STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555259	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 30 final sampled residents (Residents 11 and 98) were assessed to determine if it was safe for them to self-administer their medications prior to self-administering their medications. * Resident 98 had a tube of Preparation H (topical medication used for hemorrhoids) and a tube of mometasone furoate (topical corticosteroid medication used for certain skin conditions) at the bedside. Resident 98 did not have a physician's order for self-administration of medications at the bedside. * A bottle of Lumify eye drops (medication to temorarily relieve eye redness and itching) and a bottle of Systane eye drops (medication to temporarily relieve dry, irritated eyes) were kept at Resident 11's bedside table. Resident 11 had self-administered the Lumify and Systane eye drops without being assessed for self-administration of medications. In addition, there were no physician's order for the eye drops medications and self administer of the eye drops medication were obtained. These failures had the potential to negatively impact the residents' physiological well-being and potential for inappropriate use of the medications. Findings: Review of the facility's P&P titled Self-Administration of Medications revised 12/2016 showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The facility's P&P showed as part of the overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administrating medications is clinically appropriate for the resident. In addition to the general evaluation of the decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's ability to read and understand medication labels, comprehension of the purpose and dosage and administration time for his or her medications, ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medications. Further review of the facility's policy showed self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Staff shall identify and give to the charge nurse any medications found at the bedside that are bit authorized for self-administration, for return to the family or responsible party. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 10/21/24 at 1039 hours, during the initial tour of the facility, Resident 98 was observed to have a clear plastic container with a tube of Preparation H (topical medication to treat hemorrhoids) and a tube of mometasone furoate (topical medication to treat certain skin conditions) on Resident 98's bedside drawer. Medical record review for Resident 98 was initiated on 10/21/24. Resident 98 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 98's Order Summary Report dated 10/22/24, showed a physician's order dated 7/30/24, for Preparation H external cream 1%, to apply topically to the rectum as needed four times a day for hemorrhoidal pain; however, there were no physician's orders for Resident 98 to self-administer medications and use of mometasone furoate. Review of Resident 98's H&P examination dated 7/31/24, showed Resident 98 had the capacity to make medical decisions. Review of Resident 98's plan of care failed to show a care plan problem to address Resident 98's ability to self- administer medications. Review of Resident 98's medical record failed to show Resident 98 was assessed for the self-administration of the medication. On 10/23/24 at 1347 hours, an interview and concurrent medical record review for Resident 98 was conducted with LVN 5. LVN 5 stated for any medication kept at the resident's bedside for the resident to self-administer, there should be a physician's order for the self-administration of medication, a care plan, and a self-administration of medication assessment to ensure the resident was able to self-administer the medication. LVN 5 reviewed Resident 98's medical record and verified the above findings. On 10/23/24 at 1405 hours, an observation at Resident 98's bedside and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 98 had a tube of Preparation H and a tube of mometasone furoate at the bedside. During this observation, Resident 98 stated he self-administered the medications two times a day. On 10/24/24 at 1138 hours, an interview was conducted with the DON. When asked about the facility's process for the resident's self-administration of the medication, the DON stated upon residents' request to self-administer a medications, the facility would conduct an assessment to determine if the resident was able to self-administer the medications and if able, the facility would obtain a physician's order and initiate a care plan to address the resident's self-administration of medications. When asked about the risk of keeping the medications at bedside, the DON stated there was a risk of potential exposure and access to the medication by other residents, and the risk of the resident being unable to administer the medication safely. On 10/24/24 at 1403 hours, the DON was informed and acknowledged the above findings. 39670 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 10/21/24 at 1017 hours, during an initial tour of the facility, Resident 11 was observed to have the bottles of Lumify and Systane eye drop medications at the bedside table. Resident 11 stated the eye drop medications were her medications and she used the eye drops for dry eyes and redness. Resident 11 stated she had self-administered the eye drop medications every time she felt that she needed it. Medical record review for Resident 11 was initaiated on 10/21/24. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Order Summary Report dated 10/22/24, did not show the physician's orders for the Lumify and Systane eye drop medications. There was no physician's order for the resident to self-administration of the medications. Review of Resident 11's plan of care did not show a care plan problem to address Resident 11's ability to self-administer the medications and eye problems. Further review of Resident 11's medical record failed to show a documented evidence Resident 11 was assessed for self-administration of the medication. On 10/22/24 at 0907 hours, an interview and concurrent medical record review for Resident 11 was conducted with LVN 10. LVN 10 verified Resident 11 was able to take her medications independently. LVN 10 stated he was not aware about any medication of Resident 11 at bedside. LVN 10 stated if the resident wanted to take their own medication, there should be an assessment done if the resident was safe on taking their own medication. LVN 10 was informed about Resident 11's eye drop medications at bedside. LVN 10 stated Resident 11was alert and did not tell the staff about her eye drop medications. LVN 10 verified there were no physician's order, self -administration assessment of medication, and care plan for Resident 11's eye drop medications at the bedside. LVN 10 also added, he was not aware about Resident 11's eye problem. On 10/22/24 at 0940 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 3. RN 3 stated Resident 11 was alert, oriented, and able to verbalize her concerns to the staff. RN 3 was asked about the facility's process about the medication at the bedside. RN 3 verified there should be no medication at the bedside of the residents. RN 3 stated if medication was found at the bedside of the residents, they would asked the resident or family member to bring the medication to home. RN 3 was made aware about Resident 11's eye drop medications at the bedside. RN 3 stated she was not aware of Resident 11 having the eye drop medications at the bedside and eye problem. RN 3 verified there were no physician's orders for the eye drop medications and for the resident to self administer her own medication. Also, RN 3 verified there were no assessment for self administration of the medication and plan of care. On 10/23/24 at 1425 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation and interview, the facility failed to maintain a homelike environment for one nonsampled resident (Resident 102). * Resident 102 resided in Room A. Room A was observed with scratches and chipped pain on the wall adjacent to Resident 102's bed. This failure had the potential to negatively impact the resident's quality of life. Findings: Medical record review for Resident 102 was initiated on 10/21/24. Resident 102 was admitted to the facility on [DATE]. On 10/23/24 at 0944 hours, an observation and concurrent interview was conducted with Resident 102. Resident 102 was observed in her room (Room A) lying on her bed. The wall adjacent to Resident 102's bed was observed in disrepair, with scratches and areas without paint. Resident 102 stated she would like her room to remain neat and clean as she spent a lot of time in her room. Resident 102 stated the wall needed to be repaired and painted. On 10/24/24 at 1430 hours, the DON was informed and verified the above findings.

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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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 implement the comprehensive care plan for one of 30 final sampled residents (Resident 55). * Resident 55's care plan for the use of continuous oxygen therapy showed to administer oxygen at a rate of two liters per minute; however, the nursing staff failed to implement the care plan as evidenced by having administered continuous oxygen therapy to Resident 55 at a rate of four liters per minute. This failure posed the risk for not providing appropriate an individualized care to the resident. Findings: Review of the facility's P&P titled Care and Treatment revised 5/2017 showed it is the policy of the facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial well being in accordance with the interdisciplinary comprehensive assessment and plan of care. Medical record review for Resident 55 was initiated on 10/21/24. Resident 55 was admitted to the facility on [DATE]. Review of Resident 55's physician's order dated 2/13/24, showed to administer continuous oxygen via nasal cannula at 2 liters per minute if the resident's oxygen saturation levels less than 90%. Review of Resident 55's plan of care showed a care plan addressing for the use of continuous oxygen therapy. Interventions showed to administer continuous oxygen at a rate of two liters per minute via nasal cannula. On 10/21/24 at 0914 hours, an observation, interview, and concurrent medical record review was conducted with LVN 9. LVN 9 verified Resident 55's continuous oxygen was being administered via nasal cannula at a rate of four liters per minute. LVN 9 verified the physician's order showed to administer continuous oxygen via nasal canula at a rate of two liters per minute. LVN 9 then verified Resident 55's care plan for the use of continuous oxygen therapy showed to administer continuous oxygen at the rate of two liters per minute via nasal cannula.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed the conduct the status post change of condition assessments for one of three closed records reviewed (Resident 138). * Resident 138 had a change of condition involving an episode of vomiting, abdominal discomfort, and refusing to eat. The facility failed to follow up with the physician regarding the change of condition in a timely manner, failed to monitor Resident 138's vital signs, and failed to conduct and assessment related to the resident's change in condition. These failures had the potential for Resident 138's changes in medical condition not being identified, potentially delaying necessary care and treatment. Findings: Review of the facility's P&P titled Significant Change in Condition, Response revised ,d+[DATE] showed it is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The nurse will perform and document an assessment of the resident and identify need to additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. The resident will then be placed on the 24 hour report and nursing will provide no less than three days of observation, documentation, and response to any interventions. An attempt to identify the cause for decline, when it occurs, needed assist and resident behavior/ acceptance of increased need of assistance will be monitored. There will be certain circumstances where immediate attention will be warranted, and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his/her clinical judgement and shall contact the physician based on the urgency of the situation. Closed medical record review for Resident 138 was initiated on [DATE]. Resident 138 was admitted to the facility on [DATE], and had expired in the facility on [DATE]. Review of Resident 138's eINTERACT Change in Condition Evaluation dated [DATE] at 1414 hours, showed Resident 138 had a change in condition regarding a left second toe dry scab, one episode of vomiting, complaint of abdominal discomfort, and refusing to eat breakfast and lunch. The documentation showed the following: * The change in condition started in the morning on [DATE]. * The following vital signs were taken after the change in condition occurred: - at 1023 hours on [DATE], a blood pressure of ,d+[DATE] mmHg - at 1019 hours on [DATE], a pulse of 82 bpm (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 1435 hours on [DATE], a respiratory rate of 17 breaths per minute - at 1017 hours on [DATE], a temperature of 97.6 degrees F. - at 1016 hours on [DATE], an oxygen saturation of 95% on room air. * Under the section for abdominal/gastrointestinal evaluation showed Resident 138 had nausea and/or vomiting, decreased appetite/fluid intake. The documentation failed to show if there was an assessment conducted related to Resident 138's complaints of abdominal pain. * The physician was notified of the change of condition on [DATE] at 1400 hours. * The family/healthcare agent was notified of the change in condition on [DATE] at 1200 hours. Review of Resident 138's Nursing progress note dated [DATE] at 1421 hours, showed in part, Resident 138 noted with one episode of vomiting. Resident 138 complained of abdominal discomfort. Vitals remained stable and in range. Resident was afebrile. Refused breakfast and lunch during the shift. Provider was made aware .Orders carried out. The family member was made aware of change in condition. Resident 138 was also noted with left second toe dry scab. Treatment was initiated, and would continue to monitor. Review of Resident 138's Nursing progress note dated [DATE] at 2137 hours, showed at 1520 hours, Resident 138 was alert, awake, and verbally responsive. No pain, no facial grimacing noted. Resident 138 appeared pale, cold, and clammy. The AM shift staff endorsed that the resident had an episode of vomiting. At 1600 hours, the resident was reassessed and noted with labored breathing. Oxygen was given via non-rebreather mask, but the resident still grasping some air. At 1610 hours, the vital signs was unable to appreciate. Resident 138 was so pale and non responsive and not breathing anymore. Both hands and feet are cold. The RN supervisor declared Resident 138 was expired at 1615 hours. On [DATE] at 0802 hours, a concurrent interview and closed medical record review was conducted with LVN 1. LVN 1 stated Resident 138 was served breakfast, refused breakfast, and vomited. LVN 1 stated she told the CNA to clean him up and did a Change Of Condition Evaluation. LVN 1 could not recall what time Resident 138's change of condition occurred; however, LVN 1 verified the Change of Condition Evaluation showed she notified the physician at 1400 hours. LVN 1 verified there was no documented evidence of the subsequent vital signs after the initial vital signs were taken as per the change of condition evaluation. On [DATE] at 0830 hours, a concurrent interview and clsoed medical record review was conducted with RN 1. RN 1 stated Resident 138 was stable prior to [DATE], and had no issues with the abdominal discomfort or eating meals. RN 1 stated she would have checked a new set of vital signs if there was a change of condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0930 hours, a concurrent interview and closed medical record review was conducted with the DON. The DON was asked her expectation when there was a change of condition. The DON stated they did the Change of Condition Evaluation, called the doctor regarding the nursing assessment, and observed and monitored for the change of condition. The DON stated a change of condition meant it was not normal for the resident and they noticed something different. The DON acknowledged the above findings. The DON stated Resident 138's change of condition started at 1023 hours, and acknowledged the documentation showed the physician was not notified until 1400 hours (about three and a half hours later). The DON stated they always wanted the nurses to notify the physician as soon as possible when they could. The DON verified there was no documented evidence an assessment was completed regarding Resident 138's abdominal discomfort. The DON verified there was only one vital signs taken during the shift and there was no documented evidence of the additional vital signs or follow up vital signs were taken. The DON stated if a resident appeared pale, cold, and clammy, it was not normal and would need to check the resident and their vital signs at the time. The DON acknowledged Resident 138 was not reassessed until 1600 hours.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development and worsening of pressure injuries and promote the healing of existing pressure injuries for one of three final sampled residents (Resident 840) reviewed for pressure injuries. * The facility failed to provide Resident 840 with the LAL mattress as ordered by the physician. Additionally, the facility failed to ensure Resident 840's pressure injuries were assessed weekly in accordance with the facility's policy and the resident's plan of care. These failures had to potential for Resident 840 to not receive the appropriate care and services to promote healing or prevent the development and worsening of pressure injuries. Findings: Review of the facility's P&P titled Skin and Wound Monitoring and Management Care Guidelines revised 2/2023 showed it is the policy of this facility that a resident having pressure ulcers receives the necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing. Further review of the facility's P&P showed the assessment of wounds on admission and readmission included the following: A. A licensed nurse (which may be the Wound Nurse) must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, discoloration, or other unusual findings must be documented on the Comprehensive Admission Assessment. B. A licensed nurse (which may be the Wound Nurse) must assess/revaluate each wound that exists on the resident. This assessment/evaluation should include, but not be limited to: a. Measuring the wound. b. Staging the wound. c. Describing the natures of the wound (e.g. pressure, stasis, or surgical wound) d. Describing the location of the wound. e. Describing the characteristics of the wound. C. A licensed nurse (which may be the Wound Nurse) must assess/evaluate the wound at least weekly, whether present on admission or developed after admission which exists on the resident. Further review of the facility's P&P showed all risk factors identified on assessment should be documented in the resident's medical record, and when appropriate, be addressed through a care plan designed to minimize the possibility of skin breakdown. To prevent the development of skin breakdown or to prevent existing pressure ulcers from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc.): a. Obtain a physician's order for the appropriate pressure reducing/relieving devices based on assessment/evaluation of resident need. i. If insurance approval is needed, facility staff should facilitate the approval process to the extent possible. Review of the facility's P&P titled Wound Management revised 5/2022, showed a weekly skin assessment will be completed on all residents and documented in the nurses notes. Each wound will be measured in centimeters weekly. Measurements, size and depth, drainage, odor, color and a short statement on progress (or lack of) will be documented on the wound flow sheet. a. On 10/21/24 at 0910 hours, during the initial tour of the facility, Resident 840 was observed to be lying on his back. The resident did not have a pressure relieving mattress. On 10/22/24 at 1113 hours, Resident 840 was observed lying on his left side. The resident did not have a pressure relieving mattress. Medical record review for Resident 840 was initiated on 10/21/24. Resident 840 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 840's Progress Note H&P examination dated 10/16/24, showed Resident 840 had no capacity to make medical decisions. Review of Resident 840's Order Summary Report showed the following physician's orders: - dated 10/16/24, for a low air loss mattress for wound management when available. - dated 10/19/24, to admit the resident to 1 Heart Hospice Care. Review of Resident 840's plan of care showed a care plan problem dated 8/28/24, addressing Resident 840's pressure injuries upon admission and the risk for worsening pressure injuries. The interventions included to provide low air loss mattress for wound management. Review of Resident 840's plan of care showed a care plan problem dated 10/16/24, addressing Resident 840's right upper back unstageable pressure injury (full-thickness tissue loss where the wound base is covered with dead tissue) that was reclassified as a Stage 4 (full-thickness tissue loss that may expose bone, tendon or muscle) thoracic spine pressure injury on 9/18/24. The interventions included to provide low air loss mattress for wound management with settings per the resident's weight (when available). Review of Resident 840's plan of care showed a care plan problem dated 10/16/24, addressing Resident 840's actual impairment of the skin integrity related to the presence of pressure injury to his sacrococcyx (tailbone). The interventions include to provide low air loss for wound management and monitor the function/setting every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of Resident 840's LN- Initial Admission Record dated 8/28/24, showed the following documentation: Site 1: left upper back, unstageable pressure injury; Site 2: right upper back, unstageable pressure injury; and Site 3: sacrococcyx, unstageable pressure injury. Review of Resident 840's LN- Skin Pressure Ulcer Weekly dated 8/29/24, showed the following documentation: Site 1: left upper back unstageable pressure injury, measuring 2.5 cm (length) x 2.5 cm (width) and UTD for depth measurement; Site 2: right upper back unstageable pressure injury, measuring 4.0 cm x 2.0 cm and UTD for depth measurement; and Site 3: sacrococcyx unstageable pressure injury measuring 1.5 cm x 1.0 cm and UTD for depth measurement. Review of Resident 840's LN- Skin Pressure Ulcer Weekly dated 9/14/24, showed the following documentation: Site 1: left upper back unstageable pressure injury resolved; Site 2: right upper back unstageable pressure injury, measuring 3.0 cm x 1.0 cm and UTD for depth measurement; and Site 3: sacrococcyx unstageable pressure injury resolved. Review of Resident 840's LN- Skin Pressure Ulcer Weekly dated 9/18/24, showed Resident 840's right upper back unstageable pressure injury was reclassified as thoracic spine Stage 4 pressure injury by the wound care consult. The comments section showed the wound care physician recommended to continue the current treatment and provide low air loss mattress. Review of Resident 840's LN- Skin Pressure Ulcer Weekly dated 9/26/24, showed the following documentation: Site 1: sacrococcyx unstageable pressure injury measuring 2.0 cm x 2.0 cm and UTD for depth measurement. However, the assessment did not show documented evidence Resident 840's Stage 4 pressure injury to the thoracic spine was assessed. (continued on next page)

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Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 1351 hours, an interview and concurrent medical record review for Resident 840 was conducted with LVN 4. LVN 4 verified Resident 840 did not have the low air loss mattress in place as ordered by the physician on 10/16/24. LVN 4 stated the hospice company began caring for Resident 840 on 10/19/24, and the hospice company was informed regarding Resident 840's need for the LAL mattress. LVN 4 stated he informed the SSD regarding Resident 840's need for the LAL mattress via messages in the PCC (Point Click Care-cloud-based software used by facility). LVN 4 stated he then followed up verbally with the hospice company and the SSD regarding Resident 840's need for the LAL mattress. In addition, LVN 4 verified Resident 840's LN- Skin Pressure Ulcer Weekly for 9/26/24, did not show the documented assessment for Resident 840's Stage 4 pressure injury to the thoracic spine. LVN 4 stated the assessment for Resident 840's Stage 4 pressure injury to the thoracic spine should have been performed and documented on the LN- Skin Pressure Ulcer Weekly dated 9/26/24. On 10/22/24 at 1413 hours, an interview and concurrent medical record review for Resident 840 was conducted with the SSD. The SSD verified Resident 840 was admitted to hospice care on 10/16/24, and she was responsible to obtain the authorization from the insurance company for Resident 840's LAL mattress order. The SSD stated she did not recall if she received a message from LVN 4 in the PCC regarding Resident 840's need for LAL mattress. The SSD stated the facility would provide the LAL mattress for the residents who were waiting for insurance approval and for those residents whose insurance did not cover the LAL mattress. The SSD stated she requested the LAL mattress from the facility's central supply department via a messages in the PCC. The SSD stated after the LAL mattress was requested from the central supply department, she then would follow up with LVN 4 or the other treatment nurse to verify if the resident received the LAL mattress. However, the SSD verified there was no documentation in Resident 840's medical record to show the SSD had followed up with LVN 4 or the other treatment nurse regarding Resident 840's LAL mattress. On 10/22/24 at 1420 hours, an interview and concurrent medical record review for Resident 840 was conducted with the DON. The DON verified Resident 840 had a physician's order for the LAL mattress. However, the DON also verified Resident 840 did not have the LAL mattress in place at the time of the interview. The DON verified the facility provided the LAL mattress for the residents who needed it while waiting for the insurance approval. The DON verified the facility should have provided the LAL mattress as soon as possible to Resident 840. The DON stated LVN 4 had been following up on Resident 840's need for the LAL mattress but verified there was no documented evidence in Resident 840's medical record to show the facility staff had followed up Resident 840's need for LAL mattress. On 10/24/24 at 1335 hours, a follow-up interview was conducted with the DON. The DON stated the facility's Admission Coordinator communicated with the hospice company on 10/15/24, prior to Resident 840's admission to the facility. The DON stated the hospice company was responsible for providing Resident 840's LAL mattress per the communication between the Admission Coordinator and hospice company. The DON verified Resident 840 was readmitted to the facility on [DATE], and admitted to hospice care on 10/19/24. The DON stated the expectation was for the facility to provide the LAL mattress while waiting for the hospice company to deliver the LAL mattress. The DON verified and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of four final sampled residents (Resident 91) reviewed for falls was free from accident hazards. * The facility failed to place the floor mats on both sides of Resident 91's bed as ordered by the physician and resident's care plan for Resident 91. This failure had the potential for serious injury to the resident. Findings: Review of the facility's P&P titled Fall Management System revised 6/2018 showed it is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls to minimize complications if a fall occurs. On 10/21/24 at 1157 hours, and 10/21/24 at 1605 hours, Resident 91 was observed lying in bed and no floor mats were in place. Medical record review for Resident 91 was initiated on 10/21/24. Resident 91 was admitted to the facility on [DATE]. Review of Resident 91's Change in Condition Evaluations dated 2/27, 4/26, and 8/15/24, showed Resident 91 had sustained a fall in the facility on each of the listed dates. Review of Resident 91's Fall Risk Evaluation dated 4/26 and 8/15/24, showed Resident 91 was a high risk for falling. Review of Resident 91's IDT note dated 4/29/24, showed the IDT recommended for the bilateral floor mats to be placed and Resident 91 was notified and agreeable with the plan of care. Review of Resident 91's Order Summary Report dated 10/21/24, showed a physician's order dated 4/26/24, for the bilateral floor mats. Review of Resident 91's plan of care showed a care plan focus dated 1/31/24, addressing Resident 91's risk for repeat falls. The interventions included the bilateral floor mats on both sides of the bed. On 10/22/24 at 1126 hours, a concurrent observation, interview, and medical record review was conducted with RN 3. RN 3 verified Resident 91 had a history of falling in the facility. RN 3 was informed and verified the above findings. RN 3 stated the supervisors were responsible for following up on the fall interventions and used the floor mats for safety. On 10/24/24 at 0953, the DON was informed of and acknowledged the above findings.

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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** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure five of five final sampled residents (Residents 27, 55, 98, 101, and 440) reviewed for respiratory care were provided with the appropriate respiratory care when: * The facility failed to ensure Resident 440's physician's order for the use of CPAP machine was clarified to the physician. In addition, the facility failed to provide proper maintenance for the CPAP machine use at bedside. * The facility failed to follow the physician's order for the administration of continuous oxygen and failed to ensure the nasal cannula was stored in a sanitary manner for Resident 55. * The facility failed to clarify the physician's order for the oxygen administration when the order for the use of oxygen did not specify the amount of oxygen to be administered for Resident 55. * The facility failed to ensure Resident 98's nebulizer mask was stored in a sanitary manner. * The facility failed to ensure Resident 101's nasal cannula was stored in a sanitary manner when not in use. * The facility failed to ensure Resident 27's nasal cannula tubing was stored in a sanitary manner. These failures had the potential to effect the respiratory health and well-being of the residents in the facility. Findings: 1. Review of the facility's P&P titled Care of BiPAP and CPAP revised 2/2022 showed the equipment setup should have an obtained physician's order with the inspiratory and expiratory settings. The care and maintenance of the CPAP machine includes to follow the manufacturer suggested use. On 10/21/24 at 0921 hours, during the initial tour of the facility, Resident 440's CPAP machine was observed on the top of bedside drawer with the tube and mask placed inside the clear plastic bag. Resident 440 stated the staff assisted her in putting the mask on at night and taking it off when she woke up. Review of the ResMed Airsense 10 CPAP User Guide, undated, showed it is important to regularly clean the device to make sure the optimal therapy was received. Regularly cleaning the CPAP tubing assembly, water tub and mask to prevent the growth of germs that can adversely affect the resident health. Medical record review for Resident 440 was initiated on 10/21/24. Resident 440 was admitted to the facility on [DATE], with a diagnosis of sleep apnea. (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 Resident 440 H&P examination dated 10/14/24, showed Resident 440 had mental capacity to make medical decisions. Review of Resident 440's Order Summary Report dated 10/22/24, showed a physician's order dated 10/20/24, for the care of CPAP humidified container and mask. Another physician's order dated 10/13/24, showed to apply CPAP ResMed Airsense 10 with a setting: per home. Further review of the medical record showed no documented evidence the CPAP machine setting was clarified from the physician about the specific inspiratory and expiratory settings of the CPAP machine. On 10/22/24 at 0926 hours, a follow-up interview was conducted with Resident 440. Resident 440 stated she did not know and had seen the nurses cleaning the CPAP machine. On 10/22/24 at 0931 hours, an interview for Resident 440 was conducted with LVN 10. LVN 10 verified Resident 440's use of the CPAP machine when sleeping at night. LVN 10 stated the night shift nurses were responsible for placing and taking off the CPAP machine for the resident. On 10/22/24 at 1402 hours, an interview and concurrent medical record review for Resident 440 was conducted with LVN 11. LVN 11 verified Resident 440's CPAP machine at the bedside. LVN 11 stated the night shift nurses were responsible in putting on the CPAP machine and taking off from the resident; and also responsible in cleaning the CPAP machine, mask, and tubing. LVN 11 verified the the order for the CPAP setting was per home. LVN 11 verified the physician's order for the setting on the CPAP machine was not specific setting for the resident use for proper therapy and treatment. LVN 11 was able to show a physician's order for cleaning of the machine once a week and the CPAP mask, however, there was no physician's order for the cleaning of the tubing assembly and water tub daily as per the manual instruction of the CPAP machine. On 10/23/24 at 1425 hours, an interview for Resident 440 was conducted with the DON. The DON was informed and verified the above findings. 37726 2. Medical record review for Resident 55 was initiated on 10/21/24. Resident 55 was admitted to the facility on [DATE]. a. Review of Resident 55's physician's order dated 2/13/24, showed to administer continuous oxygen via nasal cannula at two liters per minute if the resident's oxygen saturation levels less than 90%. On 10/21/24 at 0908 hours, an observation and concurrent interview was conducted with Resident 55. Resident 55 was observed lying in bed with a continuous oxygen being administered through an oxygen concentrator at four liters per minute via nasal cannula. Resident 55 was asked if he adjusted the rate of the oxygen he was receiving, to which he replied no, the staff was responsible for setting the oxygen rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 0914 hours, an observation, interview, and concurrent medical record review was conducted with LVN 9. LVN 9 verified Resident 55's continuous oxygen was being administered via nasal cannula at four liters per minute. LVN 9 then obtained Resident 55's oxygen saturation level which was measured at 99% (on 4 liters per minute). LVN 9 verified the physician's order showed to administer continuous oxygen via nasal cannula at a rate of two liters per minute (if Resident 55's oxygen saturation levels were less than 90%). LVN 9 then lowered the oxygen rate from four liters per minute to two liters per minute. LVN 9 then obtained Resident 55's oxygen saturation level (on two liters per minute) which was measured at 97%. An additional observation was conducted with LVN 9. Resident 55's wheelchair was observed adjacent to Resident 55's bed. Attached to Resident 55's wheelchair was an oxygen tank, with oxygen tubing and a nasal cannula connected to the oxygen tank. Resident 55's nasal cannula was observed hanging unpackaged on the wheelchair. LVN 9 verified the findings and stated Resident 55's nasal cannula needed to be stored in a clean bag for infection control. 44175 b. On 10/23/24 at 0854 hours, Resident 55 was observed lying in bed and was observed receiving oxygen at 3 liters per minute via nasal cannula. On 10/23/24 at 1336 hours, during a concurrent observation and interview with the RN 1, Resident 55 was observed receiving oxygen at 3 liters per minute via nasal cannula, RN 1 verified the observation. Medical record review for Resident 55 was initiated on 10/23/24. Resident 55 was admitted in the facility on 6/30/22, and readmitted on [DATE]. Review of the Physician Order Summary showed an order dated 10/21/24, to administer oxygen at 2-4 liters per minute via nasal cannula. Further review of the physician's order did not specify the amount of the oxygen to be administered and the parameters to titrate the rate of oxygen administration. Review of the MAR dated October 2024 showed Resident 55 received oxygen 2-4 liters per minutes via nasal cannula on 10/21 and 10/22/24. Further review of the MAR for Resident 55 failed to show the amount of the oxygen administered. On 10/23/24 at 0911 hours, a concurrent interview and medical record review for Resident 55 was conducted with RN 1. RN 1 verified the above findings and stated the physician's order for the oxygen for Resident 55 needed to be clarified to specify the amount of oxygen to be administered. On 10/23/24 at 1410 hours, a concurrent interview and medical record review for Resident 55 was conducted with the DON. The DON verified and acknowledged the above findings. 48882 3. On 10/21/24 at 1039 hours, an observation was conducted at Resident 98's bedside. Resident 98's nebulizer (used to deliver vaporized medicine into the airway) mask was observed hanging on the side of the bedside drawer without a storage bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 98 was initiated on 10/21/24. Resident 98 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 98's Order Summary Report dated 10/22/24, showed a physician's order dated 9/20/24, to administer ipratropium bromide inhalation solution (breathing treatment medication) 3 ml to inhale orally every six hours for acute respiratory failure. Review of Resident 98's MAR for October 2024 showed Resident 98 was administered ipratropium bromide inhalation solution breathing treatments every six hours from 10/1/24 to 10/12/24, and from 10/14/24 to 10/22/24 at 0000, 0600, 1200, and 1800 hours. On 10/22/24 at 1504 hours, an observation was conducted at Resident 98's bedside. Resident 98's nebulizer mask was observed hanging on the side of Resident 98's bedside drawer. On 10/22/24 at 1511 hours, an interview and concurrent observation of Resident 98 was conducted with LVN 8. LVN 8 stated Resident 98 received routine breathing treatments via the nebulizer mask; and when the nebulizer mask was not in use, it should be put in a clean storage bag. LVN 8 verified the above finding and was observed placing the nebulizer mask inside a storage bag. On 10/24/24 at 1403 hours, the DON was informed and acknowledged the above findings. 4. On 10/21/24 at 0936 hours, an observation was conducted of Resident 101's room. Resident 101's nasal cannula oxygen tubing was observed not in use and hanging across Resident 101's opened bedside drawer. The nasal cannula tubing was connected to the oxygen concentrator machine with the flow meter set at two liters per minute. Medical record review for Resident 101 was initiated on 10/21/24. Resident 101 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 101's Order Summary Report dated 10/23/24, showed a physician's order dated 9/4/24, to administer oxygen at two liters per minute via nasal cannula if the oxygen saturation level less than 90%. On 10/21/24 at 0955 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated Resident 101 used oxygen on an as needed basis. LVN 1 stated when oxygen was not in use, the oxygen nasal cannula should be stored in a bag. LVN 1 verified Resident 101's nasal cannula was hanging on the bedside drawer and LVN 1 was observed placing the nasal cannula inside a storage bag. On 10/24/24 at 1138 hours, an interview was conducted with the DON. The DON stated when oxygen was not in use, the nasal cannulas and masks should be placed in a storage bag for infection control purposes. On 10/24/24 at 1403 hours, the DON was informed and acknowledged the above findings. 47476 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an initial tour of the facility on 10/21/24 at 0955 hours, Resident 27's nasal cannula tubing was observed on the floor next to her bed. Resident 27 stated she had shortness of breath and had been off oxygen for two days. On 10/21/24 at 1005 hours, a concurrent observation and interview was conducted with LVN 9. LVN 9 verified the above findings. LVN 9 was observed to pick up the nasal cannula tubing from the floor and throw it away in the trash. LVN 9 stated she would need to bring Resident 27 a new nasal cannula tubing, label it with the date and time and place the tubing in a plastic bag. LVN 9 stated she needed to store the nasal cannula tubing in a plastic bag for infection control. Medical record review for Resident 27 was initiated on 10/21/24. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's Order Summary Report dated 10/21/24, showed a physician's order dated 10/11/24, to administer oxygen two liters per minute via nasal cannula to keep the oxygen saturation level greater than 90% as needed. On 10/24/24 at 0953 hours, the DON was informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure appropriate pain management for two of two final sampled residents (Residents 85 and 98) reviewed for pain management. * The facility failed to administer pain medication according to the physician's order for Resident 98. * The facility failed to ensure Resident 85 was consistently provided non-pharmacological interventions for pain prior to the administration of narcotic pain medication. These failures put Residents 85 and 98 at risk for ineffective pain management. Findings: Review of the facility's P&P titled Recognition and Management of Pain revised 7/2017 showed it is the policy of the facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility P&P showed the facility assists each resident with pain management to maintain or achieve the highest practicable level of well-being and functioning by: - Interviewing or observing the resident to determine if pain is present, - Identifying circumstances when pain can be anticipated, - Evaluating pain and working with the resident to develop a plan of care that considers their needs, preferences, and goals, and - Developing and implementing a plan, using non-pharmacologic and/or pharmacologic interventions to manage and/or prevent pain. 1. Medical record review for Resident 98 was initiated on 10/21/24. Resident 98 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 98's Order Summary Report dated 10/22/24, showed the following physician's orders dated 7/30/24: - to administer acetaminophen (analgesic) 325 mg two tablets by mouth every four hours as needed for mild pain/ headache, pain levels of 1-3 (on a pain scale of 0 to 10, 0 = no pain and 10 = worst pain), - to administer tramadol hcl (narcotic pain medication) 100 mg one tablet every six hours as needed for moderate and severe pain, pain levels of 4-10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 98's MAR for October 2024 showed Resident 98 was administered the acetaminophen medication 325 mg two tablets by mouth every four hours as needed for mild pain or headache (pain level of 1-3) on the following dates and times when the resident's pain level was not within the pain levels of 1-3 as ordered: - On 10/2/24 at 1130 hours, a pain level of 4. - On 10/3/24 at 1020 hours, a pain level of 6. - On 10/4/24 at 1330 hours, a pain level of 4. - On 10/6/24 at 0000 hours, a pain level of 5. - On 10/10/24 at 1414 hours, a pain level of 5. - On 10/12/24 at 0500 hours, a pain level of 4. - On 10/14/24 at 0100 hours, a pain level of 4. - On 10/14/24 at 0500 hours, a pain level of 4. - On 10/19/24 at 2031 hours, a pain level of 4. - On 10/21/24 at 0014 hours, a pain level of 5. Review of Resident 98's plan of care showed a care plan problem initiated on 7/30/24, addressing Resident 98's risk for acute/chronic pain or discomfort. The interventions showed to administer an analgesia medication as per the orders for Tylenol and tramadol. On 10/23/24 at 1122 hours, an interview and concurrent medical record review for Resident 98 was conducted with LVN 5. LVN 5 stated the pain medication was administered to the resident depending on the resident's pain level and the physician's order. LVN 5 reviewed Resident 98's medical record and verified the above findings. LVN 5 reviewed Resident 98's progress notes and stated there were no documentation showing the physician was informed on the above dates and times that Resident 98 was administered pain medication outside of the ordered parameters. On 10/24/24 at 1138 hours, an interview was conducted with the DON. The DON stated all the pain medications should be administered as ordered by the physician. The DON stated if the pain medication was administered outside of the ordered parameters, the nurse was expected to inform the physician and document in the progress notes. When asked about the risk of administration of the pain medication outside of the ordered parameters, the DON stated there may be a risk of ineffective pain management for the residents. On 10/24/24 at 1403 hours, the DON was informed and acknowledged the above findings. 47476 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 85 was initiated on 10/21/24. Resident 85 was readmitted to the facility on [DATE]. Review of Resident 85's Order Summary Report dated 10/21/24, showed the following physician's orders: - dated 4/25/24, for Dilaudid (opioid pain medication) oral liquid 1 mg/ml 1 ml by mouth every two hours as needed for mild pain, shortness of breath. - dated 4/25/24, for Dilaudid oral liquid 1 mg/ml 2 ml by mouth every two hours as needed for moderate pain. - dated 4/25/24, for Dilaudid oral liquid 1 mg/ml 3 ml by mouth every two hours as needed for severe pain. - dated 4/16/24. for non-pharmacological interventions for pain as needed, which were coded as follows: 1 = repositioning 2 = dim light/quiet environment 3 = relaxation 4 = distraction 5 = music 6 = massage Review of Resident 85's MAR for the months of August, September, and October 2024 showed Resident 85 received a dose of the Dilaudid medication on 8/3, 8/5, 8/6, 8/7, 8/16, 8/20, 8/24, and 10/11. Further review of the MAR failed to show documented evidence non-pharmacological interventions were attempted prior to the Dilaudid medication administrations on the above listed dates. On 10/23/24 at 1521 hours, a concurrent interview and medical record review was conducted with RN 3. RN 3 stated the non-pharmacological interventions would be done when the resident was complaining of pain and would be documented before giving the pain medication. RN 3 verified there was no documented evidence non-pharmacological interventions were attempted prior to the administration of Resident 85's pain medication. On 10/24/24 at 0953 hours, the DON was informed and acknowledged the above findings.

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	555259	A. Building B. Wing	10/24/2024

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Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on interview, medical record review, facility document review, and facility P&P review, the Pharmacy Consultant failed to recognize the irregularity for one of five sampled residents (Resident 75) reviewed for unnecessary medications when Resident 75 who was a diabetic and on Insulin (an injectable medication used to lower blood sugar) did not have any HbA1C level checked for 10 months. This failure placed Resident 75 at an increased risk for developing preventable dangerous effects from uncontrolled high blood sugar. Findings: Review of the facility's P&P titled Medication Regimen Review (MRR) revised on 8/2017 showed the Pharmacist reviews each resident's medication regimen at least once a month in order to identify irregularities, MRR included identification of irregularities and use of unnecessary drugs. Medical record review for Resident 75 was initiated on 10/23/24. Resident 75 was admitted to the facility on [DATE]. Reviewed of Resident 75's H&P examination dated 1/23/2024, showed the physician's plan was to check the resident's HbA1C routinely three to six months. Further review of the medical record showed no documented evidence of the HbA1C test. Review of the MRR from December 2023 to October 2024 showed no recommendation from the pharmacy consultant regarding the HbA1C test for Resident 75. On 10/24/24 at 1003 hours, during a concurrent interview and medical record review was conducted with the DON. The DON was informed of the above findings. The DON stated the HbA1C test frequency depended on the physician's order. The DON reviewed Resident 75's Physician Order and stated she did not see any HbA1C order. The DON stated if the HbA1C level was not checked, the blood sugar could increase and lead to serious complications such as diabetic ketoacidosis (a life-threatening problem that affects people with diabetes), sepsis (a life-threatening complication of an infection), and potential death. The DON verified and acknowledge the above findings. On 10/24/24 at 1115 hours, a telephone interview was conducted with the facility's PC. The PC stated he did not usually make recommendation about the HbA1C for the resident on insulin because it was more meaningful in the outpatient care setting than long term care Skilled Nursing Facilities.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P&P review the facility failed to ensure the residents were free from the unnecessary psychotropic medications for four of five final sampled residents (Residents 45, 75, 85, and 101) reviewed for the unnecessary medications. * The facility failed to ensure the PRN order for the antipsychotic (medications used to treat symptoms of psychosis) medication was limited to 14 days for Resident 45. * The facility failed to ensure the non-pharmacological interventions were implemented prior to the administration of psychotropic medications for Resident 85. * The facility failed to ensure the nonpharmacological interventions were implemented prior to the administration of psychotropic medications for Resident 101. * The facility failed to ensure Resident 75 had informed consent and GDR for melatonin, was monitored for side effects for melatonin and mirtazapine, and had non-pharmacological interventions implemented prior to the administration of psychotropic medications. These failures had the potential to place resident at risk for receiving unnecessary medication and increased risk of serious adverse reactions from the medications. Findings: Review of the facility's P&P titled Psychotropic Medication undated showed upon initial comprehensive assessment, the SSD designee shall review new admission for any psychiatric, mood or behavior disorders, mental and psychological difficulties, and /or the physician orders for psychotropic medications. The facility's Interdisciplinary Team (IDT) will review to ensure PRN medication are to be within guidelines. Medical record review for Resident 45 was initiated on 10/23/24. Resident 45 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 45's H&P examination dated 9/23/24, showed Resident 45 had no capacity to make medical decision. Review of Resident 45's Physician Order Summary dated 9/23/24, showed an order for quetiapine fumarate (antipsychotic) 25 mg one tablet by mouth as needed for nightly for psychosis behavior manifested by spitting at staff when angry. Further review of the medical record for Resident 45 failed to show documented evidence of the physician evaluation and the justification for the use of PRN antipsychotic more than 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 0911 hours, a concurrent interview and medical record review for Resident 45 was conducted with RN 1. RN 1 verified the above findings and stated a PRN antipsychotic medication should only be limited to 14 days. RN 1 further stated she was not able to find the documentation of the physician if Resident 45 had been evaluated and the reason for the use of PRN antipsychotic medication for more than 14 days. On 10/23/24 at 1410 hours, an interview and concurrent medical record review for Resident 45 was conducted with the DON. The DON verified and acknowledged the above findings. 47476 2. Medical record review for Resident 85 was initiated on 10/21/24. Resident 85 was readmitted to the facility on [DATE]. Review of Resident 85's Order Summary Report dated 10/21/24, showed the following physician's orders: - dated 4/16/24 and 5/24/24, for non-pharmacological interventions as needed for the use of alprazolam (an antianxiety medication), which were coded as follows: 0. Back rub, 1. Redirection, 2. Speak to/ approach in a calm manner, 3. Reposition, 4. Offer snacks/ fluid/milk, 5. Assess for pain, 6. Provide a quiet environment, 7. Encourage to express feelings, 8. Take to activities, 9. Provide reassurance. - dated 10/10/24, for alprazolam oral tablet 0.25 mg one tablet by mouth at bedtime for anxiety disorder for 14 days manifested by verbalization of feeling anxious. - dated 10/10/24, for alprazolam oral tablet 0.25 mg one tablet by mouth every eight hours as needed for anxiety for 14 days manifested by verbalization of feeling anxious. - dated 4/16/24, for eszopiclone (a sedative-hypnotic drug used to help with sleep) oral tablet 2 mg one tablet by mouth at bedtime for insomnia manifested by inability to sleep at night. - dated 4/16/24, for fluoxetine (antidepressant medication) oral tablet 10 mg one tablet by mouth one time a day for depression manifested by verbalization of feeling sad. - dated 4/16/24, for mirtazapine (antidepressant medication) oral tablet 15 mg one tablet by mouth at bedtime for depression manifested by poor PO intake. Further review of Resident 85's Order Summary Report failed to show an order for the non-pharmacological interventions related to the use of eszopiclone, fluoxetine, and mirtazapine medications. Review of Resident 85's plan of care showed the following care plan focuses: - initiated on 8/23/23, to address Resident 85's use of antidepressant medications, fluoxetine and mirtazapine. The interventions included to provide non-pharmacological interventions. - initiated on 4/25/24, to address Resident 85's use of antianxiety medication, alprazolam. The interventions included to provide non-pharmacological interventions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- initiated on 4/16/24, to address Resident 85's use of hypnotic therapy medication, eszopiclone. The interventions included to provide non-pharmacological interventions. Review of Resident 85's MAR for the months of August, September, and October 2024 showed the following: - the mirtazapine medication was administered to Resident 85 daily. - the fluoxetine medication was administered to Resident 85 daily, except on 8/21 (blank administration record). - the eszopiclone medication was administered to Resident 85 daily, except on 9/13 and 9/17-9/19 (blank administration record, and did not receive the medication per MAR coding). - the alprazolam medication was administered to Resident 85 on 8/3, 8/5, 8/9 - 8/11, 8/15, 8/18, 9/17-9/30, and 10/1-10/9. Further review of Resident 85's MAR for the months of August, September, and October 2024 showed Resident 85 received non-pharmacological interventions only one time on 8/10/24, related to the use of alprazolam medication. There was no documented evidence non-pharmacological interventions attempted for the use of Resident 85's other daily doses of the psychotropic medications. On 10/23/24 at 1521 hours, a concurrent interview and medical record review was conducted with RN 3. RN 3 stated they did the non-pharmacological interventions only for the use of antianxiety and antipsychotic medication. RN 3 verified there was no documented evidence the non-pharmacological interventions attempted for Resident 85's use of the mirtazapine, fluoxetine, and eszopiclone medications. Additionally, RN 3 verified there was no documented evidence the non-pharmacological interventions attempted for Resident 85's used of alprazolam medication other than on 8/10/24. On 10/24/24 at 0953, the DON was informed and acknowledged the above findings. 48882 3. Review of the facility's P&P titled Psychotropic Medications revised 2/2024 showed upon the initial comprehensive assessment, the SSD designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications. The facility's Interdisciplinary Team (IDT) will review to ensure review of the plan of care shows individualized, person-centered care approaches to manage behavior with non-pharmacologic interventions. Medical record review for Resident 101 was initiated on 10/21/24. Resident 101 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 101's H&P examination dated 9/6/24, showed Resident 101 had the capacity to make medical decisions. Review of Resident 101's Order Summary Report dated 10/23/24, showed the following physician's orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 7/6/24, for non-pharmacological interventions as needed for the use of lorazepam (antianxiety), which were coded as follows: 0. Back rub, 1. Redirection, 2. Speak to/ approach in a calm manner, 3. Reposition, 4. Offer snacks/ fluid/ milk, 5. Assess for pain, 6. Provide a quiet environment, 7. Encourage to express feelings, 8. Take to activities, 9. Provide reassurance. - dated 9/11/24, for lorazepam 0.5 mg one tablet by mouth every six hours for anxiety manifested by panic attacks and - dated 9/28/24, for paroxetine hcl (antidepressant) 30 mg one tablet by mouth at bedtime for depression manifested by constant worrying about current health condition. Further review of Resident 101's Order Summary Report failed to show a physician's order to implement non-pharmacological interventions for the use of the paroxetine medication for depression. Review of Resident 101's plan of care showed a care plan problem initiated on 8/28/24, addressing Resident 101's use of an antidepressant for depression manifested by constant worrying about current health conditions. The interventions showed to provide the following non-pharmacological interventions: back rub, redirection, speak to or approach the resident in a calm manner, reposition, offer snacks or fluids, assess for pain, provide a quiet environment, encourage the resident to express feelings, take to activities, and provide reassurance. Further review of Resident 101's plan of care showed a care plan problem initiated on 11/6/23, addressing Resident 101's use of an antianxiety medication for anxiety disorder. The interventions showed to provide the following non-pharmacological interventions: back rub, redirection, speak to or approach the resident in a calm manner, reposition, offer snacks or fluids, assess for pain, provide a quiet environment, encourage the resident to express feelings, take to activities, and provide reassurance. Review of Resident 101's MAR for October 2024 showed Resident 101 was administered the following: - paroxetine hcl 30 mg one tablet by mouth at bedtime from 10/1/24 to 10/13/24, and 10/15/24 to 10/23/24 at 2100 hours, and - lorazepam 0.5 mg one tablet every six hours from 10/1/24 to 10/3/24; 10/7/24 to 10/12/24; 10/14; 10/16/24 to 10/23/24 at 0000, 0600, 1200, and 1800 hours; 10/4 and 10/6/24 at 0000 and 0600 hours; 10/6 and 10/13/24 at 1800 hours; and 10/15/24 at 0000, 0600, and 1200 hours. Further review of Resident 101's MAR for October 2024 failed to show documentation of the nonpharmacological interventions implemented prior to the administration of the paroxetine hcl 30 mg at bedtime and the lorazepam 0.5 mg every six hours. Review of Resident 101's Progress Notes failed to show documentation of the nonpharmacological interventions implemented prior to the administration of the paroxetine hcl 30 mg at bedtime and lorazepam 0.5 mg every six hours. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 1048 hours, a concurrent interview and medical record review for Resident 101 was conducted with LVN 1. LVN 1 stated Resident 101 had a lot of anxiety and was administered routine lorazepam. LVN 1 reviewed Resident 101's medical record and verified the above findings. LVN 1 stated the non-pharmacological interventions should be implemented prior to the administration of an antipsychotic and should be documented in the resident's medical record to determine what interventions are effective. On 10/24/24 at 1138 hours, an interview was conducted with the DON. The DON stated for the use of an antipsychotic medication (routine or as needed), the non-pharmacologic interventions should be implemented prior to the administration of antipsychotic medication. On 10/24/24 at 1403 hours, the DON was informed and acknowledged the above findings. 45064 4. Medical record review for Resident 75 was initiated on 10/23/24. Resident 75 was admitted to the facility on [DATE]. a. Review of Resident 75's H&P examination dated 1/23/24, showed Resident 75 did not have capacity. Review of Resident 75's physician's order showed an order dated 1/31/24, for melatonin oral tablet 5 mg one tablet by mouth at bedtime for insomnia. Review of Resident 75's medical record failed to show documented evidence the informed consent for melatonin was obtained. b. Review of Resident 75's medical record failed to show documented evidence a GDR was attempted for melatonin. On 10/24/24 at 1022 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified there was no GDR attempted and no informed consent obtained for melatonin. The DON stated prior to administering any psychotropic medications, the facility needed to obtain the inform consent, monitor side effects during the time the resident receives the medications, attempt non-pharmacological interventions, and attempt to do GDR. c. Review of Resident 75's physician's order showed the following: - an order dated 8/2/24, for mirtazapine 7.5 mg one tablet by mouth at bedtime related to major depressive disorder. Review of Resident 75's MAR for October 2024 failed to show the resident was specifically monitored for side effects for mirtazapine related to appetite and melatonin. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 1014 hours, a concurrent interview and medical record review was conducted with the DON. The DON reviewed Resident 75's MAR and verified the side effects for mirtazpine were generic and common for antidepressants and were not specific to mirtazpine. The DON further verified there was no documentation of side effects monitoring for melatonin. The DON stated if the side effects of a medication were not correctly monitored, then they would be unable to identify the effectiveness of medication or know when to reduce or discontinue the medication. d. Review of Resident 75's physician's order showed the following: - an order dated 8/29/24, for quetiapine 25 mg 1/2 tablet by mouth one a day for psychosis (a mental disorder characterized by a disconnection from reality) manifested by hitting, striking out Review of Resident 75's medical record failed to show documented evidence of the implementation f non-pharmacological interventions before and during administration of quetiapine, melatonin, and mirtazipine. On 10/23/24 at 1444 hours, a concurrent interview and medical record review was conducted with the DON. The DON reviewed Resident 75's medical record and verified there was no documentation of non-pharmacological interventions attempted prior to administering the quetiapine, melatonin, and mirtazipine.

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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** 51352 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were not stored at the bedside for one nonsampled resident (Resident 107). In addition, the facility failed to ensure the proper disposal of treatment supplies for one of five medication/treatment carts (Treatment Cart 1)inspected for medication storage and labeling. *The facility failed to ensure one tube of CalaZinc (ointment used to treat and prevent skin irritation and diaper rash, and to protect minor cuts, burns, and dry, cracked skin), one spray bottle of Sea-Clens (saline-based solution for cleansing acute and chronic wounds), and one tube of Critic-Aid (ointment that helps prevent and treat most skin irritation due to incontinence) were not stored in 107's bedside drawer. * The facility failed to ensure the expired culture swabs were removed Treatment Cart 1. These failures had the potential to result in unsafe medication administration and posed the risk for inaccurate test results and treatment. Findings: Review of the facility's P&P titled Storage of Medication revised [DATE] showed the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperatures, light, and humidity controls. The nursing staff is responsible for maintaining the medication storage and preparation areas in a clean, safe, and sanitary manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. On [DATE] at 0825 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with LVN 3 for Resident 107. Resident 107 was observed awake and sitting up in bed. A tube of CalaZinc cream, one spray bottle of Sea-Clens Wound Cleanser, and a tube of Critic-Aid skin paste were observed inside Resident 107's bedside drawer. LVN 3 verified the above findings. Medical record review for Resident 107 was initiated on [DATE]. Resident 107 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 107's H&P examination dated [DATE], showed Resident 107 had the capacity to understand and make decisions. Review of Resident 107's Order Summary Report dated [DATE], did not show a physician's order for the CalaZinc cream, Sea-Clens Wound Cleanser, and Critic-Aid skin paste. Review of Resident 107's plan of care failed to show a care plan problem addressing the use of the above medications found at the resident's bedside and to store the medications at the bedside. (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 0936 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 verified Resident 107 did not have the physician's order for the above medications and/or orders to store the medications at the bedside. LVN 4 stated Resident 107 had previously brought the medications from home; however, the charge nurse was responsible for ensuring the residents did not bring the medications from home. LVN 4 stated there must be a physician's order and a care plan for any residents who wanted to keep the medications in their room. On [DATE] at 0940 hours, an interview was conducted with CNA 4. CNA 4 stated she had not seen the above medications in Resident 107's bedside drawer. CNA 4 stated she checked the residents' bedside drawers during her shift, but she had not yet checked Resident 107's bedside drawer during this shift. On [DATE] at 1105 hours, an interview and concurrent medical record review was conducted with RN 2 for Resident 107. RN 2 verified Resident 107's medical record did not show the physician's orders for the CalaZinc cream, Sea-Clens Wound Cleanser, and Critic-Aid skin paste and/or a physician's order to have these medications stored in Resident 107's bedside drawer. RN 2 stated the physician's order and care plan were required for the residents who wanted to keep the medications in their bedside drawers. On [DATE] at 1335 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings. The DON stated Resident 107's aide from the hospice company brought the above mentioned medications and left them in Resident 107's bedside drawer. The DON stated the hospice company was notified not to leave the medications at Resident 107's bedside. The DON stated the licensed staff should ensure no medications were left in the resident's bedside. 45064 2. On [DATE] at 0929 hours, an inspection of Treatment Cart 1 and concurrent interview was conducted with LVN 2. The following was observed: - One culture swab (used to collect a sample for a laboratory test to identify bacteria causing an infection) inside the fourth drawer of the treatment cart, with an expiration date of [DATE]. LVN 2 verified the above finding. On [DATE] at 1406 hours, a follow-up interview was conducted with LVN 2. LVN 2 stated she did a random check for the expiration dates of the medications and supplies in Treatment Cart 1 on [DATE], but missed the expired culture swab. LVN 2 stated the expired culture swab could be ineffective, or maybe contaminated if used on the residents. LVN 2 stated the expired supplies should be discarded from the treatment cart. On [DATE] at 1446 hours, an interview was conducted with the DON. The DON stated the expired supplies should be removed from the treatment cart immediately.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food was served at a temperature to ensure palatability for one of 30 final sampled residents (Resident 60) and two nonsampled residents (Residents 62 and 131). This deficient practice had the potential to impact the residents' nutritional status and not meet the residents' desires to be served food they felt was palatable and attractive. Findings: Review of the facility's P&P titled Meal Service dated 2023 showed meals that meet the nutrtitional needs of the residents will be served in an accurate and efficient manner, and served at the appropriate temperatures. The temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. Further review of the facility's P&P showed the recommended food temperatures at delivery to the residents are as follows: - Cold entree and fruit or cold dessert at less than or equal to 50 degrees F. - Salads, milk/cold beverage at less than or equal to 45 degrees F. - Hot entree, waffles, french toast, starch, vegetables at more than or equal to 120 degrees F. - Hot beverage, soup or hot cereal at more than or equal to 140 degrees F. On 10/21/24 at 0815 hours, during the initial tour of the facility, Resident 131 stated the hot foods were not served hot and waffles looked untoasted. On 10/21/24 at 0900 hours, during the initial tour of the facility, Resident 62 stated food was not always hot when it should be hot. On 10/21/24 at 0904 hours, during the initial tour of the facility, Resident 60 stated the food that should be served hot were not hot. When asked about the food that were not served hot, Resident 60 stated his fried eggs, bacon, pancakes, waffles, and egg sandwiches were not served hot. On 10/22/24 at 1137 hours, a trayline observation was conducted in the kitchen. The plate warmer was observed with two stacks of plates filling the inside of the plate warmer and stacked (24 plates or more per stack) above the top level of the plate warmer. On 10/22/24 at 1228 hours, a regular meal test tray observation and concurrent interview was conducted with the RD, DSS, and Administrator. The DSS took the temperatures of the following items on the test tray: - Pacific Rim Pork Roast at 104 degrees F. - Red Beans and Rice at 106 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Carrots with Parsley at 106 degrees F. - Tossed [NAME] Salad at 50 degrees F. - Apple Bread Pudding at 54 degrees F. The RD agreed the pork roast was not hot and stated it was warm. The RD also stated the temperature for the carrots and red beans and rice tasted like they were at room temperature. On 10/22/24 at 1412 hours, an interview was conducted with the DSS. When asked what the food temperatures should be at when received by the residents, the DSS stated the hot food should be 120 degrees F. When asked how the facility ensured the food was hot by the time it reached the residents, the DSS stated the plate warmer was used to warm the plates and the metal hot plates were used to keep the plates and food hot. The DSS further stated the metal hot plates were currently not being used due to parts being ordered. When asked what was being done to ensure the hot foods were delivered to the residents hot or at a palatable temperature, the DSS stated the facility was using the plate warmers. When asked about the use of the plate warmers, the DSS stated the plates were loaded into the plate warmer and the plates inside the plate warmer get really hot. When asked about the plates stacked above the level of the platewarmer (not inside the heated compartment of the plate warmer), the DSS stated those plates were warm. When asked if the stacked plates that were not inside the heated compartment of the plate warmer were sufficient to keep the hot foods hot, the DSS stated it would not keep the food hot by the time it reached the residents. On 10/24/24 at 1412 hours, the DON, RD and DSS were informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the proper labeling and dating of food in the refrigerator. * The facility failed to ensure the kitchen utensils had smooth cleanable surfaces and were in good repair. * The facility failed to ensure the kitchen utensils were stored and kept in sanitary conditions and free of food particle or residue. * The facility failed to ensure the blender and metal pans were air-dried prior to storing. These failures had the potential for cross contamination and cause foodborne illnesses in a medically vulnerable population who consumes food prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 10/21/24, showed 140 of 149 residents consumed the foods prepared in the facility's kitchen. 1. Review of the facility's P&P titled Labeling and Dating of Foods dated 2022 showed all 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. The individual preparing/handling a food shall be responsible for date marking at the time of processing and/or storage. For foods that are commercially processed, ready to eat and intended to be stored cold greater than 24 hours will be marked with a use by date. The use by date signifies the date in which food must be consumed or discarded. On 10/21/24 at 0807 hours, during the initial tour of the kitchen, an observation of Refrigerator 2 was conducted with the DSS and RD. A container of turkey meat was observed in the refrigerator unlabeled with the opened date or the use-by date. The DSS verified the above finding and stated the individual who put the container in the refrigerator should have labeled it with a use-by date. 2. According to the US FDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the US FDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. On 10/21/24 at 0807 hours, during the initial tour of the kitchen, a concurrent observation and interview was conducted with the DSS and the RD. The following was observed: - One slotted portion server with a partially melted and discolored green handle. - One portion server with a partially melted green handle, and chipped stainless steel coating in the inner and outer surfaces. - One portion server with a partially melted red handle. - One portion server with a partially melted blue handle. The DSS verified the above findings. 3. According to the US FDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the US FDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. On 10/21/24 at 0807 hours, during an initial tour of the kitchen, a concurrent observation and interview was conducted with the DSS and RD. The following was observed: - A can opener set to air-dry, with light orange food particle on the blade. - A scoop set to air-dry, with whitish-yellow food particles on the scoop. - A portion server set to air-dry, with whitish food residue on the scoop. - A portion server with brown stain. - A scoop with whitish residue. - The drawer holding clean cooking utensils had white dry particles and water droplets at the bottom of the drawer. The DSS verified the above findings and was observed taking the above items to be washed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. According to the US FDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the US FDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. Review of the facility's P&P titled 3-Compartment Procedure for Manual Dishwashing dated 2023 showed all the items are air-dried, which means no water droplets are present. On 10/21/24 at 0807 hours, during an initial tour of the kitchen, a concurrent observation and interview was conducted with the DSS and RD. The following was observed: - A blender stored on the counter ready for use, was observed still wet with visible water inside. - Multiple metal pans were observed on the shelf stacked face-down and still wet with noticeable water between the metal pans. The DSS verified the above findings and stated the blender and metal pans should be completely dry before storing to prevent the cross contamination. On 10/24/24 at 1412 hours, the DON, RD, and DSS were informed and acknowledged the above findings.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 48882 Based on observation and interview, the facility failed to ensure the garbage was properly stored and covered in one of four garbage dumpsters. This failure had the potential to attracts pest/rodents that carried diseases. Findings: According to the 2022 FDA (Food and Drug Administration) Food Code, outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 10/24/24 at 0730 hours, an observation of the facility's outside garbage dumpster was conducted. One of four garbage dumpster was observed with the right-side lid missing and exposing the garbage inside. On 10/24/24 at 0737 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the above findings. When asked about the right-side garbage dumpster lid not being used to cover the dumpster, the Maintenance Director stated the garbage dumpster had a broken lid on the right side since August 2024 and the garbage company had not replaced or repaired the lid. When asked, the Maintenance Director stated the garbage dumpster was still being used to hold garbage while waiting for the trash company to repair or replace the broken lid. On 10/24/24 at 1412 hours, the RD, DSS, and DON were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview, and facility P&P review, the facility failed to maintain the safe infection control practices to help prevent the development and transmission of diseases and infection. * The licensed nurse (LVN 1) failed to use the appropriate sanitizing wipes when disinfecting the blood pressure machine. This failure had the potential for cross contamination (spread of germs and bacteria) and infection. Findings: Review of the facility's P&P titled Cleaning and Disinfecting Non-Critical Resident-Care Items revised 2/2022 showed reusable items are cleaned and disinfected between residents. Medical record review for Resident 35 was initiated on 10/21/24. Resident 35 was admitted on [DATE]. On 10/21/24 at 0828 hours, during a medication administration observation for Resident 35, LVN 1 was observed cleaning a wrist blood pressure monitoring device with Velcro cuff with Micro Kill One Germicidal Alcohol wipes prior to obtaining Resident 35's blood pressure. LVN 1 stated she used the wrist blood pressure monitoring device with Velcro cuff for all her residents. Review of the Micro Kill One Germicidal Alcohol Wipes packaging label showed the wipes were to be used for hard, non-porous (no small holes where liquid or air can pass through). On 10/24/24 at 1352 hours, an interview and concurrent label review of Micro Kill One Germicidal Alcohol Wipe was conducted with LVN 1. LVN 1 verified she used the Micro Kill One Germicidal Alcohol Wipe to disinfect the wrist blood pressure monitoring device cuff. LVN 1 checked the label and verified the wipes were to be used for hard non-porous surfaces and the wipes were not appropriate for disinfecting the blood pressure cuff. LVN 1 further stated if the device were not cleaned properly, it can potentially spread germs and bacteria which can lead to complications such as serious illness, sepsis or potentially lead to death.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 51352 Based on interview, facility document review, and facility P&P review, the facility failed to inform the physician of the residents prescribed antibiotics with signs and symptoms not meeting McGeer's Criteria (criteria used by long-term care facilities to determine a true infection) for five of 30 final sampled residents (Residents 60, 75, 101, 110, and 840) and 24 nonsampled residents (Residents 16, 21, 24, 48, 50, 63, 96, 100, 117, 120, 123, 740, 741, 742, 743, 745, 746, 747, 748, 749, 750, 751, and 752). This failure had the potential risk for continued use of unnecessary antibiotics, potentially resulting in adverse reactions associated with antibiotics and the development of antibiotic resistant bacteria. Findings: According to the Centers for Disease Control and Prevention (CDC), antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile (a type of bacteria that can cause diarrhea and inflammation of the colon), increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review of the facility's P&P titled Antibiotic Stewardship revised 10/2022 showed the facility will implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote the appropriate use of antibiotics while optimizing the treatment of infections, and at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. Further review of the facility's P&P showed, the ASP team will: - Review data, monitor, and summarize of the rate of new antibiotics ordered, types of antibiotics, and the number of residents treated with antibiotics each month - Summarize antibiotic resistance patterns - Track measures of outcome surveillance related to antibiotic use and antibiotic resistance - Monitor antibiotics use, including the frequency of monitoring or review - Assess residents for any infection using standardized tools and criteria. A separate report will be maintained for the number of residents on antibiotics that did not meet McGeer's Criteria for active infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility may consider an antibiotic time-out (an order to stop antibiotics) when a diagnostic test or the symptoms of the resident do not support the diagnosis of an infection. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of antibiotic when the clinical picture is clearer, and more information is available. On 10/22/24 at 0932 hours, a concurrent interview and facility document review was conducted with the IP. The IP stated he was responsible for conducting surveillance of residents in the facility with infections, developing the Infection Report Monthly, the Infection Prevention and Control Surveillance Log, and mapping infections in the facility. The IP stated a Surveillance Data Collection Form was completed for each resident with signs and symptoms of an infection and were prescribed antibiotics by the facility, and also completed for residents who were admitted to the facility on antibiotics. The IP stated the Surveillance Data Collection Form was used to determine if the resident's signs and symptoms met the McGeer's criteria for a true infection. The IP stated he would indicate on the form whether the infections were HAI, CAI, or DNMC. The IP stated if a resident was prescribed antibiotics with signs and symptoms that did not meet the McGeer's criteria for a true infection, then the prescribing physician would be notified to determine if the antibiotics should be continued or discontinued. The IP stated he would document the notification of the physician on the bottom section of the Surveillance Data Collection Form or in the progress notes of the resident's electronic health record. Review of the facility's Monthly Infection Report for July 2024 showed the following documentation: - one HAI case, - nine CAI cases, - 16 residents who were prescribed antibiotic and did not meet the McGeer's criteria: Review of the facility's Monthly Infection Report Monthly for August 2024 showed the following documentation: - ten HAI cases, - nine CAI cases, - four residents who were prescribed antibiotic and did not meet the McGeer's criteria: Review of the facility's Monthly Infection Report for September 2024 showed the following documentation: - four HAI cases, - 13 CAI cases, - nine residents who were prescribed antibiotic and did not meet the McGeer's criteria: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the above residents' Surveillance Data Collection Forms for the months of July, August, and September 2024 and concurrent interview was conducted with the IP. After reviewing the residents' Surveillance Data Collection Forms, the IP verified Residents 16, 21, 60, 101, 117, 120, 742, 743, 745, 746, 747, 748, 749, 750, 751 and 752 (July 2024), Residents 16, 50, 100, and 742 (August 2024) and Residents 24, 48, 63, 75, 96, 123, 740, 741, and 840 (September 2024) did not meet the McGeer's criteria for a true infection but were prescribed antibiotics. The IP was asked to show the documentation that the physicians had been notified when the infection criteria were not met for the above residents. The IP reviewed the medical records for the above residents and stated he was unable to provide the documentation. On 10/24/24 at 1335 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the pneumococcal vaccine was administered to one of five residents (Resident 31) reviewed for immunizations. This had the potential to put Resident 31 at risk of contracting pneumococcal disease. Findings: Review of the facility's P&P titled Immunizations - Resident revised 7/2023 showed it is the policy of the facility to offer and administer influenza, pneumococcal, and COVID-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine(s) and obtaining consent. The policy further showed the purpose of the policy is to minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza, pneumococcal disease, or COVID-19 by assuring that each resident is informed about the benefits and risks of immunization; and has the opportunity to receive the influenza, pneumococcal, or COVID-19 vaccine(s), unless medically contraindicated, declined or already immunized. Medical record review for Resident 31 was conducted on 10/23/24. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 9/23/24, showed the resident did not have the capacity to make medical decisions. Review of Resident 31's Resident Vaccination Consent form dated 9/21/24, showed Resident 31's representative consented to the pneumococcal vaccination. Review of Resident 31's Immunization Report dated 10/23/24, did not show if the pneumococcal vaccine was administered after the informed consent was obtained. Further review of Resident 31's medical record failed to show documented evidence the pneumococcal vaccine was administered to Resident 31. On 10/23/24 at 1427 hours, an interview and concurrent medical record review for Resident 31 was conducted with the IP. The IP verified Resident 31's representative gave the consent for Resident 31 to receive the pneumococcal vaccine on 9/21/24. When asked what the expected time frame to administer the pneumococcal vaccine after receiving consent, the IP stated the vaccines were to be administered within five days of obtaining consent. The IP stated the admission nurse discussed the consent forms for the vaccines with the residents and/or representative upon admission to the facility. After the admission nurse obtained the consent for the vaccines from the residents or their representatives, the IP contacted the resident's primary physician to obtain an order for the vaccines. The IP stated he then would administer the vaccines to the resident and record the administration in the resident's Immunization Record. The IP stated after the administration of vaccines, the residents were monitored for adverse reactions for 72 hours, which were documented in the MAR. The IP verified the pneumococcal vaccine had not been given to Resident 31 as of 10/23/24. The IP stated he got busy during the influenza season but would follow up with the physician regarding the pneumococcal vaccination for Resident 31. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 1335 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0907 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide enough space and equipment to meet each resident's needs 37726 Based on interview, the facility failed to provide sufficient space for communal dining for three of eight residents (two final sampled residents, Residents 27 and 60; and one nonsampled resident, Resident 63) interviewed during the resident council meeting. * The residents stated the facility failed to provide a communal dining area for the residents in the facility who did not require staff assistance with meals. The residents stated only the residents who required staff assistance with meals had access to the communal dining area. This failure had the potential to inhibit socialization and negatively affect the residents' quality of life. Findings: On 10/22/24 at 0826 hours, the resident council meeting (a group of residents that meets regularly to discuss and offer suggestions about facility procedures to improve the quality of life for the residents who reside at the facility) was conducted with eight residents. Residents 27, 60, and 63 stated currently only the residents who required staff assistance with meals had access to the communal dining room. Residents 60 and 63 stated they wanted the option to eat in a communal dining room versus having to eat their meals in their rooms. Resident 27 stated she would like the option of eating in a communal setting while maintaining the option of eating in her room as well. On 10/23/24 at 1045 hours, an interview was conducted with the Administrator. The Administrator acknowledged the findings and stated the facility was in the process of providing a dining area for the residents who did not require staff assistance with meals.