STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555258	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley of the Moon Post Acute	347 Andrieux St Sonoma, CA 95476

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 Based on observation, interview and record review, the facility failed to ensure a resident right to know about, and had access to, the contact information for the Ombudsman (State Patient/Resident advocacy services) and California Department of Public Health (CDPH) and Federal and State Survey results. This failure had the potential for not allowing Residents or their family members to exercise their right to know contact advocates about their concerns regarding the care they received in the facility and how to view the results of the facility surveys and the plans of correction (A document from the facility that would state how to correct any deficiencies or findings, and to keep them from happening again.) prepared by the facility in response to a complaint investigation or recertification survey. Findings: (Cross Reference F575, F577) During an observation on 10/7/24, at 2:30 p.m., the bulletin boards across from the nursing station to the right of room [ROOM NUMBER] were observed to be blocked by one of two medicine carts. During an observation on 10/7/24, at 4:15 p.m., the activity / dining room, and the staff break room was observed to not have a poster that indicated how to contact the Ombudsman, CDPH, or where to find the facility survey results. During an observation on 10/7/24, at 4:05 p.m., the bulletin board by room [ROOM NUMBER] was not blocked by a medication cart. An observation on the bottom of the bulletin board that was previously blocked by a medication cart, indicated a notice in small font, on how to contact the Ombudsman and CDPH. During an interview on 10/07/24, at 2:51 p.m., Interview with Certified Nursing Assistant (CNA) N stated he did not know how to contact ombudsman or CDPH. He stated he did not know where the survey results for the facility were located. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Valley of the Moon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 347 Andrieux St Sonoma, CA 95476	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 10/7/24 at 2:55 p.m., Sampled Resident 2 stated I never heard of the Ombudsman or the California Department of Public Health (CDPH). She stated she did not know how to contact the ombudsman or CDPH, or locate survey results. During an interview on 10/7/23 at 3:06 p.m., Unsampled Resident 16 stated she did not know how to contact the Ombudsman, CDPH or view the survey results. During an interview on 10/07/24 at 3:27 p.m., Family Member W stated she did not know how to contact the Ombudsman, CDPH, or view the survey results. During an interview on 10/07/24, at 3:57 p.m., Unsampled Resident 17 stated he did not know how to contact the Ombudsman, CDPH, or view the survey results. During an interview on 10/7/24, at 4:10 p.m. , Licensed Staff N stated she did not know how to contact the Ombudsman, CDPH, or where the survey results were located. During an interview on 10/8/24, at 945 a.m., Unlicensed Staff X stated she did not know how to contact the ombudsman, CDPH, or where the survey results were located. During an interview on 10/8/24, at 12:25 p.m., Sampled Resident 2 and Sampled Resident 13 stated they did not know how to contact the Ombudsman, CDPH, or where the survey results were located. During an interview on 10/09/24 , at 8:40 a.m. Family Member AA stated she did not know how to contact the Ombudsman, CDPH, or where the survey results were located. During an interview on 10/09/24, at 9 a.m. , with Sampled Resident 6, he stated he did not know how to contact the Ombudsman, CDPH or where the find the survey results. During an interview on 10/09/24 , at 11:51 a.m., with Family Member BB, he stated he did not know how to contact the Ombudsman, CDPH or where to find the survey results. During and interview with the Resident Council Members on 10/9/24 at 1:30 p.m., 5 residents and one family member in attendance did not know what the CDPH was, or what a survey was, how to contact the Ombudsman and CDPH, and where to review the survey results. During an observation and interview on 10/11/24, at 9: 30 a.m., Interim DON stated she did not know where to find the contact information for the Ombudsman or the CDPH. She moved the medication cart that was parked in front of the bulletin board outside of resident room. She stated the information for the Ombudsman and CDPH, with phone numbers, was located on the bottom of the bulletin board. She stated it was pretty small and would have been blocked by the medication cart. She stated residents and family members would not have been able to see the information. She stated the risk to residents and familis was they would not know who to contact if they had a problem. She stated was unable to locate where the location of the survey results were in the unit. She asked RN E Resource where it was located, and he located a binder on top of the resident chart rack that contained the survey results and the plans of correction. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Valley of the Moon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 347 Andrieux St Sonoma, CA 95476	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility Policy and Procedure titled Resident Rights, revised 4/24, indicated The Resident has the right: .8. To filed a complaint with the State Survey and Certificate Agency concerning Resident abuse or neglect or misappropriation of Resident property in Nursing Center. 9. To contact and be visited by any represetnative of the U.S. Department of Health and Human Services, the State, the State's long term care ombudsman person or advocacy system . 10. To examine the results of the Nursing Center's most recent survey conducted by resspresentative of tthe Department of Health and Hman Services, and the plan of correction prepared by the Nursing Center in response to the survey. 25. To a posting of names, addresses and telephoen numbers of all pertinent state client advocacy groups such as survey and certification, licensing, ombudsman, protection and advocacy netrwork, and medicaid fraud control unit.

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 Based on observation, interview and record review, the facility failed to ensure residents knew about, and had access to, the contact information for the Ombudsman (State Patient/Resident advocate services) and California Department of Public Health (CDPH) and Federal and State Survey results. This had the potential for not allowing Residents or their family members to exercise their right to know contact advocates about their concerns regarding the care they received in the facility and how to view the results of the facility surveys and the plans of correction. Findings: (Cross Reference F550, F575) During an observation on 10/7/24, at 2:30 p.m., the bulletin boards across from the nursing station to the right of room [ROOM NUMBER] were observed to be blocked by one of two medicine carts. During an observation on 10/7/24, at 4:15 p.m., the activity / dining room, and the staff break room was observed to not have a poster that indicated how to contact the Ombudsman, CDPH, or where to find the facility survey results. During an observation on 10/7/24, at 4:05 p.m., the bulletin board by room [ROOM NUMBER] was not blocked by a medication cart. An observation on the bottom of the bulletin board that was previously blocked by a medication cart, indicated a notice in small font, on how to contact the Ombudsman and CDPH. During an interview on 10/07/24, at 2:51 p.m., Interview with Certified Nursing Assistant (CNA) N stated he did not know how to contact ombudsman, CDPH. He stated he did not know where the survey results for the facility were located. During an interview, on 10/7/24 at 2:55 p.m., Sampled Resident 2 stated I never heard of the Ombudsman or the California Department of Public Health (CDPH). She stated she did not know how to contact the ombudsman , CDPH or survey results. During an interview on 10/7/23 at 3:06 p.m., Unsampled Resident 16 stated she did not know how to contact Ombudsman, CDPH or view the survey results. During an interview on 10/07/24 at 3:27 p.m., Family Member W stated she did not know how to contact the Ombudsman, CDPH, or view the survey results. During an interview on 10/07/24, at 3:57 p.m., Unsampled Resident 17 stated he did not know how to contact the Ombudsman, CDPH, or view the survey results. During an interview on 10/7/24, at 4:10 p.m. , Licensed Staff N stated she did not know how to contact the Ombudsman, CDPH, or where the survey results were located. (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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/8/24, at 945 a.m., Unlicensed Staff X stated she did not know how to contact the ombudsman, CDPH, or where the survey results were located. During an interview on 10/8/24, at 12:25 p.m., Sampled Resident 2 and Sampled Resident 13 stated they did not know how to contact the Ombudsman, CDPH, or where the survey results were located. During an interview on 10/09/24 , at 8:40 a.m. Family Member AA stated she did not know how to contact the Ombudsman, CDPH, or where the survey results were located. During an interview on 10/09/24, at 9 a.m. , with Sampled Resident 6, he stated he did not know how to contact the Ombudsman, CDPH or where the find the survey results. During an interview on 10/09/24 , at 11:51 a.m., with Family Member BB, he stated he did not know how to contact the Ombudsman, CDPH or where to find the survey results. During and interview with the Resident Council Members on 10/9/24 at 1:30 p.m., 5 residents and one family member in attendance did not know what the CDPH was, or what a survey was, how to contact the Ombudsman and CDPH, and where to review the survey results. During an observation and interview on 10/11/24, at 9: 30 a.m., Interim DON stated she did not know where to find the contact information for the Ombudsman or the CDPH. She moved the medication cart that was parked in front of the bulletin board outside of resident room. She stated the information for the Ombudsman and CDPH, with phone numbers, was located on the bottom of the bulletin board. She stated it was pretty small and would have been blocked by the medication cart. She stated residents and family members would not have been able to see the information. She stated the risk to residents and familis was they would not know who to contact if they had a problem. She stated was unable to locate where the location of the survey results were in the unit. She asked RN E Resource where it was located, and he located a binder on top of the resident chart rack that contained the survey results and the plans of correction. A review of the facility Policy and Procedure titled Resident Rights, revised 4/24, indicated The Resident has the right: .8. To filed a complaint with the State Survey and Certificate Agency concerning Resident abuse or neglect or misappropriation of Resident property in Nursing Center. 9. To contact and be visited by any represetnative of the U.S. Department of Health and Human Services, the State, the State's long term care ombudsman person or advocacy system . 10. To examine the results of the Nursing Center's most recent survey conducted by resspresentative of tthe Department of Health and Hman Services, and the plan of correction prepared by the Nursing Center in response to the survey. 25. To a posting of names, addresses and telephoen numbers of all pertinent state client advocacy groups such as survey and certification, licensing, ombudsman, protection and advocacy netrwork, and medicaid fraud control unit.

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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 - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 Based on observation, interview, and clinical record review, the facility failed to maintain a portable oxygen tank inventory and properly anticipate emergent respiratory care equipment needs for six Sampled Residents (Resident 4, Resident 2, Resident 1, Resident 13, Resident 80, Resident 6), and 2 Unsampled Resident (Resident 5, Resident 9) who received oxygen therapy. The facility's inability to ensure Resident's daily and emergent oxygen needs had the potential for Respiratory Distress (shortness of breath, difficulty breathing, and possible respiratory failure), Hypoxemia (oxygen deprivation) and potential for death, during a facility evacuation that required transport of residents to county shelters or private homes. Findings: During an observation and interview, on 10/7/24 at 2:45 p.m., Sampled Resident 4 was observed in her bed. The head of her bed was at 45 degrees. Oxygen was being delivered via nasal cannula (through the nose) connected to a wall mounted medical gas delivery system at 2 Liters per minute. She stated she had to wear her oxygen, or she gets too short of breath. She stated she used it at home. During an observation and interview, on 10/7/24 at 2:55 p.m., Sampled Resident 2 was observed in her bed. The head of her bed was at 45 degrees. Oxygen was being delivered via nasal cannula connect to a wall mounted medical gas delivery system at 2 liters per minute. She stated she has trouble breathing even with the oxygen. She stated she had to have it if she didn't want to die. During an observation on 10/7/24 at 10 a.m., Sampled Resident 13 was observed sleeping in her room. The head of her bed was raised 45 degrees. Oxygen was being delivered via nasal cannula. During an observation on, 10/7/24 at 3 p.m., Sampled Resident 13 was observed sleeping in her room. The head of her bed was raised 45 degrees. Oxygen was being delivered via nasal cannula. During an observation on 10/09/24, at 8 a.m., the facility crash cart did not appear to have a tank of oxygen. During an observation and interview, on 10/9/24 at 12 p.m., Sampled Resident 1 was observed sitting up in a chair next to her bed. Oxygen was being delivered via nasal cannula connected to a wall mounted medical gas delivery system at 2 Liters per minute. She was observed talking in short phrases, talking gasping breaths, and coughing several times. She stated she wore her oxygen as much as she could so she would not get so tired. During an observation on 10/9/24, at 12:34 p.m. Unsampled Resident 9 was observed in the dining room. Oxygen was being delivered via nasal cannula connected to a portable oxygen concentrator on his wheelchair (w/c) with a portable oxygen concentrator (a device that delivers oxygen) located hanging off the back with a nasal cannula (n/c) oxygen tubing connected to the air flow port. The O2 tank level meter was set a 2/Liters per minute. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Valley of the Moon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 347 Andrieux St Sonoma, CA 95476	

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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 - Some	During an observation on 10/9/24, at 1:15 p.m., the facility crash cart was observed to not have a tank of oxygen. During a review of the crash cart binder daily log on 10/9/24, a checkmark indicated a check for a portable oxygen tank. During an interview on 10/9/24, at 2:39 p.m., the Director of Nursing (DON) stated she did not know how many residents were oxygen dependent or needed oxygen intermittently. She stated she was unable to provide an inventory of portable oxygen tanks available in the facility. She stated the facility did not have a Policy and Procedure (P&P) for Respiratory Care or Maintenance of Respiratory inventory or Equipment. She stated the use of contracted vendor included deliveries once a week. She stated she was unsure how the oxygen vendor knew how many portable oxygen tanks to deliver to the facility. DON stated she did not know how many portable tanks of oxygen were needed emergently if the facility had to evacuate residents. During an interview with Administrator on 10/9/24, at 2:44 p.m., he stated the portable oxygen tank was missing from the crash cart probably because staff took it to replace an empty portable oxygen tank for a resident. He stated to have no available oxygen tanks in the department was no problem because they could just ask the hospital for some more. He stated the ability to use the hospital portable oxygen tank inventory was part of a shared services agreement between the Skilled Nursing Facility and the Hospital. During an interview on 10/9/24, at 2:50 p.m., Engineer Q and Engineer R (who were employed by the hospital, not the facility), stated that hospital engineering had stated the skilled nursing facility ordered their own medical gas. They stated they had never spoken with the skilled nursing Administrator. They stated the extra inventory on the loading docks were available for the hospital patients. During an interview with Engineer Manager S, on 10/9/24, at 2: 55 p.m., he stated he did not know about a shared services agreement with the skilled nursing facility, to let them use their portable oxygen inventory. He stated the hospital inventory was checked daily and based on patient need. He stated in case of emergency or evacuation of the hospital, they would use all the portable oxygen tanks in the hospital to transport patients out of the hospital. He stated he had never spoken with the skilled nursing Administrator about sharing the portable oxygen tank inventory. During an interview with Administrator on 10/9/24 at 3:10 p.m., he stated staff had a lack of knowledge about what to do if they needed portable oxygen tanks delivered. He stated there was no P&P that outlined the process to utilize the hospital portable oxygen tank inventory. Administrator stated he had not considered the portable oxygen needs of continuous or intermittent oxygen needs of residents if an emergent evacuation of the facility was needed. He stated the risk to residents who needed oxygen during an emergency was they might be short of breath. Sampled Resident 4 was admitted on [DATE] with diagnoses of Heart Failure (A chronic condition in which the heart doesn't pump blood as well as it should, leading to shortness of breath and other symptoms) and Chronic Obstructive Pulmonary Disease (COPD) (A lung disease that blocks airflow and makes it difficult to breathe). Sampled Resident 4 had a Brief Interview of Mental Status (BIMS) Score of 3 (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4's medical record indicated a care plan (Not dated), that indicated Resident 4 is at risk for difficulty breathing, persistent cough, confusion, shortness of breath and fatigue related to (R/T) COPD. Resident 4 has Oxygen Therapy r/t ineffective gas exchange, Respiratory illness. O2 AT 2L/MIN (liters per minute), VIA NASAL CANNULA (A device used to deliver supplemental oxygen through your nose.) PRN (As needed) SOB / WHEEZING / O2 SAT (Saturation) (A measurement of how effective red blood cells carry oxygen) <90%. A review of Resident 4's medical record indicated a document titled Order Summary, dated 7/12/24, that indicated O2 AT 2 L/M VIA NASAL CANNULA PRN SOB/WHEEZING SAT < 90%. Sampled Resident 2 was admitted [DATE], with diagnoses of COPD, Palliative Care (Hospice), and Dependence on Supplemental Oxygen. Sampled Resident 2's BIMS score was 12. A review of Sampled Resident 2's medical record document titled Order Summary, dated 6/4/24, indicated Continuous Oxygen: Administer oxygen at 2L via nasal cannula continuously for difficulty of breathing and comfort. A review of Sampled Resident 2's medical record care plan (not dated) indicated Resident 2 has Oxygen Therapy r/t Respiratory illness, CHRONIC OBSTRUCTIVE PULMONARY DISEASE. OXYGEN SETTINGS: O2 AT 2L/MIN VIA NASAL CANNULA CONTINUOUSLY FOR SOC R/T COPD AND TO MAINTAIN SATURATION OVER 92%. Resident 2 is a risk of difficulty breathing / SOB r/t episode of low oxygen saturation. Provide oxygen as ordered. Resident 2 is at risk for difficulty breathing, persistent cough, confusion, dyspnea, SOB and fatigue R/T COPD. Give oxygen therapy as ordered by the physician. Sampled Resident 1 was admitted [DATE], with diagnoses of COPD, Heart Failure, Repeated Falls and others. Sampled Resident 1's BIMS score was 14. A review of Sampled Resident 1's medical record document titled Order Summary, dated 8/225/23, indicated Oxygen 2L via nasal cannula PRN to keep oxygen saturation greater than 92%. A review of Sampled Resident 1's medical record care plan (not dated) indicated Resident 1 is at risk for difficult breathing , persistent cough, confusion, dyspnea (Labored breathing), SOB and fatigue RT/ COPD. Oxygen 2L via nasal cannula PRN to keep oxygen saturation greater than 92%. Sampled Resident 1 has nonproductive cough r/t COPD. Provide oxygen as ordered. Sampled Resident 1 is at risk for difficulty breathing persistent cough, confusion, dyspnea, SOB and fatigue R/T COPD. Sampled Resident 13 was admitted [DATE], with diagnoses of chronic kidney disease, Palliative Care, and Anxiety. Sampled Resident 13's BIMS score was 8. A review of Sampled Resident 13's medical record document titled Order Summary, dated 7/16/24, indicated O2 at 2 L/MIN VIA NASAL CANNULA PRN SOB/WHEEZING?O2 Sat < 90%.). A review of Sampled Resident 13's medical record care plan (not dated) indicated Resident 13 is at risk of difficulty breathing / SOB r/t episode of low oxygen saturation. Provide oxygen as ordered. O2 AT 2L/MIN VIA NASAL CANNULA PRN SOB/WHEEZING/O2 SAT , 90%. Sampled Resident 80 was admitted [DATE], with diagnoses of COPD, Encounter for Palliative Care. Sampled Resident 80's BIMS score was 11. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Sampled Resident 80's medical record document titled Order Summary, dated 6/22/24, indicated O2 AT 2 L/MIN VIA NASAL CANNULA CONTINUOUSLY FOR SOB R/T CHRONIC RESPIRATORY FAILURE. A review of Sampled Resident 80's medical record care plan (not dated) indicated Resident 80 has Oxygen Therapy r/t Ineffective gas exchange, Respiratory illness (COPD, Acute and Chronic Respiratory Failure . OXYGEN SETTINGS: O2 AT 2L/MIN VIA NASAL CANNULA CONTINUOUSLY. Sampled Resident 6 was admitted [DATE], with diagnoses of COPD, Heart Failure, Chest Pain and Muscle Weakness. Sampled Resident 6's BIMS score was 15. Un-Sampled Resident 9 was admitted [DATE], with diagnoses of COPD, Heart Failure, and Muscle Weakness. Un-Sampled Resident 9's BIMS score was 13. A review of Un-Sampled Resident 9's medical record indicated a document titled Order Summary, dated 7/6/24, that indicated O2 AT 2L/MIN VIA NASAL CANNULA CONTINUOUSLY FOR SOB R/T COPD. A review of Un-Sampled Resident 9's medical record care plan indicated Un-sampled Resident 9 has Oxygen Therapy r/t Ineffective gas exchange, Respiratory illness. OXYGEN SETTINGS: Continuous Oxygen: Administer oxygen at 2 L via nasal cannula continuously for difficulty of breathing and comfort. Un-Sampled Resident 5 was admitted [DATE], with diagnoses that included Chronic Kidney Disease, Acute Kidney Failure, Muscle Weakness, History of Falling. Un-Sampled Resident 5 had a BIMS score of 10. A review of Un-Sampled Resident 5s medical record indicated a document titled Order Summary, dated 7/27/23, that indicated Oxygen 2L via nasal cannula PRN to keep oxygen saturation greater than 92%. A review of Un-Sampled Resident 5's medical record care plan indicated Un-Sampled Resident 5 is on Oxygen Therapy as need r/t ineffective gas exchange. Oxygen 2L via nasal cannula PRN to keep oxygen saturation greater than 92%. Review of a P&P titled Crash Cart, revised 5/24, indicated Equipment to be included on the modified crash cart at all times: .H. Oxygen full tank. After each use, supplies will be cleaned and re-stocked as needed. A request was made to the facility to review of copy of the skilled nursing facility and hospital shared services agreement. A copy of the shared services agreement was not received before the end of the survey. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an article titled AARC (American Association for Respiratory Care) Clinical Practice Guideline Oxygen Therapy in the Home or Alternate Site Health Care Facility, Original publication: Respir Care 1992;37(8):918-922., indicated for respiratory care and oxygen use, Long-term oxygen therapy (LTOT) in the home or alternate site health care facility is normally indicated for the treatment of hypoxemia. LTOT has been shown to significantly improve survival in hypoxemic patients with chronic obstructive pulmonary disease (COPD). LTOT has been shown to reduce hospitalization s and lengths of stay. May be used for portability, ambulation, and as backup to a stationary oxygen system in the event of power failure or equipment malfunction. Equipment maintenance and supervision: All oxygen delivery equipment should be checked at least once daily by the patient or caregiver. Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. Oxygen therapy should be administered in accordance with the physician prescription. Oxygen therapy use in chronic obstructive pulmonary disease for the treatment of chronic hypoxemia should be administered continuously (i. e., 24 hours per day) unless the need has been shown to be associated only with specific situations (e.g., exercise and sleep). 31424 During an interview and inspection of the emergency crash cart on 10/09/24 at 1:33 p.m., LVN K reviewed the contents of the crash cash cart, both inside and outside. LVN K stated the nurses on night shift (7 p.m. to 7 a.m.) checked the crash cart (to ensure all contents were present). LVN K confirmed the crash cart did not contain portable oxygen (although it was listed on the contents list and had been signed off as checked by night nurses). LVN K stated Resident 80's portable oxygen had been low earlier that day and she had taken the oxygen tank located on the crash cart for Resident 80's use. LVN K stated she had called Central Supply Staff V (Staff V, who worked at a sister facility) on Tuesday (the prior day) and again earlier that morning to reorder oxygen for the facility. When asked to clarify if she had called Staff V twice (yesterday and today) to reorder the oxygen but it was not provided, LVN K stated the oxygen was not delivered. She stated they sometimes had delivery issues. During an interview and inspection of the oxygen storage closet on 10/09/24 at 1:33 p.m., LVN K confirmed there were no full, portable oxygen tanks in the closet; LVN K confirmed the closet contained eleven empty oxygen tanks. LVN K stated the following residents required oxygen: Resident 80, Resident 9, Resident 2, Resident 13 and Resident 5 During a follow-up interview and inspection of the oxygen closet on 10/09/24 at 2:30 p.m., the Director of Staff Development (DSD) and LVN K stated staff found two, full portable oxygen tanks in the oxygen closet that had been hidden from view in the back during the earlier inspection (at 1:33 p.m.). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 10/09/24 at 3:35 p.m., Staff V was asked about his involvement with reordering oxygen supplies at the facility. Staff V stated he ordered oxygen for the facility every Wednesday and it was delivered Thursday. Staff V stated the maximum amount he could order for the facility was twelve tanks as the facility only had oxygen racks (storage unit that safely holds oxygen tanks) that accommodated that number. When asked if he had gotten a call the previous day from staff alerting him to their low oxygen supply, Staff V stated they called at 8 p.m. (after-hours on Wednesday) and indicated they were running low. Staff V stated he subsequently placed and emergency oxygen order that morning at approximately 9 a.m. or 10 a.m. (over twelve hours later). When asked if he had had placed emergency oxygen orders in the past, Staff V stated this morning was the second time he had placed an emergency order and stated he did not track oxygen ordering/supply replacement for the facility. During an interview 10/09/24 at 4:46 p.m., the Administrator stated the facility currently had six (full) oxygen tanks in the oxygen closet. When asked why Staff V's oxygen order (from that morning) had not yet arrived, Administrator stated the shipment would be arriving tomorrow (Friday) because deliveries took 24-hours and there were no same-day deliveries.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 31424 Based on interview and record review, the facility: 1) Failed to ensure Registered Nurses (RNs) had accurate, verified competencies (verification of essential job functions; skills/ability required to perform safe nursing care) in their employee files when 2 of 2 sampled Registered Nurses (RN B and RN C) did not have documented, complete PICC line (peripherally inserted central catheter) competencies per facility policy, and 2) Failed to ensure Licensed Vocational Nurse L (LVN L) had accurate competencies in his employee file when LVN L's employee file indicated he had PICC line competencies, but LVN's are not legally nor professionally qualified to care for PICC lines. These deficiencies caused potential for unsafe nursing practice and potentially placed PICC residents at risk of harm. (A PICC line is an intravenous catheter [also called a central line] that is inserted into a vein in the arm, which is advanced toward the heart until the tip rests in the vein near the heart. A PICC is used to administer medication directly into the large vein near the heart). Findings: Review of the facility's self-assessment titled, 2024 (Facility Name) Facility Assessment, subtitled, Services and Care We Offer Based on Residents' Needs (dated 2024) indicated the facility, .cares for many different residents with various types of care needs. The list below identifies the most common or frequently provided services . Under the heading, Specific Care or Practices, the document indicated Medications required, . administration of medications that residents need by route - including . intravenous (.central lines [PICCs]) . Review of facility policy titled, Medication Administration, subtitled, Intravenous (IV) Administration of Drugs via Central Venous Catheter (CVC) or Peripherally Inserted Central Catheters (PICC) (undated) indicated, . IV drugs shall be administered by a registered nurse . Under subtitle, Procedures, the policy indicated, All central lines will be capped or have and extension set applied . IV tubing is changed as follows: Continuous central line infusion every 24 hours . Monitoring PICC Insertion Site . Check the insertion site daily . Monitor for signs and symptoms of systemic (widespread) infection . Check for patency (the line is open, not clotted off) . (document) Resident's tolerance and response to therapy . Dressing Changes . PICC dressing should be changed: Frequency: Once a week for a clear dressing . Sooner or as needed . Flushing of PICCs . Flushing is recommended to promote and maintain patency and prevent the mixing of incompatible medications and solutions . Flush 10ml (milliliters) 0.9% sodium chloride (IV solution) daily when not in use, before and after each use, blood draws, transfusion (blood) . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent review of employee files on 10/11/24 at 9:23 a.m., Human Resources Staff (HR A) reviewed RN A, RN B and Licensed Vocational Nurse (LVN) C's employee files. HR A stated RN B was hired 6/23/2023 and she had her initial skills evaluated on 6/23/23. The skills list titled, Licensed Nurse Skills Competency Checklist indicated RN B had met the requirements for Central Venous (PICC) . catheter flushing (flushing with saline to keep the line patent) and Central Venous Catheter Changes (dressing changes). The evaluator did not document the method of evaluation (discussion versus visualization of skill performance) under the Description and Rationale columns of the skills list evaluation (Conversely, her PPE use [gloves/gowns/masks] was evaluated by demonstration of putting on and taking off PPE appropriately). HR A reviewed RN B's skills check list dated one year later on 6/27/24 and stated she had competency checked for .IV care (PICC line .). Review of the check list indicated RN B's PICC evaluation was dated 7/14/24; the method of instruction was, discussion (not assessment of skill performance). Review of both skills lists (from 2023 and 2024) indicated RN B's competency/skill regarding PICC IV Tubing or Monitoring CVC/PICC Insertion Site (both included in the PICC policy) was not assessed (and those skills were not listed on the skills list). During the same interview and concurrent review of employee files on 10/11/24 at 9:23 a.m., HR A reviewed RN C's employee file and stated she was hired 11/17/2022 and had her initial skills assessed and dated on 11/17/2022. The skills checklist indicated she was assessed for PICC flushing and catheter changes. The list indicated RN C was not evaluated for PICC skills regarding IV tubing or Monitoring of the PICC insertion site and the evaluation method (discussion versus visual assessment of skill performance) was not documented (both the description and rationale columns were blank). Review of RN C's skills check list dated two years later on 8/2/24 indicated she was evaluated for IV care (PICC line .) using discussion as the method of instruction (conversely, her hand hygiene [washing] was evaluated by demonstration). During the same interview and concurrent review of employee files on 10/11/24 at 9:23 a.m., HR A reviewed LVN L's nursing competencies. HR A stated LVN L was hired on 4/23/2024 and his skills competency check list was dated 7/2024. The list indicated on 8/5/24, he was assessed to be competent in IV care (PICC line .) using the method of discussion. (LVN's are legally not permitted to work with PICC lines: they are not allowed to perform flushing, dressing changes, administer medications or work with the tubing). During an interview on 10/11/24 at 10:42 a.m., the Director of Staff Development stated the facility accepts and admits residents with PICC lines. During a telephone interview on 10/11/24 at 12:04 p.m., the DON was asked about registered nurse's PICC competencies. The DON stated all nurses (RN's and LVN's) go through annual competency checks utilizing the Nurse Skill Competency Checklist. When asked how skills were assessed, the DON stated an example of assessing nurse competency was observing them pass medication. The DON stated the facility did not usually have residents with PICC lines but when they did, she gave the nurses impromptu inservices (education/training that nurses receive while on the job to improve their skills and performance). When queried about PICC competency including IV care (PICC line) (not reflecting specific items like monitoring/flushing/dressing changes - items identified as required in the policy), the DON stated the RN PICC skills list was, not itemized but she planned to change that. Regarding LVNs, the DON stated she educated the LVN's on what to look for (regarding PICC lines). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/24 at 1:00 p.m., RN E (Resource nurse) was asked if it was acceptable to assess an RN's PICC competency with discussions, versus actual observation of a nurse's PICC skills, and RN E stated, no Review of facility policy titled, Nurse Staff Competency (revised 1/2022) indicated, It is the policy of this facility to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety . The policy indicated, .b. The competency in skills and techniques necessary to care for residents' needs include but (are) not limited to: . Basic nursing skills . 4. Director of Staff Development, Nurse Manager or designee must validate all skills listed on the form for competent performance . Review of the facility's LVN job description (dated 12/17/2021) indicated working with PICC lines was not located in the section titled, Essential Duties And Responsibilities. According to the Journal of Infusion Nursing (the official publication of the Infusion Nurses Society), revised 2016, subtitled, Standards of Practice, further subtitled, Section One: Infusion Therapy Practice, further subtitled, 5. Competency Assessment and Validation, indicated, 5.1 As a method of public protection to ensure patient safety, the clinician is competent in the safe delivery of infusion therapy and vascular access device (VAD) insertion and/or management .5.3 Competency assessment and validation is performed initially and on an ongoing basis .5.4 Competency validation is documented in accordance with organizational policy. Subtitle, Practice Criteria, indicated, B. Use a standardized approach to competency assessment and validation across the health care system to accomplish the goal of consistent infusion practice C. Validate clinician competency by documenting the knowledge, skills, behaviors, and ability to perform the assigned job .1. Validate initial competency before providing patient care .

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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** 38088 Based on observation, interview and record review, the facility did not ensure the safety of one sampled resident (Sampled Resident 1), when medication that was ordered to be administered on an empty stomach was administered at the same time as two medication that were ordered to be administered with food. This medication administration was the result of not following the physician's order and had the potential to result in medication not being absorbed properly and the risk of Sampled Resident 1 to experience side effects that included gastric upset, nausea and gastric reflux. Finding: During an observation on 10/8/24, at 8:51 a.m., Licensed Vocational Nurse K administered Gabapentin (Medication used to treat pain), Omeprazole DR (Medication used to decrease the amount of acid produced by the stomach.) and Metformin (Medication used to treat diabetes) to Sampled Resident 1. During an interview and record review on 10/8/24 at 8:55 a.m., Licensed Vocational Nurse K stated breakfast was served between 7:30 a.m. and 8 a.m. She stated at 9 a.m. Sampled Resident 1 would have been considered to have a full stomach from breakfast. She stated she was unsure if any of Sampled Resident 1's medication was ordered to be administered with food. A review of the Medication Administration Record (MAR) indicated Sampled Resident 1's physician had ordered the Omeprazole DR to be administered on an empty stomach, and Gabapentin and Metformin to be administered with food. Licensed Vocational Nurse K stated, Should I have given it? She reviewed the physicians ordered and stated the Policy and Procedure for a medication error was to call the physician and get instructions. During an interview on 10/8/24 at 9:17 a.m., Director of Staff Development (A nursing role that is responsible to plan implement and evaluate educational programs to improve the skills and knowledge of nursing staff) stated she had educated Licensed Vocational Nurse K. She stated for medication administration, medications that are ordered to be given on an empty stomach should be administered at 6:30 a.m. She stated if medication were administered incorrectly, the nurse should call the doctor. She stated administration of a medication with food, that is ordered to be administered on an empty stomach, would have been a medication error. She stated the potential risk of harm to a resident would have been pain, Gastroesophageal reflux (A condition which the stomach contents leak backward from the stomach in the food pipe.), and malabsorption (An imperfection absorption of stomach contents which may inhibit the physician ordered amount of medication.). During an interview on 10/8/24 at 9:27 with Interim Director of Nursing, she stated if there was a medication error, the nurse would have to complete a medication error form, notify the medical director and the result would be reported to the Quality Assurance committee for review. She stated the definition of a medication error is a medication not given at the correct time. She stated it was important to administer medication prescribed for GERD on an empty stomach, because to administer it on a full stomach would have affected the absorption of Omeprazole DR. She stated administration of Omeprazole DR with food was a medication error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/08/24 at 10:20 a.m., Pharmacist stated she does not attend Quality Assurance Committee and only hears about medication errors from the nurses. She stated there were no Policy and Procedures for medication errors and did not respond about what the definition of medication error was. She stated administration of the physician ordered GERD medication with food was No harm, no foul, if there was no patient reaction to it. She would not say if a physician ordered food to be administered on an empty stomach, she would not state how long before breakfast or after breakfast should the administration take place in order to ensure it was administered according to the physician's orders. Pharmacist stated the manufacturers recommendations to administer GERD medication on an empty stomach were simply recommendation. She stated medication administration had to follow physician's orders, and if the GERD medication was administered with food, the resident might not absorb the medication effectively and the resident would not get the maximum benefit of the medication. Sampled Resident 1 was admitted to the facility on [DATE], with diagnoses that included Benign Neoplasm of the transverse colon (Cancer of the colon which is in the intestine of the body), Hemorrhage of the anus and rectum (Uncontrolled profuse bleeding from the part of the body that holds and expels stool in the body.), acute posthemorrhagic anemia (A condition that develops when a person loses a large volume of blood.), Diverticulosis (multiple pouches in the colon that collect digested food / stool.), Gastrointestinal hemorrhage (Bleeding anywhere in the area from the mouth to the rectum.), GERD. A review of Sampled Resident 1's medical record indicated a document titled Order Summary Report, dated 10/17/24, indicated Omeprazole Oral Capsule Delayed Release 20 MG (Omeprazole/e) Give 1 capsule by mouth in the morning for GI ppx **Give 30 minutes before breakfast*Give on an empty stomach, dated 10/9/24. A review of Sampled Resident 1's medical record indicated a document titled Medication Administration Record (MAR): Omeprazole Oral Capsule Delayed Release 20 MG (Omeprazole) Give 1 capsule by mouth in the morning for GI ppx (please) Give on an empty stomach. A review of Sampled Resident 1's medical record indicated the MAR administration time of 8 a.m. was indicated for; -Omeprazole Oral Capsule Delayed Release 20 MG (Omeprazole) Give 1 capsule by mouth In the morning for GI ppx (please) Give on an empty stomach Order Date 09/05/23. - metFORMIN HCI ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCI)e 1tablet by mouth one time a day for DM Give with food DO NOT CRUSH Order Date-09/05/2023. A review of a facility Policy and Procedure, titled PREVENTING AND DETECTING ADVERSE CONSEQUENCES AND MEDICATION ERRORS. Dated 10/2019, indicated The interdisciplinary team reviews the resident's mediation regimen for efficacy and actual or potential medication-related problems on an ongoing basis in accordance with the policy on Medication Management. A review of the medication guide for Omeprazole DR titled MEDICATION GUIDE OMEPRAZOLE DELAYED-RELEASE CAPSULES, USP(oh mep? ra zole)10 mg, 20 mg and 40 mg, dated February 2015 indicated How should I take Omeprazole Delayed Release Capsules? Take omeprazole delayed-release capsules exactly as prescribed by your doctor. Do not change your dose or stop omeprazole delayed-release capsules without talking to your doctor. Take omeprazole delayed-release capsules at least one hour before a meal. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an articled from the National Institute of Health (NIH) National Library of Medicine National Center of Biotechnological Information, titled Medication Dispensing Errors and Prevention, by Rayhan A. Tariq; Rishik Vashisht; Ankur Sinha; Yevgeniya Scherbak, titled Common Medication Administration Errors, indicated Incorrect Timing - Being completely accurate with scheduled doses in both home and healthcare settings is challenging. Significant alterations in the absorption of some medications occur in the presence or absence of food. The result may be underdosing or overdosing.