STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555276	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Bruno Skilled Nursing	890 El Camino Real San Bruno, CA 94066

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43913 Based on observation, interview and record review, the facility did not ensure that resident's unique care instructions for one resident (Resident 12) are made private, when care instructions are posted in two places in her bedroom wall. This failure can result in exposing her medical condition to other residents and visitors. Findings: Review of Admission Record, dated, 6/18/24, indicated, admitted to SNF on 10/28/22 with diagnoses including: Parkinson's Disease(a disorder of the central nervous system that affects movement including tremors), Diabetes Mellitus(a condition when the body has trouble controlling blood sugar) Major Depressive Disorder(a mental health disorder characterized loss of interest in activities causing impairment in daily life). Review of MDS (Minimum Data Set) Section C, BIMS (Brief Interview for Mental Status) result is 8= with cognitive impairment. During an interview on 6/12/24 at 3:30 PM, with CNA 2, per CNA 2, the daughter was the one who posted it for her mother's care. Not sure if we can post it here. During an interview on 6/12/24 at 3:40PM, with DON, per DON, there is nothing wrong with that, its instructions for CNAs since we have registry working here. Maybe the name should not be there. I know its dignity and privacy. It is the family who wanted it posted. Review of care plan, not found for the posting of instructions. Review of facility's Policy and Procedure, Resident's Rights, dated 2/2021, indicated, Policy Statement, Employees shall treat all residents with kindness, respect and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to: a. a dignified existence; b. be treated with respect, kindness, and dignity.

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49264 Based on observation, interview, and record review, the facility failed to ensure that a resident could safely administer a medication when one out of one sampled residents (Resident 11) did not receive an assessment or education regarding the self-administration of doxycycline (an antibiotic). This failure could result in the resident inappropriately taking the medication resulting in overdose (taking beyond the safe amount of a medication), drug interactions (typically unwanted reaction between two medications that someone takes), or unrecognized side effects of the medication. Findings: A review of the facility policy and procedure titled, Self-Administration of Medications, undated, indicated that the interdisciplinary team (IDT) should assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The policy and procedure further indicated that The IDT considers the following factors when determine whether self-administration of medication is safe and appropriate . the resident can follow directions and tell time to know when to take the medication .resident comprehends the medications' purpose, proper dosage, timing, signs of side effects and when to report these to the staff. In addition, it indicated, If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. During a concurrent observation and interview on 06/12/24 at 3:16 PM with Resident 11, inside of Resident 11's room, a bottle of doxycycline labeled for Resident 11 was observed on the resident's bedside table. Resident 11 indicated that they have been taking the medication because I have a bacterial infection. During a concurrent observation and interview on 06/12/24 at 3:18 PM with Registered Nurse (RN) 1, at Resident 11's bedside, a bottle of Doxycycline labeled for Resident 11 was observed on the resident's bedside table. RN stated that Resident 11 takes medications by himself and that she is not aware of a care plan for the doxycycline at bedside. During an interview on 06/13/24 at 12:23 PM with the Case Manager (CM), the CM stated that residents who self-administer medication should have a self-mediation assessment and the medication should also be in their care plan. During a concurrent interview and record review on 06/13/24 at 4:13 PM with the Director of Nursing (DON), Resident 11's care plan for self-administration of medication, dated 10/19/23, was reviewed. The care plan indicated that the resident could self-administer five different medications. The DON stated that medications the resident was care planned to self-administer were an inhaler [handheld device used to deliver medication to lungs to help with breathing] and vitamin, triamcinolone cream [cream applied to skin to reduce redness or irritation], ketoconazole [an antifungal] . nitroglycerin [medication used to reduce chest pain]. The DON stated these were the only medications she is aware that the resident self-administers. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 06/13/24 at 4:51 PM with the Assistant Director of Nursing (ADON), a nursing assessment for Resident 11 titled, NURSING - SELF-ADMINISTRATION OF MEDICATION OBSERVATION, dated 02/28/24, was reviewed. The nursing assessment indicated that a licensed staff reviewed five medications for Resident 11 to self-administer. The ADON stated that these were the same five medications in the resident's current care plan for medication self-administration. The ADON stated that he was not aware of the resident taking Doxycycline stating, not sure how he [Resident 11] got that one. The ADON further stated that his concern for a resident self-administering a medication they were not educated on is the Resident's risk for overdose. During a concurrent interview and record review on 06/14/24 at 9:25 AM with the DON, Resident 11's care plan for self-administration of medication, updated on 06/13/24, was reviewed. The care plan included doxycycline as a self-administered medication. The DON stated that care plan was updated the day prior. The DON also stated that the resident was taking the doxycycline prior to the care plan being updated. During a concurrent interview and record review on 06/14/24 at 11:11 AM with the DON, Resident 11's medication orders, dated 06/14/24, was reviewed. The medication orders did not indicate that the resident is taking doxycycline. The DON stated that since the resident is self-administering doxycycline, the medication should be there [in the list of medication order] but it is currently not.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49264 Based on interview and record review, the facility failed to have a valid copy of a resident's Physician Orders for Life-Sustaining Treatment (POLST, a written medical order that assists people in making decisions about medical treatment and life saving measures during end-of-life care or medical crisis) when one of twelve sampled residents (Resident 47) had a POLST lacking a clear signature or identity of who the POLST was discussed with. This failure has the potential to result in a resident's end-of-life choices not being honored. Findings: A review of Resident 47's Minimum Data Set (MDS, a resident assessment tool), dated 04/30/24, indicated that Resident 47 was admitted in April of 2024. It further indicated that the resident has a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 13 (scores of 0-7 suggest severe cognitive impairment, 8 to 12 suggests moderate cognitive impairment, and 13 to 15 suggest that cognition is intact). A review of Resident 47's POLST, dated 04/27/24, indicated that To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant .and (2) the patient or decisionmaker.' During a concurrent interview and record review on 06/14/24 at 11:23 AM with the Director of Nursing (DON), Resident 47's POLST, dated 04/27/24, was reviewed. In a section of the POLST asking if the information was discussed with the Patient or Legally Recognized decision maker, neither option was chosen. The DON stated that the section is blank stating, there's nothing there. When asked whether the resident or a decision maker signed the POLST, the DON stated, I don't know there are two signatures I can't understand. When asked if there is a printed name of either a patient or the legally recognized decision maker, the DON stated, it's missing the name. The DON further stated, it's incomplete because there is no name.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on interview and record review, the facility failed to provide the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage, Form CMS-10055 (SNF ABN, Form Centers for Medicare & Medicaid Services-10055 - a written notice used to inform the resident/beneficiary of potential financial liability for the non-covered stay and the right to appeal to receive care and services which may not be covered by Medicare) for one of three sampled residents (Resident 32) receiving Medicare Part A services. This failure had the potential for residents and/or resident representative not being aware of the financial liability and the right to appeal for the denial or termination of resident's Medicare Part A services. Findings: Review of Resident 32's admission record indicated, was admitted on [DATE] with diagnoses including orthopedic aftercare following surgical amputation of right lower extremity, non-pressure wound on left calf, type 2 diabetes mellitus (high blood sugar), and end stage kidney disease. The admission record also indicated Resident 32 is responsible for himself and his own decision maker. Review of Resident 32's SNF Beneficiary Protection Notification Review form indicated, Medicare Part A Skilled Services started on 5/12/24 and last covered day was 5/31/24. The form also indicated the facility initiated the discharge from Medicare Part A when benefit days were not exhausted. During an interview on 6/14/24 at 9:28 AM, the Case Manager (CM) stated, Resident 32 reached his maximum potential and saving the remaining Part A days for his upcoming surgery. The CM stated that a NOMNC CMS 10123 (Notification of Medicare Non-Coverage - is a CMS approved form delivered to the resident/beneficiary receiving covered skilled nursing services) was provided to Resident 32 before the last covered day. Review of the NOMNC issued to Resident 32 indicated, Resident 32 signed the form on 5/30/24. During a follow up interview on 6/14/24 at 9:56 AM, the CM stated Resident 32 was not provided with the SNF ABN because he went to dialysis on the day it was supposed to be issued. During concurrent interview, the CM called the previous Social Services Director (SSD) to confirm that a SNF ABN was not issued to Resident 32. During a concurrent telephone interview, SSD stated she was not able to issue Resident 32 with the SNF ABN because he was out for dialysis that day, I miss it. During further interview, the CM stated that SNF ABN along with the NOMNC, is provided to residents discharged from skilled services (Medicare Part A) and stayed at the facility. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CMS document titled Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) Form CMS-10055 (2018), indicated, . Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49264 Based on interview and record review, the facility failed to report an injury of unknown origin within the required timeframes in one out of one sampled resident (Resident 8) when Resident 8 reported hip pain that was later diagnosed as a pathological fracture (a break in the bone because of disease rather than physical trauma). This failure has the potential to result in delayed identification and investigation of possible harm occurring from abuse. Findings: A review of Resident 8's face sheet (summary of resident's demographic and admitting information), dated 06/14/24, indicated that Resident 8 was initially admitted on January of 2024 with multiple diagnoses including END STAGE RENAL DISEASE [failure of the kidneys to function properly], ANEMIA [lack of healthy blood cells], and MUSCLE WASTING AND ATROPHY [thinning or loss of muscle] A review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 05/08/24, indicated that Resident 8 had a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 8 (scores of 0-7 suggest severe cognitive impairment, 8 to 12 suggests moderate cognitive impairment, and 13 to 15 suggest that cognition is intact). A review of a change of condition nursing note for Resident 8, written by the Director of Nursing (DON) and dated 04/16/24, indicated that Resident 8 was c/o [complaining of] pain on Right hip. Resident has no reported falls while in the facility .Xray [image of bones and tissue in the body to identify injury] . with conclusion . right distal femoral fracture [a break in the lower part of the upper thigh bone] .order 'may send to ED [emergency department] for further evaluation'. During an interview with the DON on 06/13/24 at 10:04 AM, the DON stated that she was the registered nurse taking care of Resident 8 on 04/16/24. The DON recalled that the resident was complaining of pain and an X-ray was done. The DON further stated that at the time the pain was reported, Resident 8 had not fallen or preformed an activity that could explain the pain. When asked if she would consider this complaint of pain on 04/16/24 as an unusual occurrence, the DON stated of course. In addition, the DON stated yes when asked if this event should have been reported to the California Department of Public Health, but she does not see any nursing notes related to a report being made. A review of an interdisciplinary team (IDT) note for Resident 8, dated 04/18/24, indicated that On 4/16/24 . LN [Licensed Nurse] notified MD [Medical Doctor] that resident was experiencing right hip pain . The resident had no recollection of any recent falls or injuries, no presentation of any signs and symptoms of psychosocial or emotional distress; no skin discoloration or visible skin trauma was noted on the right hip and surrounding area .Per further investigation and interview staff who cared for the resident prior to the transfer and several days before, staff observed no falls or receive reports of fall or apparent injuries during their shift .the interdisciplinary team deemed the resident's injury as likely a spontaneous (pathological) fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/14/24 at 11:48 AM with the Director of Staff Development (DSD), the DSD stated injuries of unknown origin should be reported to the California Department of Public Health. A review of a facility policy titled, Investigating Resident Injuries, last revised April 2023, indicated that If an incident/accident is suspected, the nurse supervisor/DON will do an investigation .If the nursing and medical assessment determines an 'injury of unknown source' the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines .'Injury of unknown source' is defined as an injury that meets both of the following conditions .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and . The injury is suspicious because of . the extent of the injury; or . the location of the injury .the number of injuries observed at one particular point in time . or the incidence of injuries over time. A review of facility policy titled, Recognizing Signs and Symptoms of Abuse/Neglect., last revised January 2011, indicated that Signs of Actual Physical Abuse include Fractures, dislocations or sprains of questionable origin. A review of facility policy titled Abuse, Neglect, Exploitation And Misappropriation Prevention Program, last revised April 2021, indicated that the facility should investigate and report any allegations within timeframes required by federal requirements.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on interview and record review, the facility failed to ensure the admission and annual Minimum Data Set (MDS, a resident assessment tool) assessment was completed within the required period of 14 calendar days of admission and Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) for four of 12 sampled residents (Resident 29, Resident 16, Resident 17, and Resident 8). Failure to complete a comprehensive resident assessment within the required timeframe could result in delayed identification of needs and significant issues that may affect the physical, mental, and psychosocial well-being of Resident 29, Resident 16, Resident 17, and Resident 8. Findings: 1. Review of Resident 29's admission record indicated, was admitted to the facility on [DATE]. Review of Resident 29's 5-day/admission MDS assessment with an ARD of 4/16/24 indicated, the assessment was signed by the RN assessment coordinator as complete on 4/30/24, 16 days after admission. During concurrent record review and interview on 6/14/24, at 10:32 AM, the MDSC reviewed Resident 29's 5-day/admission MDS assessment with an ARD of 2/26/24 and stated the MDS was completed on 4/30/24. The MDSC further stated, Resident 17's annual MDS assessment should have been completed and signed on 4/27/24. 2. Review of Resident 16's admission record indicated, was admitted to the facility on [DATE]. Review of Resident 16's annual MDS assessment with an ARD of 1/8/24, indicated, the assessment was signed by the Registered Nurse (RN) assessment coordinator as complete on 1/24/24, 16 days after the ARD. During a concurrent record review and interview on 6/14/24, at 10:42 AM, the MDS Coordinator (MDSC) reviewed Resident 16's annual MDS assessment with an ARD of 1/8/24 and confirmed the MDS was completed late. The MDSC stated, Resident 16's annual MDS assessment should have been completed and signed on 1/21/24. 3. Review of Resident 17's admission record indicated, was admitted to the facility on [DATE]. Review of Resident 17's annual MDS assessment with an ARD of 2/26/24, indicated, the assessment was signed by the RN assessment coordinator as complete on 3/14/24, 17 days after the ARD. During concurrent record review and interview on 6/14/24, at 11:01 AM, the MDSC reviewed Resident 17's annual MDS assessment with an ARD of 2/26/24 and stated the MDS was completed late. The MDSC further stated, Resident 17's annual MDS assessment should have been completed and signed on 3/9/24. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/24, at 11:05 AM, the MDSC stated, the admission MDS assessment should be completed on the 14th day of admission while the annual MDS assessment need to be completed 14 days after the ARD. 49264 4. A review of Resident 8's face sheet (summary of resident's demographic and admitting information), dated 06/14/2024, indicated that Resident 8 was readmitted on [DATE]. During a concurrent interview and record review on 06/14/24 at 10:52 AM with the MDSC, Resident 8's 5-day/admission MDS assessment, with an ARD of 05/08/24, was reviewed. The 5-day/admission MDS assessment indicated that the assessment was signed by the RN assessment coordinator as complete on 06/04/24, 29 days after admission. The MDSC stated that It [the assessment] was signed late. Review of facility's undated policy and procedure titled, Comprehensive Assessments, indicated, Comprehensive assessments are conducted to assist in developing person-centered care plans. 1. Comprehensive assessments are conducted in accordance with the criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. 2. Admission Assessment - The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 .3. Annual Assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) .Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates . Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, .The OBRA (Omnibus Budget Reconciliation Act of 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents . The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 . The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates . The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 41545 Based on interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA, is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline) for one of 12 sampled residents (Resident 3) who was admitted to hospice care on 11/11/23. This failure could potentially delay the provision of appropriate treatment and services for Resident 3. Findings: Review of Resident 3's admission record indicated, was admitted to hospice on 11/11/24 with diagnoses including stroke, respiratory failure, pulmonary fibrosis (a disease where there is scarring of the lungs which makes it difficult to breathe), and lung involvement in systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs). Review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) with an Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) 11/14/23, indicated, a SCSA was completed when Resident 3 was enrolled to hospice care. During concurrent interview and record review on 6/13/24, at 11:37 AM, Licensed Vocational Nurse (LVN) 2 reviewed Resident 3's electronic health record (EHR) and stated Resident 3 was determined to be on hospice care on 11/9/23 and was admitted to hospice care on 11/11/23. Review of Resident 3's Order Summary Report dated 6/14/24, indicated, Resident 3 had an order to admit to hospice on 11/11/23. During an interview on 6/14/24, at 10:45 AM, MDS Coordinator (MDSC) stated, residents placed on hospice will need a significant change in status assessment and should be completed 14 days from the day resident was admitted to hospice. During concurrent record review, indicated, Resident 3's SCSA MDS was signed by the RN assessment coordinator as complete on 11/26/23, 16 days after Resident 3 was admitted to hospice. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, .The OBRA (Omnibus Budget Reconciliation Act of 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents . An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than) . The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met .

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San Bruno Skilled Nursing	890 El Camino Real San Bruno, CA 94066

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS, a resident assessment tool) quarterly assessment was completed at least every 92 days following the previous OBRA (Omnibus Budget Reconciliation Act of 1987) assessment for three of 12 sampled residents (Resident 20, Resident 3, and Resident 17). Failure to complete quarterly resident assessment within the required timeframe could result in delayed identification of needs and significant issues that may affect the physical, mental, and psychosocial well-being of the residents. Findings: 1. Review of Resident 20's admission record indicated, was admitted to the facility on [DATE]. Review of Resident 20's quarterly MDS with an Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) of 5/9/24 indicated, the assessment was signed by the RN assessment coordinator as complete on 6/4/24, 26 days after the ARD. During concurrent interview and record review on 6/14/24, at 10:39 AM, the MDS Coordinator (MDSC) reviewed Resident 20's quarterly MDS and stated, the MDS should have been completed and signed on 5/22/24. The MDSC also stated that the quarterly MDS assessment should be signed 14 days after the ARD. 2. Review of Resident 3's admission record indicated, was readmitted to the facility on [DATE]. Review of Resident 3's quarterly MDS with an ARD of 5/14/24 indicated, the assessment was signed by the RN assessment coordinator as complete on 6/4/24, 21 days after the ARD. During concurrent interview and record review on 6/14/24, at 10:45 AM, the MDSC reviewed Resident 3's quarterly MDS and stated, the MDS should have been completed and signed on 5/27/24. 3. Review of Resident 17's admission record indicated, was admitted to the facility on [DATE]. Review of Resident 17's quarterly MDS with an ARD of 5/16/24 indicated, the assessment was signed by the RN assessment coordinator as complete on 6/2/24, 17 days after the ARD. During concurrent interview and record review on 6/14/24, at 11:00 AM, the MDSC reviewed Resident 3's quarterly MDS and stated, the MDS should have been completed and signed on 5/29/24. Review of facility's undated policy and procedure titled, Comprehensive Assessments, indicated, Comprehensive assessments are conducted to assist in developing person-centered care plans. 1. Comprehensive assessments are conducted in accordance with the criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual . (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, .The OBRA (Omnibus Budget Reconciliation Act of 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents . The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored . The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type . The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA, SCPA, SCQA, or Annual assessment + 92 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41545 Based on observation, interview, and record review, the facility failed to ensure a person-centered care plan was implemented for three of 12 sampled residents (Resident 3, Resident 29, and Resident 16) when: 1. The facility did not ensure oxygen (O2) at 5 liters per minute (LPM) via nasal cannula (NC, a device that delivers extra oxygen through a tube and into the nose) was administered to Resident 3. 2. The facility did not ensure O2 at 2 LPM via NC was administered to Resident 29. 3. The facility did not ensure two-persons assist was provided for Resident 16 during transfer from bed to wheelchair using a sit-to-stand/standing lift. The deficient practice resulted in Resident 3 and Resident 29 to not receive the appropriate amount of oxygen as prescribed by the physician; and can increase the risk for an accident such as a fall and/or injury to Resident 16. Findings: 1. Review of Resident 3's admission record indicated, was readmitted on [DATE] with diagnoses including stroke, respiratory failure, pulmonary fibrosis (a disease where there is scarring of the lungs which makes it difficult to breathe), and lung involvement in systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs). During an observation on 6/11/24 at 11:58 AM, in resident's room, Resident 3 was sitting on the edge of the bed wearing an ill-fitting non-rebreather mask on top of the nasal cannula During a concurrent observation and interview on 6/11/24 at 12:02 PM, in resident's room, Licensed Vocational Nurse (LVN) 1 stated, Resident 3 is nebulizer treatment (help control breathing problems like wheezing and help loosen lung secretions) for shortness of breath (SOB) as needed (PRN) via a non-rebreather mask which runs for 30 minutes. During concurrent observation, LVN 1 checked on the O2 concentrator (a device that help you breathe) and stated Resident 3 is on 2 LPM (liters per minute) continuous via NC per concentrator. Review of Resident 3's active order dated 5/10/24, indicated, O2 @ 5 LPM via nasal cannula continuous per concentrator/tank. Can be titrated up to 5 LPM as needed to keep O2 > 90% every shift. Review of Resident 3's care plan for oxygen initiated and revised on 5/6/24, indicated, Resident requires the use of oxygen continuous related to acute respiratory failure, dyspnea (difficulty of breathing) . Intervention: Administer oxygen at 3-5 L via nasal cannula per concentrator/tank . Educate the resident on the importance of keeping oxygen on and at the prescribed setting . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 29's admission record indicated, was admitted to facility on 4/14/24 with diagnoses including heart failure, pneumonia (inflammation and fluid in your lungs caused by a bacterial, viral or fungal infection), respiratory failure, and chronic obstructive pulmonary disease (COPD - lung disease that cause airflow blockage and breathing related problems). During an observation on 6/12/24 at 9:48 AM, in resident's room, Resident 29 was sleeping in bed with O2 via NC attached to an oxygen concentrator. During further observation, the flowmeter and dial on the oxygen concentrator showed Resident 29's O2 was on 3 LPM. During concurrent interview and record review on 6/12/24 at 12:29 PM, LVN 3 reviewed Resident 29's active orders and stated, Resident 29 has an order on 4/14/24 for O2 administration at 2 LPM via NC continuously per concentrator for SOB. Resident 29's active orders dated 4/14/24, indicated, O2 @2LPM via nasal cannula continuous per concentrator/tank every shift for SOB. The active orders also indicated, O2 @2LPM via nasal cannula PRN (as needed) per concentrator every 8 hours as needed. Administer Oxygen if O2 saturation is less than 92% or there is shortness of breath (SOB). During concurrent observation and interview on 6/12/24 at 12:32 PM, in resident's room, LVN 3 checked the O2 concentrator and confirmed the flowmeter showed Resident 29 was receiving O2 at 3 LPM via NC per concentrator. LVN 3 immediately lowered Resident 29's O2 at 2 LPM and stated, it (O2) should be at 2 LPM. Review of Resident 29's care plan for oxygen initiated on 4/14/24 and revised 6/11/24, indicated, Resident requires the use of oxygen continuous related to acute respiratory failure, COPD . Intervention: Administer oxygen at 2L via NC . Educate the resident on the importance of keeping oxygen on and at the prescribed setting . 3. Review of Resident 16's admission record, indicated, was admitted on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following a stroke affecting right dominant side, aphasia (a language disorder that affects a person's ability to communicate), and vascular dementia (a brain damage caused by multiple strokes). During an observation on 6/12/24 at 9:53 AM, in resident's room, a sit-to-stand lift/standing lift (specialized medical devices designed to assist individuals with limited mobility in transitioning from a seated to a standing position) and a blue colored sling was observed by the foot of the bed. The RNA assisted Resident 16 to sit on the edge of the bed, put on the blue sling, moved the sit-to-stand lift close to the bed and wheelchair. The RNA then began to transfer Resident 16 from bed to wheelchair by herself. During an interview on 6/12/24 at 10:02 AM, the RNA stated, Resident 16 required two persons assist with transfer, two person assist but since I'm used to him I can do it by myself. The RNA further stated, This one (standing lift) I can do it myself. I'm familiar with him. I know if it's safe or not. During an interview on 6/13/24 at 12:26 PM, Certified Nursing Assistant (CNA) 1 stated, Resident 16 required two persons assist with transfer from bed to wheelchair but with the use of the standing lift, Resident 16 required one person only since resident is able to help by grabbing on to the bar of standing lift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 16's care plan for use of standing lift, initiated on 1/20/21, indicated, Resident is on standing lift. Risk for falls/skin breakdown . Interventions: Assess equipment (sling) before use. 2 person assist with transfer. Gentle handling during transfer .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49264 Based on interview and record review, the facility failed to update a care plan after an interdisciplinary team (IDT) assessment when one of twelve sampled residents (Resident 41) with care plans had a body weight that was beyond the recommendation from their care plan. This failure has the potential to result in the clinical staff not recognizing significant changes in weight due to a difference in care planned goals versus those decided by an interdisciplinary team. Findings: During a concurrent interview and record review on 06/13/24 at 9:48 AM with the Director of Nursing (DON), Resident 41's care plan for nutrition, initiated on 05/14/24, was reviewed. The care plan indicated a focus of Nutritional Risk: Resident has the potential for altered nutrition and/or hydration status related to medical diagnosis . The DON reviewed the care plan and stated that Resident 41's goal was to maintain a body weight within 5% of 195 pounds (lbs). During a concurrent interview and record review on 06/13/24 at 9:48 AM with the Director of Nursing (DON), Resident 41's most current body weight record, dated 06/04/24, was reviewed. The body weight record indicated that Resident 41 was 182.8 lbs on 06/04/24. The DON stated that this weight is below 5% of 195 lbs. During a concurrent interview and record review on 06/13/24 at 10:59 AM with the Consultant Registered Dietician (RD), an IDT note for Resident 41, dated 05/30/24, was reviewed. The note indicated that the IDT was due to a weight variance as Resident lost 8.6lb [pounds] . The IDT further stated, Recommend to continue with current plan-weight loss may be partially r/t [related to] dx [diagnosis of] CHF [congested hear failure, a condition in which the heart does not pump as well]. The RD stated that based on this IDT, weight loss was acceptable. During a concurrent interview and record review on 06/13/24 10:59 AM with the RD, Resident 41's care plan for nutrition, initiated on 05/14/24, was reviewed. The care plan indicated Resident 41's goal to maintain a body weight within 5% of 195 pounds (lbs). The RD verified that the IDT's interpretation of the weight loss does not coincide with the care planned weight goals stating, I should update the care plan. The RD further stated that rather than 5% variation in weight, the resident would better benefit from a goal based on body mass index (BMI, a value calculated based on a someone's height and weight) stating potentially I should use BMI instead of weights.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on observation, interview, and record review, the facility failed to ensure care and treatment provided meet professional standards when the physician's order for oxygen (O2) administration was not followed for two of 12 sampled residents (Resident 29 and Resident 3). The deficient practice had the potential to compromise the health and safety of Resident 29 and Resident 3. Findings: 1. Review of Resident 3's admission record indicated, was readmitted on [DATE] with diagnoses including stroke, respiratory failure, pulmonary fibrosis (a disease where there is scarring of the lungs which makes it difficult to breathe), and lung involvement in systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs). Review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 5/14/24, indicated, problem with memory and cognitive (thought process) skills for daily decision making. During an observation on 6/11/24 at 11:58 AM, in resident's room, Resident 3 was sitting on the edge of the bed wearing an ill-fitting non-rebreather mask on top of the nasal cannula (NC, a device that delivers extra oxygen through a tube and into the nose). During a concurrent observation and interview on 6/11/24 at 12:02 PM, in resident's room, Licensed Vocational Nurse (LVN) 1 stated, Resident 3 is nebulizer treatment (help control breathing problems like wheezing and help loosen lung secretions) for shortness of breath (SOB) as needed (PRN) via a non-rebreather mask which runs for 30 minutes. During concurrent observation, LVN 1 checked on the O2 concentrator (a device that help you breathe) and stated Resident 3 is on 2 LPM (liters per minute) continuous via NC per concentrator. Review of Resident 3's active order dated 5/10/24, indicated, O2 @ 5 LPM via nasal cannula continuous per concentrator/tank. Can be titrated up to 5 LPM as needed to keep O2 > 90% every shift. Review of Resident 3's care plan for oxygen initiated and revised on 5/6/24, indicated, Resident requires the use of oxygen continuous related to acute respiratory failure, dyspnea (difficulty of breathing) . Intervention: Administer oxygen at 3-5 L via nasal cannula per concentrator/tank . Educate the resident on the importance of keeping oxygen on and at the prescribed setting . 2. Review of Resident 29's admission record indicated, was admitted to facility on 4/14/24 with diagnoses including heart failure, pneumonia (inflammation and fluid in your lungs caused by a bacterial, viral or fungal infection), respiratory failure, and chronic obstructive pulmonary disease (COPD - lung disease that cause airflow blockage and breathing related problems). Review of Resident 29's MDS dated [DATE], indicated, moderate cognitive impairment. The MDS Section O: Special Treatments and Programs indicated; Resident 29 was on continuous oxygen therapy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/12/24 at 9:48 AM, in resident's room, Resident 29 was sleeping in bed with O2 via NC attached to an oxygen concentrator. During further observation, the flowmeter and dial on the oxygen concentrator showed Resident 29's O2 was on 3 LPM. During concurrent interview and record review on 6/12/24 at 12:29 PM, LVN 3 reviewed Resident 29's active orders and stated, Resident 29 has an order on 4/14/24 for O2 administration at 2 LPM via NC continuously per concentrator for SOB. Resident 29's active orders dated 4/14/24, indicated, O2 @2LPM via nasal cannula continuous per concentrator/tank every shift for SOB. The active orders also indicated, O2 @2LPM via nasal cannula PRN (as needed) per concentrator every 8 hours as needed. Administer Oxygen if O2 saturation is less than 92% or there is shortness of breath (SOB). During concurrent observation and interview on 6/12/24 at 12:32 PM, in resident's room, LVN 3 checked the O2 concentrator and confirmed the flowmeter showed Resident 29 was receiving O2 at 3 LPM via NC per concentrator. LVN 3 immediately lowered Resident 29's O2 at 2 LPM and stated, it (O2) should be at 2 LPM. Review of Resident 29's care plan for oxygen initiated on 4/14/24 and revised 6/11/24, indicated, Resident requires the use of oxygen continuous related to acute respiratory failure, COPD . Intervention: Administer oxygen at 2L via NC . Educate the resident on the importance of keeping oxygen on and at the prescribed setting . Review of facility's undated policy and procedure titled, Oxygen Administration, indicated, .Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders for facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident . Procedure . 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered .

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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 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** 41545 Based on observation, interview, and record review, the facility failed to provide adequate supervision and safe transfer technique for one of 12 sampled residents (Resident 16) when: a. The Restorative Nursing Assistant (RNA) transferred Resident 16 from bed to wheelchair using a sit-to-stand lift (or standing lift) by herself when the care plan indicated two persons. b. The mesh and/or material of the standing sling used for Resident 16 were frayed and torn and one of the belts had a missing buckle. Failure to provide adequate supervision and safe transfer technique may result in an accident and can increase the risk for fall and/or injury. Findings: Review of Resident 16's admission record, indicated, was admitted on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following a stroke affecting right dominant side, aphasia (a language disorder that affects a person's ability to communicate), and vascular dementia (a brain damage caused by multiple strokes). Review of Resident 16's Minimum Data Set (MDS, a resident assessment tool) dated 4/9/24, indicated, moderate cognitive (thought process) impairment. Under the functional abilities section indicated, Resident 16 was dependent and required two or more helpers (persons) with chair/bed-to-chair transfer. During an observation on 6/12/24 at 9:53 AM, in resident's room, a sit-to-stand lift/standing lift (specialized medical devices designed to assist individuals with limited mobility in transitioning from a seated to a standing position) and a blue colored sling was observed by the foot of the bed. The RNA assisted Resident 16 to sit on the edge of the bed, put on the blue sling, moved the sit-to-stand lift close to the bed and wheelchair. The RNA then began to transfer Resident 16 from bed to wheelchair by herself. During an interview on 6/12/24 at 10:02 AM, the RNA stated, Resident 16 required two persons assist with transfer, two person assist but since I'm used to him I can do it by myself. The RNA further stated, This one (standing lift) I can do it myself. I'm familiar with him. I know if it's safe or not. During further interview, the RNA stated there were two slings used for the standing lift but stated she prefer the sling she used for Resident 16 because this sling (blue) is easy to put. During concurrent observation, the RNA showed the sling she used for Resident 16, the mesh/material of the sling were frayed and torn and one of the belts had a missing buckle. The RNA stated, There should be two locks (buckle) and there's only one. I need to request a new one. Missing one lock. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 4:14 PM, the Director of Maintenance (DM) stated, the staff are not supposed to use an equipment or device if there's a broken or missing part. During an interview on 6/13/24 at 12:26 PM, Certified Nursing Assistant (CNA) 1 stated, Resident 16 required two persons assist with transfer from bed to wheelchair but with the use of the standing lift, Resident 16 required one person only since resident is able to help by grabbing on to the bar of standing lift. Review of Resident 16's care plan for use of standing lift, initiated on 1/20/21, indicated, Resident is on standing lift. Risk for falls/skin breakdown . Interventions: Assess equipment (sling) before use. 2 person assist with transfer. Gentle handling during transfer . During an interview on 6/13/24 at 3:44 PM, the Assistant Director of Nursing (ADON) stated, mechanical lift requires two persons but not sure with standing lift. The ADON further stated, there was no recent training for staff on the use of mechanical lift. During an interview on 6/14/24 at 11:52 AM, the Director of Staff Development (DSD) stated, there was no recent training for staff on transfers, It's been a while. During an interview on 6/14/24 at 1:05 PM, the Director of Rehab (DOR) stated, rehab staff do not provide transfer training for long term residents since the CNAs know already how to transfer the long term residents. Review of facility's undated policy and procedure titled, Lifting Machine, Using a Mechanical, indicated, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device . 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 2. Mechanical lifts may be used for tasks that require: . b. Transferring a resident from bed to chair . 3. Types of lifts that may be available in the facility are: . c. Sit-to-stand lifts . Steps . 2. Measure the resident for proper sling size and purpose, according to manufacturer's instructions. 3. Select a sling bar that is appropriate for the resident's size and task .8. Make sure that all necessary equipment (slings, hooks, chains, straps and support) is on hand and in good condition . Sling Care . 3. Discard any worn, frayed, or ripped slings . Document the following in the medical record: . 4. The names of and titles of staff assisting. Review of the user manual for Stand Up Patient Lift, revised 12/2013, indicated, .Using the Sling . Stand Assist Slings: The belt MUST be snug, but comfortable on the patient, otherwise the patient can slide out of the sling during transfer, possibly causing injury . Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately. DO NOT alter slings . Review of the Invacare Patient Sling Reference Guide, revised 04/2007, indicated, .Inspect sling before each use for wear, tears and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately. Do not alter slings. Use only on Invacare lifts .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 26917 Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate below five percent (5%). During the medication pass on 6/11/24, three medication errors were observed out of twenty-six opportunities for two out of four residents, resulting in an error rate of 11%. This failure had the potential to result in more than minimal harm in the health and safety of residents. Findings: A review on 6/11/24 of the facility's policy, titled Administering Medications, indicates that the individual administering medication must verify the resident's identity prior to dispensing medication. Accepted methods of identification include checking photo identification via the medical record, and, if necessary, seeking verification of resident identification from other facility personnel. During an observation on 06/11/24 at 9:36 AM Registered Nurse 1 was observed preparing medications for Resident 10. The nurse attempted to identify Resident 10 by asking for her name; however, Resident 10 did not speak English. RN 1 did not speak Resident 10's language. RN 1 then proceeded to administer medications without seeking further verification of the resident's identity. During an interview with RN 1 on 06/11/24 at 10:15 AM, RN 1 stated that she did not identify the patient by photograph because no picture had been taken of RN 1. She further explained that when she attempted to communicate with the resident, the resident was unable to speak English, which prevented her from verifying the resident's identity before administering medications. A review of the manufacturer's instructions for MiraLAX indicates that the medication should be administered with 4 to 6 ounces of fluid and taken immediately after mixing. Waiting too long before consuming the mixture can cause it to thicken, potentially leading to choking. It is crucial to follow the recommended dosage and administration guidelines provided by the manufacturer to ensure safety and efficacy. During an observation on 06/11/24 at 9:36 AM, Registered Nurse 1 administered MiraLAX mixed with 4 ounces of fluid to Resident 10. The resident consumed approximately half of the mixture and then left the remaining portion on the bedside table. It was visually apparent that some solute had settled at the bottom of the glass, indicating the presence of the medication. The remaining medication was not consumed during the entire medication pass, and after the medication pass ended the medication was left at bedside. During an interview conducted at 10:20 AM on 06/11/24, Registered Nurse 1 stated that she had not observed Resident 10 consume the entire glass of MiraLAX. She acknowledged that, at the end of the medication pass, approximately half a glass of the mixture was left at the resident's bedside. The nurse further admitted that in the future, she would ensure that the entire dose is consumed or remove any remaining medication at the end of the medication pass. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Flonase package insert, prior to administration, patients should blow their nose. The proper technique involves holding one nostril closed while inserting the medication into the other nostril. Patients should then inhale deeply through their nose and exhale through their mouth to ensure optimal delivery and absorption of the medication. Adhering to these instructions can help maximize the effectiveness of the treatment and minimize potential side effects. During an observation at 9:49 AM, Licensed Vocational Nurse 1 administered Flonase to Resident 36. However, the resident did not blow their nose before administration, and their nostrils were not closed alternately during the process. Instead, both nostrils remained open while each received one spray, with the resident breathing through their nose. This observation indicates that the administration did not fully adhere to the recommended guidelines for optimal Flonase administration. During an interview conducted on 06/11/24 at 10:10 AM, Licensed Vocational Nurse 1 acknowledged that he did not instruct Resident 36 to blow their nose before administering Flonase. He also admitted that he had not directed the resident to close one nostril while inhaling the medication through the other, nor did he advise the resident to exhale through their mouth following administration. LVN 1 acknowledged his oversight and expressed a commitment to improving his practice in the future.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43913 Based on observation, interview and record review, the facility did not ensure safe food handling practices when jewelries were worn during food handling, when two kitchen staff observed wearing yellow bracelets on both arms during food preparation and handling. This failure can result in food contamination, when it touches food products. Findings: During the initial tour of the kitchen, on 6/11/24, at 9:30 AM, observed CDM(Certified Dietary Manager), with yellow bracelets in both arms and kitchen [NAME] wearing yellow bracelets in both arms while preparing food for lunch. During an interview on 6/11/24 at 11 AM, with CDM, and Cook, CDM stated, I know, we took them out now. We Indians feel bare if we don't have anything on our arms. Sorry, but its out now. Per Cook, it's a sign that you're married for Indians, but I took it out. Review of facility Policy and Procedure, Food Prepararion and Service, dated, 11/22, indicated, under Food and Distribution and Service, 9.Food and nutrition service staff keep fingernails trimmed and clean. Jewelry is worn minimally and hand jewelry (i.e) wedding ring is covered with gloves.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 26917 Based on observation, interview, and document reviews it was found that the facilities' Quality Assessment Performance Improvement (QAPI) program was ineffective. Despite its purpose to proactively identify and prevent medication administration errors, it fell short. This was evident during a medication pass observation conducted during the survey, which revealed a concerning 11% medication error rate (See F759). Findings Based on observation, interview and document reviews (See deficiency under F759) the facility was found to have a medication error rate of 11% during a medication pass on 06/11/24 between the times of 9:00 AM and 10:45 AM, which exceeds the acceptable threshold of 5%. This rate was derived from observing three errors out of twenty-six medication administration opportunities involving two of four residents. Such a high error rate poses a risk to the residents' health and safety. The first error involved a failure to properly identify Resident 10 before administering medication. Registered Nurse 1 attempted to verify the resident's identity by asking for her name, but the resident did not speak English, and the nurse did not seek further verification. Consequently, the medication was administered without confirming the resident's identity, contrary to the facility's policy requiring photo identification or verification from other staff. The second error pertained to the administration of MiraLAX to the same resident by the same nurse. Although MiraLAX should be consumed immediately after mixing with 4 to 6 ounces of fluid, the resident only drank half and left the rest on the bedside table, where the medication settled and was not fully consumed. The nurse admitted she had not ensured the entire dose was taken or removed the leftover medication. The third error involved the improper administration of Flonase to Resident 36. Licensed Vocational Nurse 1 did not follow the correct procedure, which includes the patient blowing their nose beforehand and closing one nostril while inhaling the spray into the other. Instead, the resident inhaled the medication with both nostrils open and without the proper breathing technique. The nurse acknowledged these mistakes and expressed a commitment to adhere to proper procedures in the future. During an interview on 6/11/24 at 3:30 PM an interview was conducted with four members of the Quality Committee: the Director of Staff Development, the Assistant Director of Nursing, the Director of Nursing and the Administrator. During the interview, it was discovered that the quality committee members had attended only a single meeting within the past year. Additionally, the interviewed members could not recall any specific discussions or topics pertaining to medication errors that took place during that meeting. During this interview, it was also noted that they had not identified any recent issues related to medication pass observations. Furthermore, they did not have a sufficient ongoing performance improvement project specifically aimed at addressing medication errors that showed a measurable improvement in reducing medication errors. The Quality Committee members acknowledged the need for improvements in the medication administration process. They expressed concern over the survey results, which indicated a medication error rate of 11%.

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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** 49264 Based on observation, interview, and record review, the facility failed to implement and maintain its infection control program for two of two sampled residents (Resident 32 and Resident 34) on transmission-based precautions (specific protections used when a someone has an infection that could be spread easily) when: 1. Resident 32 did not have personal protective equipment (PPE, equipment used to minimize exposure to a hazard) directly outside of the room. 2. Licensed Vocational Nurse (LVN) 1 did not wear full PPE when handling the urine collection bag (Foley bag) of Resident 34, who's on enhanced barrier precautions (EBP- refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Additionally, the PPE cart for Resident 34, was placed next to his roommate and not in his care area. Failure to implement infection prevention practices has the potential to result in increased spread of a communicable disease or infectious bacteria to staff and other residents. Findings: 1. A review of Resident 32's face sheet (summary of resident's demographic and admitting information), dated 06/14/2024, indicated that Resident 32 was admitted in May of 2024 with multiple diagnoses including INFECTION OF AMPUTATION STUMP [the leg after surgical removal of a section of it], RIGHT LOWER EXTREMITY A review of Resident 32's care plan, dated 05/13/24, indicated a focus of Resident requires contact single room isolation precautions [use of gloves and gown to decrease risk of infection transmission due to touch] due to klebsiella (infectious bacteria) and MRSA (Methicillin-resistant staphylococcus aureus, infectious bacteria that are resistant to a group of antibiotics) infection . The care plan further indicated interventions including use of personal protective equipment as recommended for type of infection. A review of the facility policy and procedure, titled Isolation - Transmission-Based Precautions & Enhanced Barrier Precautions, last revised April 2024, indicated that for residents under contact precautions, Staff and visitors wear gloves (clean, non-sterile) when entering the room Staff and visitors wear a disposable gown upon entering the room. During an observation on 06/11/24 at 10:15 AM, there was no available PPE outside of Resident 32's room. During an observation on 06/11/24 at 12:12 PM, there was no available PPE outside of Resident 32's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 06/11/24 at 12:14 PM with Licensed Vocational Nurse (LVN) 1 outside of Resident 32's room, there was not PPE outside of Resident 32's room. LVN 1 stated that he is expected to wear a gown, gloves, and mask before entering the resident's room. LVN 1 further stated that normally there should be PPE available outside of the resident's room in a cart. When asked where the PPE cart is for the resident, LVN 1 stated I have no idea . I guess they took them out. During a concurrent observation and interview on 06/11/24 at 12:19 PM with LVN 2 outside of Resident 32's room, there was not PPE outside of Resident 32's room. LVN 2 stated that PPE should be used prior to going into the room. When asked where the PPE is for Resident 32, LVN 2 stated, they removed it. During an interview on 06/14/24 at 11:52 AM with the Infection Preventionist (IP), the IP stated that she expects for PPE to be available directly outside of a resident's room that is on contact precautions. The IP further stated that if there is no PPE outside of the room, there is a concern that people are entering without PPE. The IP stated that this could increase the risk for spread of an infection or bacteria to staff or residents. 41545 2. Review of Resident 34's admission record indicated, was admitted on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following a stroke affecting left non-dominant side, aspergillosis (an infection caused by a type of mold [fungus]), encephalopathy (a group of conditions that cause brain dysfunction), and respiratory failure. During an observation on 6/11/24 at 12:07 PM, in resident's room, there was a small green star sticker next to Resident 34's name by the door and an uncovered Foley bag hanging on the side of the bed. A PPE cart was also observed next to Resident 34's roommate's foot of the bed and by the bathroom door. During an interview on 6/11/24 at 12:14 PM, LVN 1 stated, the green star next to Resident 34's name means on enhanced barrier precautions because of his Foley catheter. LVN 1 also stated that gown, gloves, and mask were required when providing care to residents on EBP. During concurrent observation, LVN 1 pointed at the PPE cart and stated, the PPE cart belongs to Resident 34 and should be inside the room by the resident's care area. During an observation on 6/11/24 at 2:29 PM, in resident's room, Resident 34's Foley bag did not have a label and a cover (dignity bag). During concurrent observation and interview on 6/11/24 at 2:31 PM, in resident's room, LVN 1 touched Resident 34's Foley bag with no PPE (gowns, gloves, mask) worn. LVN 1 stated the Foley bag should be inside a dignity bag for resident's privacy. During an interview on 6/13/24 at 5:03 PM, the Infection Preventionist (IP) stated that for EBP, gown, gloves and mask are required during direct contact with the resident including touching a Foley bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 34's care plan dated 5/28/24, indicated, .Resident requires enhanced barrier precautions during high-contact resident care activities due to the presence of: Indwelling device: Foley Catheter not known to be infected or colonized with any MDRO (multidrug resistant organism) . Interventions . Ensure items for following EBP are in place (gloves, gown, alcohol-based hand rub, face-shield, signage, trash receptacle .) . Utilize PPE (gown and gloves; face-shield as indicated) during high contact resident care activities (.device care, wound care). According to the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group letter with a subject of Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated, .EBP recommendations now include use of EBP for residents' with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status . According to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated, Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs356. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: . Device care or use: central line, urinary catheter . Review of facility's policy and procedure titled, Isolation - Transmission-Based Precautions & Enhanced Barrier Precautions, revised April 2024, indicated, .Enhanced Barrier Precautions are indicated for residents with any of the following: . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. 1. Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of staff hands, clothes, and the environment such as: .b. Device care, for example, urinary catheter . 3.PPE supplies such as gowns and gloves may be placed near or outside the resident's room .

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on observation, interview, and record review, the facility failed to provide a sufficient space to accommodate group activities and communal dining for 43 residents. This failure resulted in limiting residents to participate in group activities and communal dining; caused inconvenience to residents whose rooms were in the hallway where the activities are conducted; and placed residents at risk for feelings of being isolated or depressed. Findings: The facility is licensed for 45 beds and the resident census on 6/11/24 was 43. During an observation on 6/11/24 at 9:29 AM, in the hallway between room [ROOM NUMBER] and 5, four residents were sitting on their wheelchair with one staff in front of them playing music on an iPad (a brand of a tablet computer). During an interview on 6/11/24 at 9:48 AM, Resident 32 mentioned about the noise outside his room especially when they play music or karaoke in the hallway. Resident 32 stated, a man comes every Wednesday to sing karaoke together with the residents in the hallway outside his room. Resident 32 further stated, he would close his door whenever the noise from the activities outside his room became loud. During an interview on 6/11/24 at 12:17 PM, the Activities Assistant (AA) stated, there is no designated activity room that is why group activities are conducted in the hallway. During an observation on 6/11/24 at 12:18 PM, in the hallway, Today's Activities June 11th 2024 Tuesday was posted on the wall between room [ROOM NUMBER] and 7 indicating, 9:30 daily news, 10:00 music/coffee social, 10:30 movement exercise/balloon toss, 11:30 table games, 2:00 ball toss, 2:30 word finds/puzzles. During an interview on 6/11/24 at 12:19 PM, the Activities Director (AD) stated, group activities are conducted in the hallway since there is no designated activity or dining room. The AD also stated the number of residents joining depends how many are up. The AD further stated residents in the room close to the hallway where the activities are conducted do not like the noise and would close the door to minimize the noise. During concurrent observation, two tables were in the hallway right outside a resident's room who was on transmission based precautions (are used in addition to standard precautions when the route of transmission is not completely interrupted). The AD stated the two tables were set up in the hallway for the board games. During an observation on 6/12/24 at 11:06 AM, on the patio outside the rehab room, six residents were on their wheelchairs listening and watching [person's name] sing and dance for them. During dining observation on 6/12/24 at 12:15 PM, residents were eating their meals (lunch) inside their rooms. (continued on next page)

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During concurrent observation and interview on 6/12/24 at 12:16 PM, in resident's room, Resident 20 was sitting on a wheelchair at his bedside eating his meal. During concurrent interview, Resident 20 stated that he prefers to eat sitting up on a chair rather than in bed, would be nice to have a dining room. Resident 20 also stated he participates in the activities conducted in the hallway, plays bingo three times a week. Resident 20 further stated, It would be nice to have a room than the hallway. During an interview on 6/14/24 at 1:39 PM, the Administrator (ADM) stated, the designated spot for activity/dining were the therapy (rehab) room, the hallway, or outside on the patio when weather permits. Review of facility's policy and procedure titled, Activity Programs, revised August 2006, indicated, .9. Adequate space and equipment are provided to ensure that needed services identified in the resident's plan of care are met. 43913 During an interview on 6/11/24 at 9:30 AM, with Certified Dietary Manager (CDM), per CDM all meals are served in the patient's rooms. There is no one who eats in the dining room, there is no dining room. Since pandemic, everyone eats in their own room. They did not open that room for dining , its now a rehab room. During an interview on 6/14/24 at 10:43 AM, with Administrator, per Administrator it's patient's preference, they prefer to eat in the room or in the hallway. We have a dining room set up in the patio offered to patients, but nobody wants to go. There are tables and chairs in the rehab room that we can set up for small group if they want to.