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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to ensure the baseline care plans were developed to reflect the specific care needs for two of 20 final sampled residents (Residents 686 and 438). * The facility failed to ensure a baseline care plan was developed to address the administration of oxygen for Residents 686 and 438. This failure had the potential for the residents' care needs not being met. Findings: 1. Medical Record review for Resident 686 was initiated on 1/29/25. Resident 686 was admitted to the facility on [DATE]. Review of Resident 686's H&P examination dated 1/27/25, showed Resident 686 was status post diagnosis of acute respiratory failure secondary to congestive heart failure. Review of Resident 686's Order Summary Report showed a physician's order dated 1/25/25, showed to administer the oxygen at a rate of 3 liters per minute via nasal cannula. On 1/30/25 at 0903 hours, an observation, interview, and concurrent medical record review was conducted with LVN 6. Resident 686 was observed lying in bed with continuous oxygen being administered through an oxygen concentrator, at a rate of 4 liters per minute via nasal cannula. Resident 686 stated he utilized the oxygen for shortness of breath. LVN 6 verified Resident 686's physician order dated 1/25/25, showed to administer oxygen at a rate of 3 liters per minute via nasal cannula; however, Resident 686 was receiving oxygen at a rate of 4 liters per minute. Review of Resident 686's baseline care plans failed to show a baseline care plan was developed to address the administration of oxygen to Resident 686. On 1/30/25 at 1005 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 reviewed Resident 686's plan of care and verified the facility failed to initiate a care plan for the administration of the the resident's oxygen. Cross reference to F695, example #1. (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	39683 2. Medical record review for Resident 438 was initiated on 1/29/24. Resident 438 was admitted to the facility on [DATE]. Review of Resident 438's Order Summary Report showed a physician's order dated 1/23/25, for continuous oxygen at 3 liters per minute via nasal cannula. Review of Resident 438's Plan of Care failed to show Resident 348 was receiving the supplemental oxygen. On 1/29/25 at 0904 hours, Resident 438 was observed lying in bed with the supplemental oxygen being administered at 3 liters per minute via nasal cannula. On 1/30/25 at 1227 hours, an interview and concurrent medical record review was conducted with the IP. The IP stated the oxygen administration should be documented in the resident's plan of care. The IP verified and stated Resident 438's care plan for oxygen use should have been initated.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of two final sampled residents (Resident 38 and 587) observed for medication administration were free from the medication errors. * The facility failed to ensure Resident 38's IV medication was dated and documented time of administration. * The facility failed to ensure Resident 587's PIV was dated and labeled. These failures posed the risk for the residents to develop complications related to the IV therapy. Findings: Review of the facility's P&P titled Nursing Clinical undated showed to label the IV container with the resident's name, medication, dose initials of nurse, time, date, document additives on resident record and dispose of needles and syringes properly. 1. During the initial tour of the facility on 1/29/25 at 1029 hours, Resident 38 was observed in bed awake, receiving an IV antibiotic medication Vancomycin one gram. However, Resident 38's IV medication bag label was undated, no time it was hanged and no signature of the nurse who administered the antibiotic medication. On 1/29/25 at 1137 hours, an observation and concurrent interview for Resident 38 was conducted with RN 1. The RN 1 verified the above findings. Medical record review for Resident 38 was initiated on 1/29/25. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's MDS dated [DATE], showed a BIMS score of 14 (meaning cognitively intact). Review of Resident 38's Order Summary Report showed the following physician's order dated 1/9/25: - for Vancomycin one gram intravenously every 12 hours for abdominal abscess, to remain on IV antibiotic until at least 2/27/25. On 2/3/35 at 1430 hours, an interview was conducted with the Administrator and Interim DON. The Administrator and Interim DON was informed and acknowledged the above findings. 47474 2. Medical record review for Resident 587was initiated on 1/29/25. Resident 587 was admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 587's H&P examination dated 1/27/25, showed Resident 587 had the capacity to understand and make decisions. Review of Resident 587's Order Summary Report for February 2025 showed a physician's order dated 1/26/25, for ceftriaxone (a medication used to treat infection) 2 gm IV once daily for UTI until 1/30/25. Further review of the physician's orders showed to start a PIV line (peripheral intravenous) and change the site every 72 hours and PRN for infiltration or soiling. On 1/29/25 at 1111 hours, an observation of Resident 587 was conducted in the resident's room. Resident 587 was observed with a single-lumen PIV line to the right hand with undated and unlabeled dressing. On 1/29/25 at 1119 hours, a concurrent observation and interview was conducted with RN 1 in Resident 587's room. RN 1 verified Resident 587's PIV line dressing was not dated or labeled. RN 1 stated the PIV sites should be dated and labeled to ensure the PIV lines were changed as ordered by the physician and for the staff member to know how long the resident had the PIV line. On 2/4/25 at 1430 hours, an interview with the Administrator and DON was conducted. All of the above findings were acknowledged and verified.

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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** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care for two of 20 final sampled residents (Residents 686 and 438) reviewed for respiratory care and two nonsampled residents (Residents 28 and 436). * The facility failed to follow the physician's order for the administration of the oxygen for Resident 686. The facility administered continuous oxygen to Resident 686 at a higher rate than what was ordered by the physician. * The facility failed to ensure the oxygen tubing was labeled with the date when it was changed for Residents 28 and 438. * The facility failed to ensure the nebulizer tubing for Resident 436 was dated. These failures had the potential to negatively impact the residents' medical conditions. Findings: Review of the facility's P&P titled Use of Oxygen (undated) showed it is the policy of this facility to promote resident safety in administering oxygen. 1. Medical Record review for Resident 686 was initiated on 1/29/25. Resident 686 was admitted to the facility on [DATE]. Review of Resident 686's H&P examination dated 1/27/25, showed Resident 686 was status post diagnosis of acute respiratory failure, secondary to congestive heart failure. Review of Resident 686's Order Summary Report showed a physician's order dated 1/25/25, to administer the oxygen at a rate of 3 liters per minute via nasal cannula. On 1/29/25 at 1211 hours, an observation was conducted for Resident 686. Resident 686 was observed with continuous oxygen being administered through an oxygen concentrator at a rate of 5 liters per minute via nasal cannula. On 1/30/25 at 0903 hours, an observation, interview, and concurrent medical record review was conducted with LVN 6. Resident 686 was observed lying in bed with continuous oxygen being administered through an oxygen concentrator, at a rate of 4 liters per minute via nasal cannula. Resident 686 stated he utilized the oxygen for shortness of breath. LVN 6 verified Resident 686's physician order dated 1/25/25, showed to administer the oxygen at a rate of 3 liters per minute via nasal cannula, however, Resident 686 was receiving oxygen at a rate of 4 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 0926 hours, an observation, interview, and concurrent medical record review was conducted with LVN 6. Resident 686 was observed lying in bed. LVN 6 was observed lowering Resident 686's continuous oxygen from a rate of 4 liters per minute to a rate of 3 liters per minute (in accordance with the physician's order). LVN 6 stated she was unsure who increased Resident 686's rate of oxygen above the physician's ordered rate of 3 liters per minute. LVN 6 then obtained Resident 686's oxygen saturation (on 3 liters per minute) which was measured at 87%. Resident 686 complained of difficulty breathing during inspiration. LVN 6 stated she would notify the physician of Resident 686's complaint of difficulty breathing and the decreased of the resident's oxygen saturation. Review of Resident 686's medical record failed to show documented evidence of a staff member entry when the resident's continous oxygen was increased from a rate of 3 liters per minute to 4 litters per minute and the reason for the increase. There was no documented evidence the physician was notified prior to the increase on 1/30/24 at 0926 hours. 39683 2. Medical record review for Resident 28 was initiated on 1/29/24. Resident 28 was readmitted to the facility on [DATE]. Review of Resident 28's Order Summary Report showed a physician's order dated 3/26/24, for continuous oxygen at a rate 2 lpm via nasal cannula. On 1/29/25 at 0851 hours, Resident 28 was observed lying in bed with the supplemental oxygen being administered at a rate of 2 lpm via nasal cannula. On 1/29/25 at 1020 hours, an interview was conducted with LVN 1. LVN 1 stated the oxygen tubing should be changed weekly and as needed. LVN 1 stated the date when it was changed should be written on the tubing. On 1/29/25 at 1219 hours, an interview was conducted with the Central Supply. The Central Supply stated the oxygen tubing was changed every Friday. The Central Supply stated Resident 28's nasal cannula tubing was dated 1/13/25, when she changed out the tubing that morning. 3. Medical record review for Resident 438 was initiated on 1/29/24. Resident 438 was admitted to the facility on [DATE]. Review of Resident 438's Order Summary Report showed a physician's order dated 1/23/25, for continuous oxygen at a rate of 3 lpm via nasal cannula. Review of Resident 438's Plan of Care failed to show if Resident 438 was receiving a supplemental oxygen. On 1/29/25 at 0904 hours, Resident 438 was observed lying in bed with supplemental oxygen being administered at a rate of 3 lpm via nasal cannula. The nasal cannula tubing was undated. On 1/29/25 at 1020 hours, an interview was conducted with LVN 1. LVN 1 stated the oxygen tubing should be changed weekly and as needed. LVN 1 stated the date when it was changed should be written on the tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1024 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 438's bedside. LVN 1 verified Resident 438's nasal cannula tubing was undated. 4. Medical record review for resident 436 was initiated on 1/29/24. Resident 436 was admitted to the facility on [DATE]. Review of Resident 436's Order Summary Report showed a physician's order dated 1/28/25, for ipratropium-albuterol solution (medication to control symptoms of lung disease) 0.5-2.5 mg/ml. Inhale 3 ml orally three times a day via nebulizer (a device that turns the liquid medicine into a mist which is then inhaled through a mouthpiece or a mask). On 1/29/25 at 1020 hours, an interview was conducted with LVN 1. LVN 1 stated the oxygen tubing should be changed weekly and as needed. LVN 1 stated there should be a date written on the tubing when it was changed or when it was intiated. On 1/29/25 at 1021 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 436's bedside. LVN 1 verified the Resident 436's nebulizer tubing was undated.

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48332 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the proper accounting and safeguarding of the controlled medications to prevent loss, diversion, or accidental exposure. * The facility failed to ensure the Narcotic Count Sheet log was signed by the incoming and outgoing licensed nurses assigned to Medication Cart B. This failure posed the risk for loss or diversion of the controlled medications in the facility. Findings: Review of the facility's P&P titled Pharmacy Services Controlled Medications revised 12/2019 under the section for Policy showed it is the policy of the facility to provide separate locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. The Procedures section showed at each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit. Review of Medication Cart B's Narcotic Count Sheet showed multiple missing incoming and/or outgoing nurses' signatures for the following dates: - on 1/11/25, for the 7-3 shift; - on 1/25/25, for the 3-11 shift; and - on 1/29/25, for the 11-7 shift. On 1/30/25 at 1242 hours, an interview and concurrent facility document review was conducted with LVN 4. LVN 4 verified multiple licensed nurses' signatures were missing in the Narcotic Count Sheet log. When asked what the Narcotic Count Sheet log was for, LVN 4 stated the incoming and outgoing nurses counted the medications at the end of each shift to ensure the narcotic medication counts were reconciled and accounted for. On 1/30/25 at 1255 hours, an interview and concurrent facility document review was conducted with the Interim DON. The Interim DON verified the missing licensed nurses' signatures on Medication Cart B's Narcotic Count Sheet. When asked what was the possible risk of not signing the Narcotic Count Sheet, the Interim DON stated when the controlled medications were not accounted for, it posed a risk for narcotic diversion.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of four residents (nonsampled resident, Resident 736) observed for medication administration was free from the significant medication errors. This failure had the potential to negatively impact the resident's health outcomes. Findings: Review of the facility's P&P titled Medication Administration revised 8/2021 showed it is the policy of this facility that medications shall be administered as prescribed by the attending physician. Medications must be administered in accordance with written orders of the attending physician. On 1/31/25 at 0845 hours 0836 hours, a medication administration observation for Resident 736 was conducted with LVN 3. LVN 3 prepared the following medications for Resident 736: - hydralazine (medication to treat high blood pressure) 25 mg one tablet. The medication bubble pack showed the directions to hold the medication if the SBP less than 110 mmHg or pulse rate less than 60 beats per minute. LVN 3 was observed checking Resident 736's blood pressure prior; however, LVN 3 was observed not checking Resident 736's pulse rate. On 1/31/25 at 0909 hours, LVN 3 stated she was ready to administer the medication to Resident 736. LVN 7 was asked to stop from administering the hydralazine medication to Resident 736 because the resident's pulse rate was not checked and there was a parameter to hold if the pulse rate was less than 60 beats per minute. On 1/31/25 at 0911 hours, LVN 3 went inside Resident 736's room to check the resident's pulse rate which was 69 beats per minutes. LVN 3 administered the hydralazine medication. Medical record review for Resident 736 was initiated on 1/31/25. Resident 736 was admitted to the facility on [DATE]. Review of Resident 736's Order Summary Report showed the following physician's order dated 1/25/25: - hydralazine 25 mg one tablet by mouth two times a day for hypertension. Hold medication if the SBP < (less than)110 mmHg or PR < (less than) 60 beats per minute. On 1/31/25 at 1301 hours, an interview was conducted with LVN 3. The LVN 3 verified and acknowledged the above findings. On 2/3/35 at 1430 hours, an interview was conducted with the Administrator and Interim DON. The Administrator and Interim DON was informed and acknowledged the above findings.

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50953 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage. * The facility failed to ensure the open packages of wound care supplies were removed from the medication cart. * The facility failed to ensure the orally used medications were stored separately from the externally used medications. These failures had the potential for medication errors and negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Medication Access and Storage revised 2/2019 showed the following: - The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. - Medication are kept and stored in these containers. - Transfer of medications from one container to another is done only by a pharmacist. 1. On 1/30/25 at 1215 hours, an inspection for Medication Cart A was conducted with LVN 2. During the inspection of Medication Cart A, the following was observed: - two open individual packages of Skin Closure Strip cut in half; and - one open individual package of calcium alginate dressing (a non-toxic, absorbent wound dressing made from seaweed) with cut portion. On 1/30/25 at 1245 hours, an interview was conducted with LVN 2. LVN 2 verified and acknowledged the above findings. LVN 2 stated all individual packs of the wound care supplies needed to be single use to make sure it was sterile. On 2/3/35 at 1430 hours, an interview was conducted with the Administrator and Interim DON. The Administrator and Interim DON was informed and acknowledged the above findings. 48332 (continued on next page)

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Review of the facility's P&P titled Care and Treatment, Subject: Medication Access and Storage dated 2/2019 showed the orally administered medications are kept separate from externally used medications, e.g., suppositories, liquids, lotions and tablets. The eye medications are kept separate from ear medications. On 1/30/25 at 1005 hours, an observation of Medication Room A and concurrent interview was conducted with the IP. The following were observed: a. inside the refrigerator, one bottle of Latanoprost eye drop solution 0.0054 % (medication to treat glaucoma-increase pressure in the eye) and nitroglycerin 0.4 mg tablets (a medication for chest pain) were stored in one rectangular gray plastic tray. b. in the middle shelft attached to the wall, the following over-the-counter medications/house supply medications were store together side by side without a separator: - one box of Clearcanal Earwax softener Drops, - one box of naloxone hydrochloride nasal spray 4 mg (medication to temporarily reverse the effects of an opioid medicine), - one bottle of Calamine Lotion (topical skin protectant), - one bottle of artificial tears (eye lubricant drops), - three boxes of Nicotine Transdermal System Patch (applied on the skin to help people quit smoking), and - and two boxes of Salonpas Lidocaine 4% patches (pain reliever patch) The IP verified the above findings, removed the medications, and stated they should be stored separately. On 2/3/25 at 1325 hours, an interview was conducted with the Interim DON. The Interim DON was notified of the above findings and acknowledged the external and internal medications should be stored separately.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47474 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure eight of eight residents who received pureed food from the kitchen received the proper diets when the facility's puree recipes and menu were not followed as evidenced by: * The facility failed to ensure the puree recipe for potatoes and menu for pureed wheat rolls were followed. This failure had the potential to negatively impact the residents' well-being. Findings: Review of the facility's census on 1/29/25, showed 95 of 98 residents received food from the kitchen. The facility's document titled Diet Type Report dated January 2025 showed the kitchen provided puree diets to eight residents in the facility. Review of the facility's P&P titled Regular Pureed Diet/IDDSI Level #4 dated 2024 showed the pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the prepared food items included on this diet should be smooth and free of lumps, hold their shape, while not being too firm or sticky, and should not weep. Portions given will account for the addition of fluids to be specified on the spreadsheet. Review of the facility's P&P titled Menu Planning dated 2023 showed the menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. The menus provide a variety of foods in adequate amount each meal. Menus are planned to consider: D. Skills of the Food and Nutrition Services employees in preparing food. E. Time necessary for food preparation and serving of food. The facility's P&P further showed the facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility. Menus are written for regular and therapeutic diets in compliance with the diet manual. Furthermore, the P&P showed standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. 1. Review of the facility's document titled Recipe: Pureed (IDDSI Level 4) Starch (Rice, Pasta, Polenta, Potatoes, etc.), dated 2024, showed to measure out the total number of portions needed for pureed diets. Puree on low speed to a paste consistency before adding any liquid and to gradually add warm milk. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 1100 hours, a concurrent observation and interview with [NAME] 1 was conducted during the puree preparation for the pureed red potatoes. [NAME] 1 was observed blending the red potatoes and then adding cold milk and vegetable broth. [NAME] 1 verified she added a total of 1/2 (half) cup of cold milk and one cup of vegetable broth to the blended red potatoes. [NAME] 1 further verified the pureed recipe for starch such as potatoes showed to add warm milk; however, [NAME] 1 stated she used cold milk and vegetable broth instead. Dietary Resource 1 was present and acknowledged the findings, the pureed starch for the red potatoes were not followed as ordered. 2. Review of the facility's document titled Winter Menus - Week 1 dated for 1/30/25, showed to use the Scoop #16, which is equivalent to 1/4 cup when serving pureed wheat roll. Review of the facility's document titled Scoop Chart, undated, showed the Scoop # 12 (scoop with a green handle) is equivalent to 1/3 cup and Scoop #16 (scoop with a blue handle) is equivalent to 1/4 (one forth) cup. On 1/30/25 at 1240 hours, a concurrent observation and interview with the Dietary Supervisor Assistant during tray line observation was conducted. The Scoop # 12 with a green handle was observed used to serve the pureed wheat roll. The Dietary Supervisor Assistant verified Scoop # 12 was used as the serving scoop for the pureed wheat roll. The Dietary Supervisor Assistant further verified the menu for pureed wheat roll showed to use Scoop #16 and stated the Scoop #12 should be changed to the Scoop # 16 as shown on the menu. On 2/4/25 at 1430 hours, an interview with the Administrator, DON, and CDM was conducted. All of the above findings were acknowledged and verified.

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	555257	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Terrace Healthcare & Rehabilitation Center	24962 Calle Aragon Laguna Hills, CA 92637

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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. 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen. * The facility failed to ensure the food preparation utensils and equipment were in good, sanitary, and cleanable working conditions. * The facility failed to ensure the food items were dated and labeled. * The facility failed to ensure the kitchen staff wore hair restraint. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's census on 1/29/25, showed 95 of 98 residents received food from the kitchen. 1. According to 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. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 1/29/25 at 0821 hours, a concurrent observation and interview with the CDM was conducted. One large pot was observed heavily marred with black discoloration. The CDM verified the findings and stated it should be changed out. On 1/29/25 at 0839 hours, a concurrent observation and interview with [NAME] 1 was conducted. The following were observed: - one green cutting board observed heavily marred; - one white cutting board heavily marred with black and orange discoloration and; - one can opener with brown discoloration (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cook 1 verified the above findings. [NAME] 1 stated there was a risk of food contamination and they will change the cutting boards and will wash the can opener. On 1/29/15 at 0900 hours, a concurrent observation and interview with Dietary Resource 1 was conducted. The following were observed: - one 1/2 cup measuring cup with oil-like substance; - one spatula strainer with white residue; and - two ice cream scoopers with chipped handles. Dietary Resource 1 verified the above findings. Dietary Resource 1 stated the kitchen equipments should be cleaned and acknowledged the chipped handles have the potential to go in the prepared foods. 2. Review of the facility's P&P titled Labeling and Dating of Foods dated 2023 showed all the food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety or product rotation (FIFO - First In, First Out). The P&P further showed the individual opening or preparing a food shall be responsible for date marking at the time of processing and/or storage. Frozen foods are dated with a delivery (received) date. a. On 1/29/25 at 0800 hours, during the intial tour of the kitchen, a concurrent observation and interview with the CDM was conducted. An unidentified food item in a clear, unlabeled, and undated plastic bag was observed in Freezer 1. The CDM verified the findings and stated he did not know why the food item was not stored in the original box. b. On 1/29/25 at 0826 hours, a concurrent observation and interview with the CDM was conducted in the kitchen. Several food items in Refrigerator 2 observed not labeled or dated: - 14 containers of white solid food substance with no date or label; - six containers of yellow diced food substance with no date or label; and - several cups of water, milk, and juices with no date or label. The CDM verified above findings. On 1/29/25 at 0930 hours, an interview with Dietary Resource 1 was conducted. Dietary Resource 1 stated the food items should be labeled and dated to ensure the kitchen staff were aware of how long the food item has been prepared. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. According to the USDA Food Code 2022, Section 2-402.11, Hair Restraints - Effectiveness showed consumers are particularly sensitive to food contaminated by hair. Hair can be both a direct and indirect vehicle of contamination. Food employees may contaminate their hands when they touch their hair. A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. The USDA Food Code 2022 further showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep hear from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. On 1/30/25 at 0925 hours, a concurrent observation and interview with the Dietary Supervisor Assistant was conducted in the kitchen. The Dietary Supervisor Assistant was observed with no hair restraint. The Dietary Supervisor Assistant verified the findings and stated he should have a hair restraint. Dietary Resource 1 was present and verified the observation. Dietary Resource 1 acknowledged the hair restraints should be worn in the kitchen. On 2/4/25 at 1430 hours, an interview with the Administrator, DON, and Certified Dietary Manager was conducted. All of the above findings were acknowledged and verified.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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's P&P review, the facility failed to ensure the medical records were accurate for one of three residents (Resident 85) reviewed for closed medical records and one of two residents (final sampled resident, Resident 44) investigated for dialysis. * Resident 85's medical record had documentation for the vital signs results and urinary output after his discharge from the facility. * The facility failed to ensure Resident 44's blood pressure access site was accurately documented in the resident's medical record. * The facility failed to ensure Resident 44's blood pressure access site was accurately documented in the resident's medical record. * These failures had the potential for the residents' care needs not being met as their medical information was inaccurate. Findings: Review of the facility's P&P titled Charting and Documentation revised February 2022 showed it is the policy of the facility to ensure the resident record is concise and reflective of the current care provided to the resident. 1. Closed medical record review for Resident 85 was initiated on 1/31/25. Resident 85 was admitted to the facility on [DATE]. Review of Resident 85's Nursing Note dated 12/9/24 at 1136 hours, showed Resident 85 was transferred to the acute hospital. Review of Resident 85's Weights And Vitals Summary showed the following: - On 12/9/24 at 1924 hours, Resident 85's BP was 130/88 mmHg, pulse rate was 76, respiratory rate was 19, and temperature was 97 degrees F. - On 12/10/24 at 0216 hours, Resident 85's BP was 132/68 mmHg, pulse rate was 68, respiratory rate was 18, and temperature was 97.8 degrees F. Review of Resident 85's Documentation Survey Report showed the following: - On 12/10/24 at 0216 hours, Resident 85 had a 240 ml of urinary output. - On 12/10/24 at 1212 hours, Resident 85 had a 240 ml of oral intake. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 2/3/25 at 0934 hours, an interview and concurrent medical record review was conducted with the Interim DON. The Interim DON reviewed Resident 85's above records and verified the records showed the vital signs and fluid intake and output were documented after Resident 85 was transferred out of the facility. The DON stated there should be no documentation of vital signs and fluid intake and output when the resident was no longer at the facility. 50953 2. Review of the facility's P&P titled Dialysis (Renal), Pre- and Post-Care revised 12/2023, showed assess resident's blood pressure (in non-fistula arm) prior to being transported to the dialysis units. Medical record review for Resident 44 was initiated on 1/29/25. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Residents 44's MDS dated [DATE], showed a BIMS score of 3 (meaning severe cognitive impairment). Review of Resident 44's Plan of Care showed a care plan problem dated 8/23/24, addressing the resident's hemodialysis related to Renal Failure/End Stage Renal Disease. The care plan interventions included no BP, no IV, no blood draw, no fingerstick on left upper extremity with AV shunt. Review of Resident 44's Order Summary Report dated 1/31/25, showed an order dated 8/23/24, for no blood pressure check, no IV, no blood draw, no fingerstick on the left upper extremity with AV shunt. Review of Resident 44's Weights and Vitals Summary from 1/15 to 1/31/25, showed documentation the BP readings were obtained from the left arm one to times each day. For example: - on 1/16/25 at 2343 hours, a BP reading of 123/67 mmHg on the left arm - on 1/17/25 at 1727 hours, a BP reading of 122/70 mmHg on the left arm - on 1/19/25 at 1051 hours, a BP reading of 138/64 mmHg on the left arm - on 1/20/25 at 0804 hours, a BP reading of 128/67 mmHg on the left arm - on 1/21/25 at 1832 hours, a BP reading of 124/70 mmHg on the left arm - on 1/23/25 at 1101 hours, a BP reading of 128/70 mmHg on the left arm - on 1/24/25 at 0905 hours, a BP reading of 142/70 mmHg on the left arm - on 1/25/25 at 0635 hours, a BP reading of 126/64 mmHg on the left arm - on 1/25/25 at 2007 hours, a BP reading of 144/82 mmHg on the left arm - on 1/27/25 at 1035 hours, a BP reading of 132/64 mmHg on the left arm (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- on 1/28/25 at 0839 hours, a BP reading of 142/70 mmHg on the left arm On 1/31/25 at 0956 hours, an interview, and concurrent medical record review for Resident 44 was conducted with the MDS Coordinator. The MDS Coordinator verified the licensed nurses' documentation of the BP monitoring showed Resident 44's blood pressures were obtained from the resident's left upper extremity. On 2/3/35 at 1430 hours, an interview was conducted with the Administrator and Interim DON. The Administrator and Interim DON was informed and acknowledged the above findings.