assessment dated [DATE], showed, no or unknown under the section to show if the resident had a weight gain of 5% or more in the last month, or 10% or more in the last 6 months. The dietary section was signed as completed by the DSS.

Review of Resident 87's Weight and Vitals Summary showed the following weights:

- on 7/3/24, a weight of 114 lbs.

- on 1/1/25, a weight of 130.8 lbs (an increase of 14%).

On 2/12/25 at 1430 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 87's weights and MDS data, and verified the MDS assessment on 1/15/25 was incorrectly coded. The MDS Coordinator stated the dietary section was completed by the DSS.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 1116 hours, an interview and concurrent medical record review for Resident 87 was conducted with the RD . The RD verified the MDS Section K assessment completed by the DSS dated 1/1/25, showed Resident 87 weighed 131 lbs. The RD verified Resident 87 had a significant weight gain of 17 lbs, 13% in six months. The RD also verified the MDS Section K Significant Weight Gain of 5% or more in the last month or gain of 10% or more in last six months completed by the DSS was coded as No or unknown. The RD stated the MDS nurse had mentioned to the DSS the Section K of the MDS dated [DATE], was incorrect. The RD verified she was not involved in completing the MDS Section K assessment nor did she check the accuracy of the MDS Section K assessment. Cross reference to F641, example #2. b. On 2/14/25 at 1012 hours, an interview was conducted with the RD. When the RD was asked about the job duties of the RD and DSS, the RD stated the DSS was responsible to complete all quarterly nutritional assessment for the residents. The RD further stated she was not involved in completing the quarterly nutritional assessments and did not check the accuracy of the quarterly nutritional assessments completed by the DSS. On 2/14/25 at 1116 hours, an interview and concurrent medical record review was conducted with the RD. The quarterly nutritional assessment for Resident 87 dated 1/14/25, showed the assessment was completed by the DSS and reviewed with the RD. The quarterly nutritional assessment showed Resident 87 weighed 130.8 lbs on 1/1/25. The section titled Weight History showed on 1/1/25, Resident 87 weighed 131 lbs; and on 7/3/24, Resident 87 weighed 114 lbs. The section titled Assessed Needs showed the resident's weight was stable and to continue with the current diet as ordered. The RD verified the quarterly nutritional assessment completed by the DSS dated 1/14/25, showed Resident 87's weight was stable. The RD verified Resident 87's weight was not stable but rather she had experienced a significant weight gain of 17 lbs, 13% in the past six months. The RD further verified the quarterly nutritional assessment dated [DATE], completed by the DSS was not accurate.

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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** 39683 Based on interview, medical record review and the facility P&P review, the facility failed to ensure the medical records were complete and accurately maintained for 12 of 33 final sampled residents (Residents 16, 25, 32, 37, 46, 47, 56, 57, 65, 87, 146, and 158). * Resident 47's POLST incorrectly showed the resident had the advanced directive and health care agent (person listed in the advanced directive who can legally make health-care decisions for the resident). * Resident 87's POLST failed to show the names of facility staff who reviewed and confirmed the form with the resident's responsible party. * Resident 57's post fall eInteract Change in Condition Evaluation V4.2 showed the incorrect time for the physician and resident notification. * Resident 158's POLST failed to show the physician's signature. * Resident 146's POLST failed to show the physician's signature. * The facility failed to ensure Resident 65's TARs regarding the treatment for xerosis and pruritus were completed. * The facility failed to ensure Resident 16's LAL monitoring of the setting and functionality was done on 2/9/25, for the NOC shift. * The facility failed to ensure accurate documentation of the meal consumption for Resident 25. * The licensed nurses failed to ensure the documentation on the MARs were complete for Residents 32, 37, 46, and 56. In addition, the licensed nurses failed to ensure the documentation on the TAR for Residents 37 was complete. These failures resulted in inaccurate medical records, which had the potential for the residents' care needs not being met as their medical information was inaccurate and incomplete. Findings: Review of the facility's P&P titled Advanced Directives revised 11/2019 showed once an advanced directive is received by the facility, it will be confirmed in the resident's medical record. The facility uses a POLST form to communicate medical interventions, procedures, and end-of-life decisions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Charting and Documentation revised 2/2022 showed it is the policy of the facility to ensure that the resident record is concise and reflective of resident status. Resident record will be completed on all residents on a schedule basis and will be reflective of current care provided to the resident. The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. Is also necessary to include data needed for identification and communication with family and friends. Rules for Charting section showed the following: 1. Notes are to be written on all long term residents by day, evening, and night shifts; frequency is determined by the individual nursing service. 2. Daily notes are required as the necessary arises. 3. New admissions must have nurse's notes on all three shifts for the first seventy-two hour. 4. Changes of condition will be documented in resident chart for at least 72 hours. 5. The admitting nurse must write a complete physical and mental nursing assessment. 6. Continuous nurse's notes are required on all residents as the necessary arises. Review of the facility's P&P titled Physician Documentation revised 11/2024 showed the following: - Progress notes must be written, signed, and dated with each visit. They may be either paper, or electronic (at least every 30 days for the first 90 days after admission, and at least done once every 60 days thereafter). - Each physician visit should include an evaluation of the resident's condition, treatment, and a review of, and a decision about, the continued appropriateness of the resident's condition and current medical regime. Review of the facility's P&P titled Specific Medication Administration Procedures: Documentation revised 1/28/25, showed the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medications. Current medication, except topicals used treatments, are listed on the resident's MAR. Topical medications used in treatments are; listed on the Treatment Administration record. The resident's MAR is initialed by the person administering the medication in the space provided under the date, and on the line for that specific medication dose administration. 1. Medical record review for Resident 47 was initiated on 2/11/25. Resident 47 was readmitted to the facility on [DATE]. Review of Resident 47's DPOA dated 4/26/24, showed, This document does not authorize anyone to make medical and other health-care decisions for the resident. There was no advanced directive located in the resident's medical record to show a health care agent had been selected. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 47's POLST dated 11/28/24, showed the resident had an advanced directive dated 4/26/24, which was reviewed and listed the resident's health care agent's information. Review of Resident 47's Social Services Assessment/Evaluation - V 2 dated 12/30/24, showed the resident had a DPOA but had no advanced directive formulated. On 2/13/25 at 1126 hours, an interview and concurrent medical record review was conducted with the Social Services Staff. The Social Services Staff stated Resident 47's provided a DPOA, but not an advanced directive. The Social Services Staff showed a scanned copy of Resident 47's POLST from the resident's medical record dated 8/2/24, which showed the resident had no advanced directive. The Social Services Staff was unsure if there was an updated POLST in the resident's paper medical record. On 2/13/25 at 1136 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 reviewed Resident 47's POLST dated 11/28/24, located in the resident's paper medical record. LVN 5 stated the POLST showed the resident had an advance directive and listed a health care agent. LVN 5 stated if the resident was to be transferred out of the facility in an emergency, the POLST would be sent with the resident to show the selected treatment and health care agent. On 2/13/25 at 1143 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified Resident 47's most recent POLST dated 11/28/24, incorrectly showed the resident had the advanced directive and health care agent. 2. Medical record review for Resident 87 was initiated on 2/11/25. Resident 87 was readmitted to the facility on [DATE]. Review of Resident 87's POLST dated 8/12/24, showed the resident had a legally recognized decision maker. In the section for the legally recognized decision maker, a box with signature (required), showed, verbal consent was obtained at 1906 hours. The form did not show the facility staff who had reviewed and confirmed the POLST information with the responsible party and witnessed the review and confirmation of the POLST. On 2/13/25 at 1044 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated when the facility staff were getting verbal or telephone consent for a signature, the process was to have two facility staff present, one facility staff to obtain the consent and the other facility staff to witness the consent was obtained. The DON stated for Resident 87's POLST, two facility staff names should have been listed on the POLST, to show the staff member who obtained the telephone consent and the other staff member who witnessed the consent was obtained. 3. Medical record review for Resident 57 was initiated on 2/11/25. Resident 57 was readmitted to the facility on [DATE]. Review of Resident 57's eInteract Change in Condition Evaluation V4.2 dated 11/28/24 at 2343 hours, showed the resident had a fall. The evaluation showed the resident's physician was notified of the fall on 11/28/24 at 2228 hours, and the resident was notified at 2230 hours. Review of Resident 57's post fall Neurological Assessment Flowsheet dated 11/28/24, showed the first neurological assessment was completed at 2330 hours. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 57's Post-Event IDT Review dated 12/2/24, showed the IDT met to discuss a fall incident that the resident had on 11/28/24 at 2330 hours. On 2/13/25 at 1608 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 57's medical record and was asked what time the resident had a fall on 11/28/24. The DON stated the medical record showed the fall occurred at 2330 hours. The DON verified the time of the physician and resident notifications were incorrectly documented as it was one hour before the resident's actual fall. 51539 4. Medical record review for Resident 146 was initiated on 2/11/25. Resident 146 was admitted to the facility on [DATE]. Review of the Resident 146's POLST dated 12/4/24, under Section D, failed to show the physician's signature. 5. Medical record review for Resident 158 was initiated on 2/12/25. Resident 158 was admitted to the facility on [DATE]. Review of the Resident 158's POLST dated 1/6/25, under Section D, failed to show the physician's signature. On 2/14/25 at 1053 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the POLST for Residents 146 and 158 were not signed by the residents' physician and stated the residents' POLST should have been signed during the physician's follow-up visit. 50967 6. Medical record review for Resident 65 was initiated on 2/12/25. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's H&P examination dated 4/27/24, showed Resident 65 had the capacity to understand and make decisions. Review of Resident 65's Order Summary Report dated 2/13/25, showed the following physician's orders: - dated 11/5/24, to apply Eucerin external lotion (moisturizer) to the body topically every shift for xerosis; and - dated 11/5/24, to apply triamcinolone acetonide (used to treat skin itching, redness, swelling, dryness, crusting, and scaling) cream 0.1% to the arms topically every shift for pruritus. Review of Resident 65's TAR for February 2025 showed missing documentation for the Eucerin external lotion and triamcinolone acetonide cream application to the resident's skin on 2/9/25, for the NOC shift (1900-0700 hours). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 1340 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated complete documentation was important because it showed care provided to the residents. On 2/14/25 at 1447 hours, an interview was conducted with the DON. The DON stated complete documentation was important to show proof of the services provided to the residents. The DON stated if the treatment or care was not documented, it was not done. The DON further stated the daily audits were done by the Medical Record Director, and the Unit Managers and RNs did random weekly checks of the residents' MARs and TARs. The DON was informed and acknowledged the above findings. 7. Review of the facility's P&P titled Skin and Wound Monitoring and Management (undated) showed the following: - Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc; - Licensed nurse to document presence of pressure reducing devices on TAR as ordered; and - Monitoring daily via medication administration and treatment administration record. Medical record review for Resident 16 was initiated on 2/13/25. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 10/29/24, showed Resident 16 had the capacity to understand and make decisions. Review of Resident 16's MDS dated [DATE], showed Resident 16 had a BIMS score of 6 indicating severe cognitive impairment. Review of Resident 16's Order Summary Report dated 2/13/25, showed the following physician's orders: - dated 1/30/25, for LAL mattress for wound management, to monitor the setting and functionality every shift and may adjust the settings based on the weight and/or the resident's comfort, every day and night shift; and - dated 1/31/25, for the sacrococcyx Kennedy terminal ulcer (a painful skin sore that appears in people who are near death) wound care treatment every shift. Review of Resident 16's TAR for February 2025 showed missing documentation on 2/9/25, for the NOC shift, to show the resident's LAL mattress was monitored for the setting and functionality as ordered by the physician. On 2/13/24 at 0938 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 verified the above findings. On 2/14/25 at 1447 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44175 8. On 2/13/25 at 1206 hours, during the dinning observation, Resident 25 was observed eating her lunch in her room. The meal tray was observed with vegetable burger, rice, dessert, salad, a cup of chicken noodle soup, a cup of milk and a cup of water. Resident 25 was observed eating couple bites of the vegetable burger, some of the chicken noodle soup, and salad. Resident 25 was observed not touching the rice and milk. On 2/13/25 at 1304 hours, an observation and concurrent interview was conducted with the CNA 3. CNA 3 was observed asking Resident 25 if she was done with her meal, Resident 25 stated yes. CNA 3 was then observed taking out the meal tray for Resident 25. CNA 3 verified Resident 25 ate around 25% of her meal tray. Medical record review for the Resident 25 was initiated on 2/11/25. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Resident 25's Physician Order Summary dated 1/2/25, showed a physician's order to monitor the resident's meal percentage intake every meal. Review of the Resident 25's Documentation Survey Report v2 dated February 2025 showed on 2/13/25 at 1251 hours, the percentage of the lunch eaten by Resident 25 was documented as 76-100%. On 2/13/25 at 1606 hours, an interview and concurrent medical record review for Resident 25 was conducted with RN 1. RN 1 was informed of the observation of Resident 25's lunch meal intake of around 25% on 2/13/25. RN 1 verified the facility staff documented 76-100% for Resident 25's lunch meal intake on 2/13/25. RN 1 stated the facility staff should accurately document the percentage of amount eaten by the resident. On 2/14/25 at 0930 hours, an interview and concurrent medical record review for Resident 25 was conducted with the DON. The DON verified and acknowledged the above findings. 49324 9. Medical record review for Resident 32 was initiated on 2/12/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's MAR for December 2024 showed the following entries with missing documentation from the licensed nurse: - to monitor the pain level using the following scale; 0 = no pain, 1-3 = mild, 4-6 = moderate, and 7-10 = severe every shift. There was no documentation for the monitoring on 12/25/24, for the night shift and 1/21/25, for the morning shift. - to administer multiple vitamins-minerals (supplement) one tablet by mouth one time a day for supplement. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation the multiple vitamins-minerals medication was administered on 1/21/25. - to provide nonpharmacological interventions for pain: 1 = Repositioning, 2 = Dim light/ quiet environment, 3 = relaxation 4 = distraction, 5 = music, and 6= massage every shift. There was no documentation a nonpharmacological interventions were provided on 12/25/24, for the night shift. - to administer Senna (stool softener) tablet 8.6 mg two tablets by mouth two times a day for constipation. There was no documentation the Senna medication was administered on 1/21/25, for the morning shift. - to monitor/document/report to the MD for signs and symptoms of anticoagulant complications: blood tinged or frank blood in the urine, black tarry stools, dark or bright red blood in stools, sudden sever headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs every shift. There was no documentation the above monitoring was performed on 1/21/25, for the morning shift. - to administer tadalafil 5 mg one tablet by mouth one time a day for benign prostatic hypertrophy (enlarged prostate). There was no documentation the tadalafil medication was administered on 1/21/25. - to administer aspirin (pain medication) low dose 81 mg one chewable tablet by mouth one time a day for cerebrovascular disorder (conditions that affect the blood vessels in the brain and spinal cord) prophylaxis. There was no documentation aspirin medication was administered on 1/21/25. - to provide health shake 4 oz with meals for supplement. There was no documentation the Healthshake was provided to the resident on 1/21/25, for the morning and evening shifts. 10.a. Medical record review for Resident 37 was initiated on 2/12/25. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's MAR for December 2024 showed the following entries with missing documentation from the licensed nurse: - to monitor the vital signs and record any Covid-19 signs and symptoms: F=fever, C = cough, S=new shortness of breath/difficulty of breathing, Z=chills, repeated shaking with chills, M = muscle pain, H = Headache, T = sorethroat , L = New loss of taste or smell, O = Congestion, R - runny nose, FA = fatigue, G = GI symptoms; diarrhea/Nausea, and NA = Not applicable, every night shift. There was documentation the monitoring was performed as ordered on 12/15/24, for the night shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- to monitor for the signs and symptoms of bleeding related to anticoagulation/antiplatelet therapy every shift. Notify the MD if any of the following signs and symptoms are present (passing blood in urine, passing blood when resident is having a bowel movement, sever bruising, prolonged nosebleeds (lasting longer than 10 minutes), bleeding gums, vomiting blood or coughing up blood, sudden severe back pain, or difficulty of breathing or chest pain every shift; and to monitor the pain level using the following scale: 0 = no pain, 1-3 = Mild, 4-6 = Moderate, and 7-10 = Severe, every shift. There was no documentation for the monitoring for the above physician's orders on 12/25/24, for the night shift. - to elevate the head of the bed to 30-45 degrees at all times on 12/25/24, for the night shift; to flush the GT tube with 50 cc of water pre and post medication administration every shift; to monitor for the signs and symptoms of pacemaker malfunction (syncope, dizziness, palpitations, slow or fast heart rate, hiccup) every shift; to observe the pacemaker site on for any signs and symptoms of infection, signs of pacemaker failure such as pulse below 60, bradycardia, syncope, palpitations, SOB, prolonged hiccups, chest pain , dizziness, weakness, swelling, discoloration, erosion of pacing wire and any pain every shift. Notify the MD if noted every shift; and to crush all crushable medications given via feeding tubes. May slow push to facilitate consumption every shift. There were no documentation the above physician's orders were performed on 12/25/24, for the night shift. b. Review of Resident 37's TAR for December 2024 showed the following entrries with missing documentation from the licensed nurse on 12/25/24, for the night shift: - to monitor the left upper extremity skin discoloration for skin breakdown and increase in size, and notify the MD every shift. - to monitor the setting and functionality of the low air loss mattress for wound management. May adjust the settings based on the weight or per the resident's comfort every shift. 11. Medical record review for Resident 46 was initiated on 2/12/25. Resident 46 was admitted to the facility on [DATE]. Review of Resident 46's MAR for December 2024 showed the following entries with missing documentation from the licensed nurse on 12/25/24, for the night shift: - to monitor the vital signs and record any Covid-19 signs and symptoms: F = fever, C = cough, S = new shortness of breath/difficulty of breathing, Z = chills, repeated shaking with chills, M = muscle pain, H = Headache, T = sorethroat , L = New loss of taste or smell, O = Congestion, R - runny nose, FA = fatigue, G = GI symptoms; diarrhea/Nausea, and NA = Not applicable every night shift. - to provide the nonpharmacological interventions for pain: 1 = Repositioning, 2 = Dim light/ quiet environment, 3 = relaxation 4 = distraction, 5 = music, and 6= massage every shift. - to monitor the pain level using the following scale: 0 = no pain, 1-3 = Mild, 4-6 = Moderate, and 7-10 = Sever every shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Medical record review for Resident 56 was initiated on 2/12/25. Resident 56 was admitted to the facility on [DATE]. Review of Resident 46's MAR for December 2024 showed the following entries with missing documentation from the licensed nurse on 12/25/24, for the night shift: - to monitor the vital signs and record any Covid-19 signs and symptoms: F = fever, C = cough, S = new shortness of breath/difficulty of breathing, Z = chills, repeated shaking with chills, M = muscle pain, H = Headache, T = sorethroat , L = New loss of taste or smell, O = Congestion, R - runny nose, FA = fatigue, G = GI symptoms; diarrhea/Nausea, and NA = Not applicable, every night shift. - to monitor for the signs and symptoms of bleeding related to anticoagulation/antiplatelet therapy every shift. Notify the MD if any of the following signs and symptoms are present (passing blood in urine, passing blood when resident is having a bowel movement, sever bruising, prolonged nosebleeds (lasting longer than 10 minutes), bleeding gums, vomiting blood or coughing up blood, sudden severe back pain, or difficulty of breathing or chest pain every shift. On 2/12/25 at 0942 hours, an interview and concurrent medical record review for Residents 32, 37, 46, and 56 was conducted with LVN 3. LVN 3 verified the missing documentation on the residents' MARs and TARs should have been completed by the assigned licensed staff. LVN 3 stated the physician's orders on the MARs and TARs for the above residents were performed, but the licensed nurse had just missed to document in the MARs and TARs. On 2/14/25 at 1531 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings.

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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 50967

Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for two of four final sampled residents (Residents 16 and 93) reviewed for hospice services

* The facility failed to ensure Residents 16 and 93 received HA visits two times a week per the hospice provider's calendar. This failure posed the risk for delays in the communication between the hospice provider and facility, which may affect the residents' care.

Findings:

Review of the facility's P&P titled End of Life Care: Hospice and/or Palliative Care revised on 12/2023 showed the following:

- Hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into the overall individualized, interdisciplinary care plan. Collaboration with Hospice will include processes for orienting staff to facility policies and procedures which may include resident's rights, documentation, and record keeping requirements; and

- However, the facility will continue to provide necessary care and services to assist the resident to achieve his or her highest practicable well-being.

1. Medical record review for Resident 16 was initiated on 2/13/25. Resident 16 was admitted to the facility on [DATE].

Review of Resident 16's Order Summary Report dated 2/13/25, showed a physician's order dated 1/15/25, to admit the resident under Hospice A with the diagnosis of heart failure.

Review of Resident 16's Hospice Visit Sign-in Monthly Calendar showed the HA visit frequency was two times a week.

Review of Resident 16's January to February 2025 Hospice Visit Sign-in Monthly Calendar during the weeks from 1/12 to 2/8/25, showed there were no HA visits conducted two times a week. In addition, during the week of 2/9 to 2/15/25, there were two scheduled HA visits on 2/11 and 2/14/25. However, there was no documented evidence of the HA visit on 2/11/25.

Reviewed Resident 16's Hospice Visit Sign-in Sheet for January and February 2025 did not show the entries or the hospice staff's names for the biweekly scheduled for the HA visits.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 0949 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 stated the HA visit was scheduled two times a week and the RN Case Manager was scheduled weekly. LVN 3 verified the above findings. LVN 3 stated the hospice staff were supposed to sign the hospice monthly calendar and the visit sign in sheet. Furthermore, LVN 3 stated the facility licensed nurse assigned to the resident would call the hospice provider when the HA visits were not completed. 2. Medical record review for Resident 93 was initiated on 2/13/25. Resident 93 was admitted to the facility on [DATE]. Review of Resident 93's Order Summary Report dated 2/13/25, showed a physician's order dated 12/17/24, to admit the resident under Hospice B with the diagnosis of cerebral atherosclerosis. Review of Resident 93's Vitas Personalized Visit Schedule for December 2024 and February 2025 showed the following: - During the weeks from 12/15 to 12/28/24, there were no HA visits conducted during these weeks. - During the week of 12/29/24 to 1/4/25, showed there was one HA visit scheduled. However, there was no documented evidence the HA visited during this week. - During the weeks of 1/5 to 2/8/25, showed there were two HA visits scheduled. However, there was no documented evidence of the HA visits during these weeks. On 2/13/25 at 0949 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the above findings. On 2/13/25 at 1015 hours, an interview and concurrent medical record review was conducted with Hospice Case Manager. The Hospice Case Manager stated all hospice disciplines that visited the resident must sign the calendar and the visit description log. The Hospice Case Manager stated when the hospice discipline or hospice staff did not sign in on both the calendar and visit description log, the visit was not done. The Hospice Case Manager verified the above findings. On 2/14/25 at 1447 hours, an interview was conducted with the DON. The DON stated all hospice staff must sign on the hospice calendar or visit log to show the visits were completed. Furthermore, the DON stated the facility licensed nurses were not required to document the visits done by the HA or aide, and only documented if there were orders received from hospice doctor. The DON was informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices to help prevent the development and transmission of diseases and infections. * The laundry and clean linen rooms were not maintained to ensure a clean area, free from potential contamination. * Resident 144 (final sampled resident)'s infection was not reported on the facility's monthly infection control log. * Residents 127 and 159's infections (nonsampled residents) were incorrectly listed as meeting McGeer's Criteria on the facility's monthly infection control log. * Two of four licensed nurses did not wear appropriate personal protective equipment (PPE) during the medication administrations for two of four residents (final sampled residents, Residents 111 and 152) who were on enhanced barrier precautions (EBP). * Two of four licensed nurses did not sanitize the BP cuff and stethoscope before and after use for two of four residents (final sampled residents, Residents 111 and 152) on EBP. * Three of four licensed nurses did not perform hand hygiene during the medication administration for three of four residents (final sampled residents, Residents 111 and 152; and nonsampled resident, Resident 68). * One of four licensed nurses did not disinfect the feeding tube after dropping it on the floor and prior to attaching it to Resident 111's GT during the medication administration. These failures resulted in inaccurate infection surveillance, which had the potential for spread of infection in the facility. Findings: 1. On 2/13/25 at 1000 hours, a laundry room inspection was conducted with the Maintenance Director. The following was observed in the clean linen room located in the basement: - Puddles of water were observed on the floor under and around the clean linen folding table, on the floor in and around two built in storage cabinets. The Maintenance Director stated the water had leaked in from the rain. - The clean linen folding table had adhesive residue with threads on the laminate, resulting in an uncleanable surface. - The clean linen room window perimeter, located above the clean linen folding table, had deteriorated and cracked paint and putty, with exposed wood and dark discoloration. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sea Cliff Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18811 Florida St Huntington Beach, CA 92648	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The wall under the above window showed signs of damage with cracks and gaps between the wall and baseboard. - The built-in wooden cabinets located along the outside wall, was filled with discharged residents' clothing and belongings. The items were stored on a wooden pallet on the floor. The pallet was sitting in a puddle of water, and the wood was warped and rotting with black and white staining. The base of one cabinet had black and dark brown discolorations at the base along the floor. - The sink had blank stains and debris with white mineral-like residue. In addition, the following was observed in the laundry room: - The sink had blank stains and debris with white mineral-like residue. -T he clothes dryer near the sink had metallic corrosion with brownish discoloration on the bottom frame. The Maintenance Director verified the above findings and stated the conditions of the cabinets could cause mold formation and the white staining could be an indicator of mold. On 2/13/25 at 1100 hours, a follow-up observation was conducted in the clean linen room. Laundry aides were observed folding clean clothes on the clean linen table, with the uncleanable surface, while a staff was wiping up the puddles of water still accumulating on the floor. 2. Review of the facility's P&P titled Infection Prevention - Surveillance of Infections and Reporting undated, showed it is the facility's policy to maintain an ongoing system of surveillance to identify possible communicable diseases or infections to ensure measures are taken to prevent any potential outbreak. An Infection Control Surveillance log will be maintained and reviewed to ensure all potential or actual infections are being identified. The Infection Control Committee will monitor these findings and report to the Quality Assurance Committee at least monthly. On 2/14/25 at 0804 hours, an infection control and surveillance review was conducted with the IP. The IP stated the facility used the McGeer's criteria to identify true infections, and the information was listed on the monthly Infection Prevention and Control Surveillance Log to be reviewed monthly with the Quality Assurance program. Review of Resident 144's Infection Surveillance - V 2 assessment dated [DATE], showed the resident was prescribed an antibiotic medication for an eye infection and the resident's symptoms met the McGeer's criteria. Review of the facility's Infection Prevention and Control Surveillance Log for November 2024 failed to show Resident 144's infection was included on the log, to be reported to and reviewed by the facility's Quality Assurance Committee. The IP verified Resident 144's infection was not included on the log and should have been. 3. On 2/14/25 at 0804 hours, an antibiotic stewardship review was conducted with the IP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of the facility's Infection Prevention and Control Surveillance Log for November 2024 showed Resident 127 was prescribed an antibiotic medication on 11/11/24, for pneumonia and the resident's symptoms met the McGeers criteria. Review of Resident 127's Infection Surveillance - V2 dated 11/14/24, showed the criteria for pneumonia was met. However, Resident 127's medical record failed to show the resident's symptoms met the McGeer's criteria for a true infection. The IP verified Resident 127's symptoms did not meet the McGeers criteria, resulting in incorrect data listing on the Infection Prevention and Control Surveillance Log for November 2024. b. Review of the facility's Infection Prevention and Control Surveillance Log for January 2025 showed Resident 159 was prescribed an antibiotic medication on 1/4/24, for other infection related to elevated WBCs and met the McGeers criteria. Review of Resident 159's Infection Surveillance - V2 dated 1/3/25, showed the McGeers criteria was met. However, review of Resident 159's medical record failed to show the resident symptoms met the McGeers criteria for a true infection. The IP verified Resident 159's symptoms did not meet the McGeers criteria, resulting in incorrect data listing on the Infection Prevention and Control Surveillance Log for January 2025. 50610 4. Review of the facility's P&P titled IPCP (infection prevention control program) Standard and Transmission-Based Precaution dated 1/28/25, showed in part, .wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. [NAME] PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogen . EBP is used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident (e.g., resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO). Indwelling medical devices include, but are not limited to central lines, PICC lines, urinary catheters, feeding tubes, and tracheostomies . Review of the facility's P&P titled Infection Prevention-Employee Exposure dated 1/28/25, showed in parts, Protective Barriers .Gowns: Wear disposable gowns when entering room .and it is anticipated that clothing will become soiled with body fluids or when contact with soiled surfaces (such as side rails or bed linens of an infected resident) is anticipated. Remove gown when the procedure is complete and prior to leaving the resident's room . a. Medical record review for Resident 152 was initiated on 2/11/25. Review of Resident 152's MAR showed the following physician's order: - dated 11/14/24, for Enhanced Barrier Precautions: PPE Required for high resident contact care activities. Indication: implanted feeding device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25 at 0815 hours, a medication administration observation via GT was conducted with LVN 8. A sign/poster for EBP was observed on Resident 152's room door. LVN 8 was observed wearing a new pair of gloves at the medication cart and entering Resident 152's room without a gown, to assess the resident's BP. After LVN 8 prepared all the medications for GT administration at the medication cart, LVN 8 stated she would need to wear a gown since Resident 152 had a GT. LVN 8 was observed wearing a new pair of gloves and a gown during the medication administration observation. On 2/11/25 at 1228 hours, an interview was conducted with LVN 8. LVN 8 stated she did not wear a gown while checking the Resident 152's BP. LVN 8 also stated a gown and gloves were required when checking the resident's BP and administering medications for the residents on EBP. b. Medical record review for Resident 111 was initiated on 2/12/25. Review of Resident 111's MAR showed the following physician's order: - dated 9/6/24, for Enhanced Barrier Precautions: PPE Required for high resident contact care activities. Indication: implanted feeding device. On 2/12/25 at 0814 hours, a medication administration observation via GT was conducted with LVN 4. A sign/poster for EBP was observed on Resident 111's room door. LVN 4 was observed wearing a new pair of gloves at the medication cart and entering Resident 111's room without a gown, to assess the resident's BP. While LVN 4 was measuring the resident's BP with the stethoscope and BP cuff, LVN 4's arms and clothing were observed touching the resident's linens and the resident's arm. Shortly after the BP assessment, LVN 4 returned to the mediation cart and started preparing nine medications for Resident 111. After preparing the medications, LVN 4 wore a new pair of gloves, returned to Resident 111's room again without a gown and proceeded to administer the medications through the resident's GT. On 2/12/25 at 1110 hours, an interview was conducted with LVN 4. LVN 4 stated he did not wear a gown while checking the resident's BP and administering the resident's medications. LVN 4 also stated he realized after finishing the medication administration, he had to be gowned up. LVN 4 stated gown and gloves were required PPE when providing care to the residents on EBP, which included the BP assessment and medication administration. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated for the residents on EBP, the facility staff providing care such as BP measurement and medication administration, need to wear the gown and gloves before entering the room. 5. Review of the facility's P&P titled IPCP standard and Transmission-Based Precaution dated 1/28/25, showed in part, .patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient . Review of the facility's P&P titled Infection Prevention-Employee Exposure dated 1/28/25, showed Environmental and Equipment Protection: Dedicated use of non-critical care equipment (i.e., sphygmomanometer, stethoscope and thermometer) will be provided to MDRO resident(s), when available. This equipment should be disinfected after each use whether dedicated to MDRO resident or shared. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 2/11/25 at 0815 hours, a medication administration observation via GT was conducted with LVN 8. A sign/poster of EBP was observed on Resident 152's room door. LVN 8 was observed bringing an uncleaned stethoscope and BP cuff to Resident 152's room, to assess the resident's BP. After the BP assessment, LVN 8 brought out the stethoscope and BP cuff to the medication cart and disinfected only the earpieces of the stethoscope with the alcohol swab. LVN 8 did not sanitize the entire parts of the stethoscope and BP cuff with the sanitizing wipe before and after use. On 2/11/25 at 1228 hours, an interview was conducted with LVN 8. LVN 8 verified she did not sanitize the BP cuff and stethoscope with the sanitizing wipe before and after use and sanitized only the earpieces of the stethoscope with the alcohol swab after use. b. On 2/12/25 at 0814 hours, a medication administration observation via GT was conducted with LVN 4. A sign/poster of EBP was observed on Resident 111's room door. LVN 4 was observed sanitizing only the earpieces of the stethoscope without sanitizing the entire parts of the stethoscope and BP cuff. Then, LVN 4 was observed bringing the stethoscope and BP cuff to Resident 111's room, to assess the resident's BP. After the BP assessment, LVN 4 brought out the stethoscope and BP cuff to the medication cart and sanitized only the earpieces of the stethoscope with the alcohol swab. LVN 4 did not sanitize the entire parts of the stethoscope and BP cuff with the sanitizing wipe before and after use. On 2/12/25 at 1110 hours, an interview was conducted with LVN 4. LVN 4 verified he did not sanitize the BP cuff and stethoscope before and after use. LVN 4 stated he should have cleaned the entire parts of stethoscope and BP cuff using the sanitizing wipe. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the BP cuff and stethoscopes should be disinfected before and after use, sanitizing the whole stethoscope from the ear parts to the diaphragm, and it should be disinfected with bleach not with the alcohol swab. 6. Review of the facility's P&P titled Infection Prevention-Hand Hygiene dated 1/28/25, showed in part, Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations: before donning sterile glove .after removing glove . a. On 2/11/25 at 0815 hours, a medication administration observation via GT was conducted with LVN 8. A sign/poster of EBP was observed on Resident 152's room door. After LVN 8 brought in all the prepared medications into Resident 152's room and placed it on the resident's bedside table, LVN 8 was observed walking out of the resident's room to the medication cart to get a cup of water for the GT administration. LVN 8 discarded the gloves she was wearing and prepared a cup of water. Before reentering to the resident's room, she wore a new pair of gloves without sanitizing her hands with the alcohol gel. After LVN 8 returned to the resident's room with a cup of water, she proceeded to administer the medications via GT. On 2/11/25 at 1228 hours, an interview was conducted with LVN 8. LVN 8 stated she did not remember whether she sanitized her hands with the alcohol gel in between changing the gloves when she walked out of the resident's room to get a cup of water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of the facility's P&P titled Administration Process dated 1/28/25, showed hands are to be washed with soap and water before and after administering injections, eye drops, eardrops, nasal sprays. On 2/11/25 at 0903 hours, a medication administration observation was conducted with LVN 6. LVN 6 was observed preparing 10 medications, including eight tablets, one nasal spray and an insulin for injection for Resident 68. After administering the tablets to Resident 68, LVN 6 trashed the empty cups, washed her hands in the resident's restroom with soap and water. Then, LVN 6 was observed wearing a new pair of gloves to assess the resident's glucose level using a lancet, glucometer and a test strip. After LVN 6 assessed the resident's glucose level, LVN 6 was observed changing the gloves without performing hand hygiene. After LVN 6 wore a new pair of gloves, she proceeded to administer the nasal spray to Resident 68's nostrils. On 2/11/25 at 1137 hours, an interview was conducted with LNV 6. LVN 6 stated she thought she cleaned her hands in between changing the gloves. However, two surveyors independently observed LVN 6 not performing hand hygiene in between changing the gloves before administering the last medication to the resident, which was the nasal spray. c. On 2/12/25 at 0814 hours, a medication administration observation via GT was conducted with LVN 4. A sign/poster of EBP was observed on Resident 111's room door. After LVN 4 administered the third medication to Resident 111's GT, LVN 4 walked out of the resident's room to get more water for the remaining gloves. Then, LVN 4 returned to the resident's room with a cup of water wearing the same gloves. LVN 4 was not observed changing the gloves. After LVN 4 re-entered the resident's room, LVN 4 resumed administering the rest of the medications via the resident's GT. On 2/12/25 at 1110 hours, an interview was conducted with LVN 4. LVN 4 stated he did not change the gloves when he walked out of the room to get more water. LVN 4 verified he came back to Resident 111's room with the same gloves on. LVN 4 stated hand hygiene was required before entering and after leaving the resident's room. LVN 4 verified he should have removed the gloves to prepare the cup of water, then donned a new pair of gloves before re-entering the resident's room. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the facility staff must perform hand hygiene in between changing the gloves using alcohol gel or washing hands with soap and water. 7. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions dated 1/28/25, showed standard precautions are infection prevention practices that apply to the care of all the residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents. Standard precaution includes use of PPE based on the predicted staff interaction with residents and the potential for exposure to blood, body fluids, or pathogens), hand hygiene, environmental cleaning and disinfection and reprocessing of reusable medical equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25 at 0815 hours, a medication administration observation via GT was conducted with LVN 8. A sign/poster of EBP was observed on Resident 152's room door. Prior to administering the medications to Resident 152, LVN 8 was observed disconnecting the feeding tube from the resident's GT and placing the feeding tube over the IV pole to hang it. After LVN 8 hung the GT tubing over the IV pole, the tubing was dropped on the floor. LVN 8 then grabbed the tubing from the floor and hung it again over the IV pole without disinfecting the tubing or replacing the tubing. Then, LVN 8 proceeded to administer the medications through the resident's GT. After finishing the medication administration, LVN 8 was observed grabbing the GT tubing from the IV pole and reattaching the tubing back to the resident's GT, without disinfecting the tubing or replacing the tubing. On 2/11/25 at 1228 hours, an interview was conducted with LVN 8. LVN 8 verified the feeding tube was dropped on the floor, but she did not disinfect the tubing. LVN 8 stated she hung the tubing over the IV pole again and started administering the medications to Resident 152. LVN 8 also stated she did not disinfect the tubing before reattaching it to the resident's GT. On 2/13/25 at 0856 hours, an interview was conducted with the DON. The DON stated the licensed nurse should have securely placed the tube in the holder attached to the feeding pump, instead of hanging the tubing over the IV pole. The DON also stated the licensed nurse should have disinfected the feeding tube after it dropped on the floor and before reattaching it to the resident's GT.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 39683 Based on interview, medical record review, facility document review, and facility P&P review the facility failed to implement an antibiotic stewardship program to reduce the risk of unnecessary or inappropriate antibiotic use when two nonsampled residents (Residents 127 and 159) were being treated for conditions which did not meet the McGeer's criteria. This failure had the potential of not accurately identifying true infections and exposing the residents to unnecessary antibiotic use. Findings: Review of the facility's P&P titled Infection Prevention and Control Program revised 9/2017 showed improving the use of antibiotics in healthcare to protect residents and reduce the threat of antibiotics resistance is a national priority, and disease caused by resistant bacteria are increasing in long term care facilities and contributing to higher rates of morbidity and mortality. The facility will promote appropriate antibiotic use while optimizing the treatment of infections, while reducing possible adverse events associated to antibiotic use. On 2/14/25 at 0804 hours, an antibiotic stewardship review and concurrent interview was conducted with the IP. The IP stated the facility used the McGeers criteria to identify true infections. The IP stated for suspected infections that did not meet the McGeer's criteria and were treated with antibiotics, the process was to notify the physician to evaluate the antibiotic usage. a. Review of the facility's Infection Prevention and Control Surveillance Log for November 2024, showed Resident 127 was prescribed an antibiotic medication on 11/11/24, for pneumonia and met the McGeer's criteria. Review of Resident 127's Infection Surveillance - V2 dated 11/14/24, showed the criteria for pneumonia was met. However, review of Resident 127's medical record failed to show the resident's symptoms met criteria for a true infection. The IP verified Resident 127's medical record failed to show the resident's symptoms met the McGeer's criteria. In addition, the resident's physician was not notified regarding the resident's antibiotic medication not meeting the McGeer's criteria and to re-evaluate the need for the use of the antibiotic medication. b. Review of the facility's Infection Prevention and Control Surveillance Log for January 2025, showed Resident 159 was prescribed an antibiotic medication on 1/4/24, for other infection related to elevated WBCs and met the McGeer's criteria. Review of Resident 159's Infection Surveillance - V2 dated 1/3/25, showed the McGeer's criteria was met. However, review of Resident 159's medical record failed to show the resident's symptoms met the McGeer's criteria for a true infection. The IP stated the facility did not have a McGeer's criteria tool for the other infections. The IP verified the resident's symptoms did to meet the McGeer's criteria, and the resident's physician was not notified.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 51423 Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in the safe operating conditions. * The facility's ice machine was not cleaned and sanitized as per the manufacturer's instructions. This failure had the potential for the essential equipment not functioning in the way it was intended and in turn cause contamination of the food, leading to illnesses for the residents. Findings: Review of the facility's Matrix showed 157 of 166 residents consumed food prepared in the kitchen. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment Food-Contact Surfaces and utensils shall be clean to sight and touch. Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023 showed the internal components are to be cleaned monthly per manufacturer's recommendations. Review of the facility's ice machine manufacturer guidelines titled Cleaning and Sanitizing Procedure Instructions (undated) showed the following: - Only use [Manitowac] approved ice machine cleaner and sanitizer for this application. - Step 1: Ice must not be on the evaporator during the clean/sanitize cycle. Press the manual harvest button in the service menu and allow the ice to harvest. Once all of the ice falls from the evaporator, turn the machine off by pushing the power button. - Step 2: Remove all ice from the bin/dispenser. - Step 3: Press the clean button, follow the prompts, and select Turn off when complete. The unit does not start dumping until you select Off or Ice mode. Water will flow through the dump valve and down the drain. When water trough has refilled (approximately 1 minute) and the display indicates: Add the proper amount of ice machine cleaner. (See chart #1 for proper amount). Chart #1 showed five ounces of cleaner was to be added to the water trough. - Step 4: Wait until the clean cycle is complete (approximately 24 minutes). - Step 5: Remove parts for cleaning. - Step 6: Mix a solution of the cleaner and warm water. Depending on the degree of mineral buildup. A large quantity of solution may be required. Use the table to mix enough solution to thoroughly clean all parts. Chart showed: use one gallon of water with 16 oz of cleaner solution. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Step 7: Use half of cleaner mixture to clean all components. Soak parts for five minutes, 20 minutes for heavily scaled parts. The cleaner solution will foam when it contacts lime scale and mineral deposits. Once the foaming stops, use a soft-bristle nylon brush, sponge or cloth to thoroughly clean the following ice machine areas: side walls, base (area above the trough), evaporator plastic parts (top, bottom, and sides), bin or dispenser. Rinse all the components with clean water - Step 8: While components are soaking, use half of the cleaner/water solution to clean all food zone surfaces of the ice machine and bin (or dispenser). Use nylon brush or cloth to thoroughly clean the following ice machine areas: side walls, base, evaporator plastic parts, bin, or dispenser. Rinse thoroughly with clean water. - Step 9: Mix a solution of sanitizer and lukewarm water. Three gallon (12 liters) of water and two ounces of sanitizer. - Step 10: Use half of the sanitizer/water solution to sanitize all removed components. Use a spray bottle to liberally apply the solution to all surfaces of the removed parts or soak the removed parts in the sanitizer/lukewarm solution. Do not rinse parts after sanitizing. - Step 11: Use half of the sanitizer/water solution to sanitize all food zone surfaces of the ice machine and bin. Use a spray bottle to liberally apply the solution: side walls, base, evaporator plastic parts, bin or dispenser. Rinse all areas thoroughly with clean water. - Step 12: Replace all removed components. - Step 13: Wait 20 minutes. - Step 14: Reapply power to the ice machine. Press the clean button and select make ice when complete. - Step 15: When ice trough was refilled, and the display indicates: add the proper amount of ice machine sanitizer to the water trough by pouring between the water curtain and evaporator. (See chart #1 for proper amount.) Showed to use 3 oz of sanitizer. On 2/11/25 at 0924 hours, an observation and concurrent interview was conducted with the Maintenance Director and MA for the ice machine located in the kitchen. The MA stated he cleaned the ice machine once a month. The MA was asked to explain the process he used to clean the ice machine. The MA stated he mixed five ounces of the ice machine cleaner/descaler with a pitcher of water. The mixture was poured into the machine and the clean cycle was started. The MA was asked how much water he mixed with the ice machine cleaner/descaler. The MA stated he filled the pitcher to the top with water. The MA verified he did not know how much water the pitcher held. The MA stated once the ice machine cleaner/descaler mixture ran through the machine, he removed the internal parts and soaked the parts in bleach in a large container. The MA then stated he put five ounces of ice machine sanitizer in the sink with water. The MA was not able to state how much water he mixed with the sanitizer in the sink. The MA stated he soaked the ice machine parts in the sanitizer/water mixture. The ice machine instructions located on the inside panel of the ice machine were reviewed with the Maintenance Director and MA. The Maintenance Director stated the MA was confused with the ice machine chemicals and the instructions were in English, which was difficult for the MA to understand.