STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER: Stanford Court Skilled Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8778 Cuyamaca Street, Santee, CA 92071	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure one of three residents reviewed for dignity was provided care in a manner that promoted dignity and respect when resident was instructed to urinate (to excrete urine) on the diaper (Resident 178). As a result, the residents' self-esteem and self-worth was devalued. Findings: Resident 178 was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care according to the facility's Admission Record. During an observation and interview on 7/30/24, at 8:57 A.M., Resident 178 was in bed and stated the morning staff told her to, Go ahead and pee on the diaper and I'll change you. During another interview with Resident 178 on 8/1/24, at 9:32 A.M., Resident 178 stated she felt, Terrible when she was told to urinate in the diaper. Resident 178 further stated she did not know if the person was a certified nurse assistant (CNA) or a licensed nurse (LN). An interview was conducted on 8/1/24, at 9:43 A.M. with CNA 11. CNA 11 stated Resident 178 used the bedpan and was continent with urination. CNA 11 further stated a bedpan was offered to residents who were not able to walk. An interview was conducted on 8/1/24, at 2:18 P.M. with CNA 12. CNA 12 stated if a resident requested to go to the bathroom, the resident will be assisted right away. CNA 12 further stated if the resident had a wet diaper, this would create skin irritation, redness and smell. During an interview on 8/2/24, at 12:59 P.M. with the Director of Nurses (DON), the DON stated residents should not be told to urinate in the diaper. The DON stated residents were admitted to the facility for rehabilitation and to restore previous activity of daily living (ADL- basic tasks of everyday life). The DON further stated it was demeaning for a resident to be told to urinate on the diaper. (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: 555290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an undated care plan for Resident 178 indicated, ADL Self-Care Performance Deficit. At risk for altered ADL self care performance r/t (related to) requires assist .toileting .Provide appropriate self performance and support needed during ADL care . During a review of the facility's policy and procedure titled Dignity, dated June 16, 2016, the policy indicated, . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .{Treated with dignity} means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .

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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 - Minimal harm or potential for actual harm

Residents Affected - Few

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 43518

Based on observation, interview, and record review the facility failed to ensure a homelike environment was provided for three out of 23 (14, 22,24) sampled residents, when resident's walls were not repaired after damaged by residents' beds.

This deficient practice created an environment that was not homelike for three residents.

Findings:

Review of Resident 14's Admission Record indicated she was admitted to the facility on [DATE].

Review of Resident 14's Minimum Data Set (MDS, a nursing assessment used in nursing homes) section C, Cognitive Patterns dated 7/3/24 indicated Resident 14 with a Brief Interview for Mental Status (BIMs, a test to determine cognitive levels in residents) score of 10, which indicates moderately impaired cognition.

Review of Resident 22's Admission Record indicated he was admitted to the facility on [DATE].

Review of Resident 22's MDS section C, Cognitive Patterns dated 6/26/24 indicated Resident 14 with a BIMs score of 13, which indicates intact cognition.

Review of Resident 24's Admission Record indicated he was admitted to the facility on [DATE].

Review of Resident 24's MDS section C, Cognitive Patterns dated 6/30/24 indicated Resident 14 with a BIMs score of 13, which indicates intact cognition.

On 7/30/24 at 9:40 A.M., an observation of room [ROOM NUMBER]-A and interview with Resident 24 was conducted. Approximately 1.5-2 feet of wall behind Resident 24's bed was observed in disrepair. Paint and drywall observed scraped and peeling in spots directly behind Resident's 24's headboard. Resident 24 stated that maintenance had never come to assess the damage on the wall.

On 7/30/24 at 11:10 A.M., an observation of room [ROOM NUMBER]-C and interview with Resident 22 was conducted. Approximately 1.5-2 feet of wall behind Resident 22's bed was observed in disrepair. Paint and drywall observed scraped and peeling in spots directly behind Resident's 22's headboard. Resident 22 stated that maintenance had never come to assess the damage on the wall.

On 7/31/24 at 11:45 A.M., an observation of room [ROOM NUMBER]-C and interview with Resident 22 was conducted. The wall behind Resident 22's headboard was observed to be covered by a plastic board. Resident 22 stated that maintenance had come and covered the damage with the board but did not repair the wall.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 11:55 A.M., an observation of room [ROOM NUMBER]-A and interview with Resident 24 was conducted. Approximately 1.5-2 feet wall behind Resident 24's bed remained in disrepair. Paint and drywall remained scraped and peeling in spots directly behind Resident's 24's headboard. Resident 24 stated that maintenance still had not come to assess the damage on the wall. On 8/1/24 at 9:15 A.M., an observation of room [ROOM NUMBER]-A and interview with Resident 14 was conducted. Wall behind Resident 14's bed was observed in disrepair. Approximately 1.5-2 feet wall behind Resident 14's bed was observed in disrepair. Multiple vertical scrapes and scratches on paint on wall in spots directly behind Resident's 14's headboard. Resident 14 stated that maintenance had never come to assess the damage on the wall. On 8/1/24 at 9:38 A.M., an observation of room [ROOM NUMBER]-C was conducted. The wall remained covered by plastic board and not repaired. On 8/1/24 at 9:40 A.M., an observation of room [ROOM NUMBER]-A was conducted. The wall remained in disrepair. On 8/1/24 at 9:47 A.M., a concurrent observation of room [ROOM NUMBER]-C and room [ROOM NUMBER]-A and interview with CNA 31 was conducted. CNA 31 stated that he was not aware of the disrepair. CNA 31 stated the process for requesting repair from maintenance was to fill out maintenance repair slip in the book at nurse's station. CNA 31 stated that he would call maintenance directly if not repaired in a timely manner. CNA 31 stated that the expectation is that the residents' rooms should be in the best condition for the health of the resident, and that they should have a homelike environment while staying at the facility. On 8/1/24 at 9:55 A.M., a concurrent observation of room [ROOM NUMBER]-C and room [ROOM NUMBER]-A and interview with LN 18 was conducted. LN 18 stated that she was not aware of the disrepair. LN 18 stated that she would call maintenance directly about the repair, and they would fill out the request sheet. LN 18 stated that maintenance checked the repair binder every day. LN 18 stated that the expectation is that the residents' rooms should be homelike while staying at the facility. On 8/1/24 at 10 A.M., a concurrent observation of room [ROOM NUMBER]-A, 112-C, and room [ROOM NUMBER]-A and interview with the Environmental Service Director (ESD) was conducted. The ESD stated that he was not aware of the disrepair. The ESD stated that the mechanical beds scraped the wall when they were too close and that he started putting up plastic protection sheets on some walls to prevent scraping. ESD stated he may need to put the plastic sheets higher. The ESD stated that plastic was put on RM 112-C's wall to protect resident from any dust or particles. The ESD stated he would have to move this resident out of the room to repair the wall completely. The ESD stated for room [ROOM NUMBER]-A, the bed was scraping the wall and he would need to do same repair as 112-C. The ESD stated that the process for receiving maintenance requests is as follows: Staff fills out a maintenance request sheet and then the maintenance workers check the maintenance binder every day in AM and PM for new requests and take verbal requests from staff. The ESD stated that he did monthly rounds on the rooms for repair. The ESD stated the expectation was the rooms should be in good condition for resident and should be homelike. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/24 at 9 A.M. a concurrent interview with the Director of Nursing (DON) and observation of pictures of damaged walls for room [ROOM NUMBER]-A, 112-C, and 103-A was conducted. DON stated that the disrepair of residents' walls was not homelike. DON stated that the expectation would be that if a damage was done to the wall, communication with maintenance about repair would be done as soon as possible. The DON stated the importance of maintaining a homelike quality for residents' rooms was to support the residents' daily living. Review of facility policy and procedure entitled Homelike Environment dated 2/2021 indicated .2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: .a. clean, sanitary, and orderly environment .

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review, the facility failed to re-evaluate one of three residents (Resident 23) reviewed for Pre-Admission Screening and Resident Review (PASARR- a federal requirement to prevent individuals with mental illness [MI], developmental disability [DD], intellectual disability [ID], or related conditions from being inappropriately placed in nursing homes for long term care). This failure had the potential for Resident 23 to not receive necessary mental health care services in an appropriate healthcare setting. Findings: Resident 23 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental health disorder with combination of hallucinations or delusions and mood disorder symptoms, such as depression or mania) according to the facility's Admission Record. An interview and joint record review was conducted on 8/1/24, at 2:30 P.M. with the case manager (CM). The CM stated the PASARR Level I was completed at the hospital prior to admission to the facility. The CM stated the admissions staff notified her if a resident was negative or positive for PASSAR Level I (a nursing facility preadmission evaluation to ensure that their residence is appropriate and to identify what specialized services they may need). The CM stated a resident review was completed within 30 days for new residents to determine if a PASARR Level II (an evaluation to confirm an individual's MI or DD and requirement for specialized services) was needed. The CM showed a calendar of PASARR resident reviews for residents. Resident 23 was not on the calendar for the month of July 2024. The CM stated a PASARR Level I resident review should have been completed at the facility because Resident 23 had a diagnosis of schizophrenia and was taking an antipsychotic medication. During an interview with the Director of Nurses (DON) on 8/2/24, at 12:59 P.M., the DON stated Resident 23's PASARR should have been re-evaluated. The DON further stated she expected the case manager to review PASARRs from the hospital for residents to receive proper care and to coordinate a different placement if needed. A review of the facility's undated policy and procedure (P&P) titled, Preadmission Screening Resident Review (PASRR) was reviewed. The P&P indicated, .If a recipient is found to be mentally ill or mentally retarded, the screening helps determine whether NF (nursing facility) care is appropriate or whether the recipient needs specialized services .

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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 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 48263

Based on observation, interview and record review, the facility failed to provide services which met professional standards of practice for one of 23 sampled residents (Resident 47) when:

1. Resident 47 was using a left-hand splint (a device to help immobilize and prevent contractures) without a Medical Doctor's (MD) order.

2. Resident 47 did not have an MD order for triamcinolone ointment (a prescribed skin cream to treat skin associated irritation such as rash) and left open at Resident 47's nightstand table.

Cross Reference F761 and F813

This failure had the potential for Resident 47 to suffer complications for an unmonitored left hand splint and potential for anaphylactic (life threatening allergy) reactions from triamcinolone side effects.

Findings:

1. Review of Resident 47's clinical record indicated Resident 47 was readmitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting left non-dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body).

A record review of Resident 47's minimum data set (MDS: a nursing assessment tool) dated 7/11/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's mental status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 47 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits.

A record review on 7/31/24 at 8:29 A.M., on Resident 47's care plan was conducted. Resident 47's care plan initiated on 4/17/22 indicated resident 47 was on, RNA (restorative nursing assistant: a program performed by a rehab nursing staff) 3x/week (three times per week) for RUE (right upper extremities [arms/hands]), PROM (passive range of motion) and RNA 3x/wk for LE (lower extremities) PROM. There was no MD order for splint use or monitoring.

On 7/31/24 at 10:13 A.M., an observation and interview was conducted with Resident 47, in Resident 47's room. Resident 47 was lying in bed with his left hand on a hand splint. Resident 47 stated that the nursing staff would put the splint on him, Once in a while. Resident 47 demonstrated being able to lift and move his right side extremities in and out, up and down motion and then stated, I can only move my right side and paralyzed on the left side. Resident 47 required help with staff for most of his care needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 9:46 A.M., an observation and interview was conducted with Resident 47, in Resident 47's room. Resident 47 stated that the nursing staff (an RNA) had put his left-hand splint on him yesterday and took it off after 2 hours. Resident 47 was observed with the left hand splint on during the interview. On 8/1/24 at 2:12 P.M., an interview and record review was conducted with RNA 1. RNA 1 stated she was the RNA that applied Resident 47's left hand splint. RNA 1 stated that she did not chart the use of Resident 47's left hand splint because Resident 47 did not have MD orders and therefore was not able to indicate the times Resident 47's hand splints were on including the duration. RNA 1 stated that any splints would require a MD orders and that it was not in her scope of practice to evaluate and get an order. On 8/1/24 at 2:57 P.M., an interview and record review was conducted with the Director of Staff development (DSD). The DSD stated that all splints need MD orders. The DSD stated that it was important to have an MD order for splint use, To prevent any error such as monitoring safety to prevent further complications from immobilization (to reduce or eliminate motion) from splint use, and to monitor for swelling, and contractures. The DSD reviewed Resident 47's clinical record and stated that Resident 47 did not have an MD order. The DSD stated that RNA 1 should not have applied a splint to Resident 47's left hand without an MD order. The DSD further stated that the proper order was for RNA 1 to inform the licensed nurse or nurse supervisor regarding the splint use, and as clinically indicated, obtain orders for rehabilitation department to evaluate for splint use and then obtain an MD order. On 8/2/24 at 9:24 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that all devices such as Resident 47's hand splint needed an MD order. A record review was conducted of the facility's policy and procedure. The facility's undated policy and procedure titled SPLINT APPLICATION indicated, .Procedure .1. A resident is referred to therapy by either the doctor or nursing to determine if a splint is needed . 2. Review of Resident 47's clinical record indicated Resident 47 was readmitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis following cerebral infarction affecting left non-dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body). A record review of Resident 47's minimum data set (MDS: a nursing assessment tool) dated 7/11/24, indicated a BIMS score of 15 out of 15 possible points which indicated Resident 47 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits. On 7/30/24 at 9:19 A.M., an observation was conducted in Resident 47's room. Resident 47's nightstand table to the left side was cluttered with personal items that included an uncapped and fully squeezed triamcinolone ointment located on the nightstand table next to Resident 47's plastic wrapped sandwich in an opened container. On 7/31/24 at 10:21 A.M., an observation and interview was conducted with Resident 47, in Resident 47's room. The triamcinolone ointment was still placed on Resident 47's left nightstand table. Resident 47 stated that the triamcinolone ointment was applied on him, but he did not know what it was for. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 9:46 A.M., an interview was conducted with Resident 47, in Resident 47's room. Resident 47 stated that the nursing staff had placed his albuterol inhaler (medication to help that relieves breathing difficulties caused by lung disease) and the triamcinolone ointment on top of the nightstand so that it was easily accessible for when Resident 47 needed it. A record review was conducted on 8/1/24 at 11:50 A.M., on Resident 47's MD orders. There was no treatment orders for Triamcinolone and/or an evaluation conducted on Resident 47 for a self-medication assessment for the use of triamcinolone. On 8/1/24 at 1:34 P.M., a concurrent interview and record review was conducted with licensed nurse (LN) 1, in the west wing nursing station. LN 1 stated that any treatments used for skin are considered medications and need MD orders. LN 1 stated that treatment creams and/or ointments (semi- solid, greasy substances used on the skin) should be stored in a safe and sanitary (clean) manner in the treatment cart. LN 1 reviewed Resident 47's clinical record and stated Resident 47 was not evaluated for self-administration for triamcinolone ointment nor was there a current MD order. LN 1 stated that Resident 47's triamcinolone cream should not have been left out in the open on top of his nightstand and should have been discarded properly since there was no treatment order for the triamcinolone ointment. LN 1 stated that it was important to have a current MD order for Resident 47 to prevent any allergic reactions. On 8/1/24 at 2:57 P.M., a concurrent interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated that triamcinolone is a prescribed treatment that needed to be ordered by an MD. The DSD stated that all LN's are responsible to make sure medications and treatments are confirmed with the MD to make sure an order is indicated or not. The DSD stated that Resident 47's triamcinolone ointment should not have been left on Resident 47's nightstand table. The DSD stated that if the ointment was ordered, it needed to be kept in the treatment cart or thrown away to avoid any cross-contamination or mistakenly used on his roommate. On 8/2/24 at 8:57 A.M., an interview was conducted with the DON. The DON stated that all treatments should be treated like medications and required MD orders. The DON stated that her expectations was for the nursing staff to discard any non-prescribed treatments appropriately and not be easily accessible for use to prevent complications such as severe skin reactions. Per the facility's policy and procedure titled PHYSICIAN MEDICATION ORDERS dated November 2017 indicated, POLICY STATEMENT Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. GUIDELINES 1. No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness.

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48263

Based on observations, interviews, and record reviews, the facility failed to provide the necessary care to maintain good grooming and personal hygiene for one of four residents (Resident 15) reviewed requiring dependent (helper does ALL the effort. Resident does none of the effort to complete the activity) assistance.

This failure resulted to Resident 15 having long, and dirty fingernails.

Cross Reference F684

Findings:

Review of Resident 15's clinical record indicated Resident 15 was readmitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting left dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body) per the facility's Admission Record.

A record review of Resident 15's minimum data set (MDS: a nursing assessment tool) dated 7/18/24 indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's mental status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 15 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits.

A record review of Resident 15's MDS dated [DATE], indicated that Resident 15's functional abilities status with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands) was dependent.

On 7/31/24 at 10:39 A.M., an observation and interview was conducted with Resident 15, in Resident 15's room. Resident 15 was seen lying in bed resting with a left-hand contracture without a hand splint. Resident 15's fingernails on both hands were long, thick, yellowish brown with brown dirt-like debris (accumulation of waste and/or dead skin) underneath her nailbeds with old chipped brownish red nail polish on the tip of the fingernails. Resident 15 stated that the staff puts on her hand splint only when they thought of doing so. Resident 15 stated she did not remember the last time they put on the hand splint or provided nail care.

On 8/1/24 at 8:53 A.M., an observation and interview was conducted with Resident 15, in Resident 15's room. Resident 15 was observed with a hand splint to her left contracted hand. Resident 15's fingernails on both hands were long, thick, yellowish brown with brown dirt-like debris underneath her nailbeds and old chipped brownish red nail polish on the tip of the fingernails. Resident 15 stated the nursing staff did not provide nail care for her.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 2:02 P.M., an interview and record review was conducted with the restorative nursing assistant (RNA: nursing staff providing rehabilitation [rehab] exercises for range of motion [ROM] as per Physician's order) 1. RNA 1 stated Resident 15's hand splints orders were for passive range of motion (PROM: exercises to help improve movement with assistance from staff to physically move the joints) and active range of motion (AROM: exercises to help movement without assistance). RNA 1 stated that Resident 15's orders included the palm guard (hand splints) to apply for four to six hours as tolerated. RNA 1 stated that it was charted that the splint was applied at 10:15 A.M., on 7/31/24 and hand hygiene for Resident 15's hands should have been done. RNA 1 stated, Her [Resident 15] fingernails are dirty, and I would not leave her like that. I would clean and clipped them for sure. On 8/1/24 at 2:25 P.M., an observation and interview was conducted with RNA 1 and Resident 15, in Resident 15's room. Resident 15 stated her left hand splint was not removed since they applied the splint after her shower from 7/31/24. Resident 15 stated, Hurting a bit when RNA 1 moved her hand to remove the splints due to the stretching. Resident 15's left hand was mildly reddened on the inside palm. Resident 15's fingernails on both hands remained long, thick, yellowish brown with brown dirt-like debris underneath her nailbeds with old chipped brownish red nail polish on the tip of the fingernails. RNA 1 stated Resident 15's left hand splint should have been removed yesterday according to the Physician's order. On 8/1/24 at 2:57 P.M., an interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated it did not look like Resident 15 was provided with sufficient nail care for both her hands because it, Should not be long and dirty. On 8/2/24 at 9:31 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that Resident 15 did not look like she was getting appropriate nail care for both hands. The DON stated Resident 15 should receive quality nail care to include trimmed and clean nails. The facility policy and procedure titled FINGERNAILS/TOENAILS, CARE OF revised, February 2018 indicated, .The purpose of this procedure are to clean the nail bed, to keep nails trimmed and to prevent infections .General Guidelines 1. Nail care includes daily cleaning and regular trimming .

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NAME OF PROVIDER OR SUPPLIER Stanford Court Skilled Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8778 Cuyamaca Street Santee, CA 92071	

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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** 48263 Based on observations, interviews, and record reviews, the facility did not ensure that a resident received needed care and services in accordance with professional standards of practice for one out of four residents reviewed requiring dependent (helper does all the effort. Resident does none of the effort to complete the activity) assistance. This failure had the potential to compromise Resident 15's health status. Cross Reference F677 Findings: Review of Resident 15's clinical record indicated Resident 15 was readmitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting left dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body). A record review of Resident 15's minimum data set (MDS- a nursing assessment tool) dated 7/18/24 indicated a, Brief Interview for Mental Status (BIMS- developed by reviewing the resident's mental status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 15 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits. A record review of Resident 15's MDS dated [DATE], indicated that Resident 15's functional abilities status with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face, and hands) was dependent. On 7/31/24 at 10:39 A.M., an observation and interview was conducted with Resident 15, in Resident 15's room. Resident 15 was seen lying in bed resting with a left-hand contracture without a hand splint. Resident 15's fingernails on both hands were long, thick, yellowish brown with brown dirt-like debris (accumulation of waste and/or dead skin) underneath her nailbeds with old chipped brownish red nail polish on the tip of the fingernails. Resident 15 stated her left hand required a splint due to the contracture (A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and was only able demonstrate opening her left hand enough to show the bottom half of her palm where the tip of her left fingernails rested. Resident 15 stated that the staff puts on her hand splint only when they think of doing so. Resident 15 stated she did not remember the last time they put on the hand splint or provided nail care. On 8/1/24 at 8:53 A.M., an observation and interview was conducted with Resident 15, in Resident 15's room. Resident 15 was observed with a hand splint to her left contracted hand. Resident 15's fingernails on both hands were unchanged from 7/31/24 observation and were still long, thick, yellowish brown with brown dirt-like debris underneath her nailbeds with old chipped brownish red nail polish on the tip of the fingernails. Resident 15 stated the nursing staff did not provide nail care for her. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 2:02 P.M., an interview and record review was conducted with restorative nursing assistant (RNA: nursing staff providing rehabilitation [rehab] exercises for range of motion [ROM] as per Physician's order) 1. RNA 1 stated Resident 15 has an order for a palm guard (hand splints) and that passive range of motion (PROM: exercises to help improve movement with assistance from staff to physically move the joints) and active range of motion (AROM: exercises to help movement without assistance). RNA 1 stated that Resident 15's orders included the palm guard was ordered for four to six hours as tolerated. RNA 1 stated Resident 15's palm guard care to include making sure the splints are not on too tight, providing hand hygiene to include nail care and checking the skin for skin breakdown before and after splint use. RNA 1 stated that it was charted that the splint was applied at 10:15 A.M., on 7/31/24 and hand hygiene for Resident 15's hands should have been done. RNA 1 stated her [Resident 15] fingernails are dirty, and I would not leave her like that. I would clean and clipped them for sure. On 8/1/24 at 2:25 P.M., an observation and interview was conducted with RNA 1 and Resident 15, in Resident 15's room. Resident 15 stated that it was yesterday in the morning shift after her shower that her left-hand splint was put on by the nursing staff and denied having the left-hand splint removed. RNA 1 removed Resident 15's hand splint and stated she would be providing hand hygiene and gathered supplies for Resident 15. Resident 15's left hand was a mildly reddened on the inside palm. Resident 15's fingernails on both hands remained the same that were still long, thick, yellowish brown with brown dirt-like debris underneath her nailbeds with old chipped brownish red nail polish on the tip of the fingernails. Resident 15 stated, Hurting a bit when RNA 1 moved her hand to remove the splints. RNA 1 stated Resident 15's left hand splint should have been removed per MD order within four to six hours as tolerated and not kept on until the next day. On 8/1/24 at 2:57 P.M., an interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated that splints required Physician's orders and need to be followed. The DSD reviewed Resident 15's RNA orders for the left hand splint that indicated RNA: 5X/Wk [five times per week] FOR L [left] PALM GUARD 4-6 [sic] HRS [hours] AS TOLERATED; OFF FOR GROOMING AND HYGIENE. The DSD reviewed Resident 15's shower record that indicated Resident 15 had a shower at 13:13 (1:13 P.M.) on 7/31/24. The DSD stated the Resident 15's left hand splint should have been removed sooner and should only be on within the time frame per Physician's order within the four-to-six-hour time frame. The DSD stated hand hygiene should have been provided to include Resident 15's fingernails on both hands to be trimmed and cut as long as Resident 15 did not have diabetes (a disease when your body is unable to control blood sugar levels). The DSD reviewed Resident 15's clinical record and indicated Resident 15 did not have a diagnosis of diabetes and therefore stated RNA's and Certified Nursing Assistants (CNAs) should be providing nail care for Resident 15 during ADL care. The DSD stated it did not look like Resident 15 was provided with sufficient nail care for both her hands because it, Should not be long and dirty. On 8/2/24 at 9:31 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that Resident 15 did not look like she was getting appropriate nail care for both hands with fingernails that looked long, yellow, thick with noticeable old nail polish on the fingertips and dirty fingernails with dirt under the nail beds. The DON also stated Resident 15's hand splint should not have been left on overnight and the Physician's orders should have been followed to prevent risks for skin breakdown and infection from splint use. The DON stated her expectations for Resident 15's hand hygiene is to inspect the skin for skin breakdown, nails were trimmed to prevent infection from accidental nail injury, and fingernail beds clean. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility's policy and procedure titled ADL CARE PROVIDED FOR DEPENDENT RESIDENTS revised March 2018 indicated, Policy Statement: A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene, receive this assistance from the facility . Per the facility's undated policy and procedure titled SPLINT APPLICATION indicated, The splint will be applied on the a.m. shift and removed on the p.m. shift .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review the facility failed to appropriately care for one of three residents' drainage tube reviewed for staff competency (Resident 177). This deficient practice had the potential for unresolved infection. Findings: Resident 177 was admitted to the facility on [DATE] with diagnoses including peritoneal abscess (collection of pus in the body below the abdomen between the hip bones) and sepsis (the body's extreme and life-threatening response to an infection) according to the facility's Admission Record. During an observation and interview on 7/30/24, at 8:42 A.M. with Resident 177, Resident 177 was sitting on a wheelchair and showed a tube with an accordion bulb connected to a drainage bag. Resident 177 stated the drain was due to an abscess and the staff did not properly took care of it. Resident 177 stated it has been two days that the accordion bulb was not squeezed (squeezed - to apply suction to drain the fluid). The accordion bulb was observed with small amount of brown fluid, and the accordion bulb was not squeezed. On 7/31/24, at 12:27 P.M. Resident 177 was sitting up in the wheelchair. The drainage tube was observed hanging on Resident 177's left side with accordion bulb which was not squeezed. During a review of physician's orders (POS) for Resident 177, the POS with start date of 7/24/24 indicated, . IR Drain insertion site Site: Left buttocks monitor for drainage, pain and s/sx (signs and symptoms) of infection until healed . During an interview on 8/1/24, at 10:32 A.M. with licensed nurse (LN) 14, LN 14 stated Resident 177 had a drain on the left buttock due to diverticulitis (small and inflamed pouches that forms in the wall of the large intestine), and the treatment nurse provided care of the drainage tube. During an interview on 8/1/24, at 1:34 P.M. with the treatment nurse (TN), the TN stated she changed Resident 177's drainage tube site dressing, then squeezed the accordion bulb for fluid to drain. The TN further stated the accordion bulb must be squeezed to create suction and drain fluid. On 8/1/24, at 1:41 P.M. an interview was conducted with LN 11. LN 11 stated she covered for the TN when TN was off. LN 11 stated she flushed Resident 177's drainage tube and covered the site with a dressing. LN 11 stated the drain worked by gravity and the accordion bulb did not have to be squeezed. LN 11 further stated the accordion bulb was squeezed only upon emptying of the drainage bag. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 8/1/24, at 1:48 P.M. with LN 16. LN 16 read the progress notes from the hospital dated 7/22/14 for Resident 177. The progress notes indicated, . drainage of deep pelvic abscess .catheter placed to accordion bag drainage . LN 16 stated Resident 177's drainage tube with accordion bulb should be squeezed at all times to create negative pressure on the tube and drain the abscess from the site. LN 16 further stated if the accordion was not squeezed, the fluid remained inside the resident's site of infection which defeated the purpose of Resident 177's use of an antibiotic to clear the infection. During a concurrent record review on 8/1/24, at 1:41 P.M. with LN 16, LN 16 stated the hospital record for Resident 177 titled, After Visit Summary, dated 7/23/24, the record indicated, .Caring for a Closed Suction Drainage Tube. A drainage tube removes fluid from around the incision. This helps prevent infection and promotes healing. The collection bulb at the end of the tube is squeezed and plugged to create suction . An interview was conducted on 8/2/24, at 12:59 P.M. with the Director of Nurses (DON). The DON stated Resident 177's accordion bulb should be squeezed to create pressure to remove fluids. The DON stated Resident 177's accordion bulb has not been squeezed when she had checked on Resident 177. The DON further stated she expected staff to ensure Resident 177's accordion bulb was squeezed to remove fluid from the abscess. During a review of the facility's policy and procedure (P&P) titled, Percutaneous (Pigtail) Drain, Care of, dated, October 2021, the P&P indicated, .The pigtail drain operates on the principle of negative pressure. Compression must be maintained on the bulb/accordion for suction to be preserved .

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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** 48263 Based on observation, interview and record review, the facility failed to store medications in a secured location for two of three residents (Resident 47 and Resident 30) reviewed for medication storage when: 1. A discontinued order for triamcinolone ointment (a prescribed skin cream to treat skin associated irritation such as rash) was kept uncapped and unsecured on Resident 47's nightstand table. Cross Reference F658 and F813 2. A prescribed Salonpas (pain patches) was kept at Resident 30's bedside table. These failures had the potential for medication misuse, effectiveness and/or severe allergic complications. Findings: 1. Review of Resident 47's clinical record indicated Resident 47 was readmitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting left non-dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body). A record review of Resident 47's minimum data set (MDS: a nursing assessment tool) dated [DATE], indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's mental status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 47 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits. On [DATE] at 9:19 A.M., an observation was conducted in Resident 47's room. Resident 47's nightstand table to the left side was cluttered with personal items that included an uncapped and fully squeezed triamcinolone ointment located on the center edge of the nightstand table next to Resident 47's plastic wrapped sandwich in an opened container. On [DATE] at 10:21 A.M., an observation and interview was conducted with Resident 47, in Resident 47's room. A Certified Nursing Assistant (CNA) was seen walking out of Resident 47's room after providing incontinent care for Resident 47. Resident 47 still had the same uncapped, fully squeezed triamcinolone ointment on the left nightstand table. Resident 47 stated that the nursing staff applied the triamcinolone ointment when providing care but did not know what the ointment was used for. On [DATE] at 11:50 A.M., a record review was conducted on Resident 47's orders for Triamcinolone ointment. There were no orders in Resident 47's clinical chart. (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 1:34 P.M., a joint interview and record review was conducted with Licensed Nurse (LN) 1, in the west wing nursing station. LN 1 stated Resident 47 did not have an order for Triamcinolone ointment and did not know why the ointment was left at the bedside. LN 1 stated that the Triamcinolone ointment should have been discarded to avoid misuse (used inappropriately such as used on a wrong person or roommate) of the medication and to prevent severe allergic reactions. LN 1 stated if Resident 47's order was current for Triamcinolone ointment that it should be kept in a secured location such as a treatment cart and not openly placed at the bedside. LN 1 further stated that even with a self-administration evaluation for medications, it was the responsibility for any LNs to be with a resident who had been evaluated to make sure that the medications/treatments were self-administered safely and therefore should be at the bedside to witness that medications/treatments were properly administered. On [DATE] at 2:57 P.M., a joint interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated that Resident 47 did not have an order for the Triamcinolone ointment and should not have been left at Resident 47's bedside unsecured. The DSD stated the proper storage of the Triamcinolone ointment should have been placed in the treatment cart where it is secured. On [DATE] at 8:57 A.M., an interview with the DON was conducted. The DON stated that the expired order for Triamcinolone ointment should not have been placed unsecured at Resident 47's bedside. The DON stated that her expectations were for all medications and treatments to be stored in a safe and secured location to avoid misuse and prevent severe allergic reactions. The facility policy and procedure titled MEDICATION LABELING AND STORAGE revised, February 2023 indicated, .Policy Interpretation and implementation .3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . 2. Review of Resident 30's clinical record indicated Resident 30 was admitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting right dominant side (a brain attack known as a stroke that stops blood flow to the brain causing right sided weakness and movement to the body). A record review of Resident 30's minimum data set (MDS: a nursing assessment tool) dated [DATE], indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's mental status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 47 had mild cognitive (pertaining to memory, judgement, and reasoning ability) deficits. On [DATE] at 8:57 A.M., An observation and interview was conducted with Resident 30, in Resident 30's room. Resident 30 was lying in bed in an upright position resting with her bedside table within reach. Resident 30's bedside table was cluttered with her belongings that included a small tray with a microwaved brown popcorn bag, breath mints, lotions, hobby scissors, over the counter (OTC) lotions and chewable Tums (anti-gas tablets), underarm deodorant, a box of prescribed Salonpas and two cups of apple juice and water. Resident 30 stated that was the usual spot where the staff kept her items. (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 2:47 P.M., a record review was conducted on Resident 30's clinical chart. Resident 30 had a self-administration safety screen that was completed on [DATE] for the OTC Tums Chewy Bites but there was no self-administration evaluation done for the prescribed Salonpas. On [DATE] at 1:34 P.M., an interview and record review was conducted with LN 1, in the west wing nursing station. LN 1 stated that Resident 30 did have a current order for Salonpas for pain, but did not have a self-administration safety screen. LN 1 stated that Resident 30's Salonpas was a prescribed medication for pain and should not been stored at her bedside unattended because no safety screen was conducted for self-administration. LN 1 stated that it was, Inappropriate to keep the Salonpas at the bedside because it needed to be applied safely to prevent misuse and stored away properly to preserve the effectiveness of the medication. On [DATE] at 02:57 P.M., an interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated Resident 30 had current orders for Salonpas for pain and should be stored in the medication cart. The DSD confirmed that Resident 30 did not have a self-administration safety screen for Salonpas and therefore should not be at Resident 30's bedside. On [DATE] at 8:57 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated if Resident 30 was not evaluated for self-administration safety for Salonpas that it should be stored in the medication cart. The DON stated any prescribed medication orders should be stored safely and securely to prevent misuse and preserve the effectiveness of medications. The DON stated complications could include severe allergic side effects if not safely monitored and administered. The facility policy and procedure titled MEDICATION LABELING AND STORAGE revised, February 2023 indicated, POLICY heading [sic] The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview and record review, the facility failed to ensure food served to all residents was in a palatable, flavorful manner that maintained the nutritional value of the menu items served. This failure had the potential to decrease residents' meal intake and contribute to weight loss. The facility census was 90. Findings: During a dining observation and interview on 07/30/24 at 9:00 A.M. to 2:55 P.M., with residents in their rooms due to a coronavirus (COVID: a respiratory illness caused by a virus that is highly contagious) outbreak at the facility. Resident food concerns addressed included: Mostly chicken they serve here at the facility and I hate chicken so my wife brings me food. The food I don't like the food and I call [Dietary Supervisor (DS) Name]. The food is the same food every day, lots of chicken and the egg salad is bad. Sick of alternative menu, because it's always same PBJ [peanut butter and jelly] and ham sandwich. Sometimes cold. Eggs in am not hot. Lunch and dinner can improve . too much chicken, and often it comes cold . alternatives are only sandwiches. They have too much chicken, too much vegetables . and it's the same every day. The food can be bland, and needs hot sauce . sometimes the soup can be cold . can request a substitute a few hours earlier . The food is poor, and that they eat chicken, mash potatoes and gravy about 4x's a week. Need better food, at times did not like what was on the menu. Stated he didn't ask for substitute and staff did not offer. Spicy, too much oregano. Stated wife also brought him food . Food was bad, no flavor. Food is terrible always cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 9:06 A.M., resident council 2024 minutes was reviewed along with a resident council meeting that addressed food concerns included: February, 2024 - residents requested variety of food choices. Res 1- stated, Why still serving tilapia?, farmed at southeast [NAME], eating each other's droplets, contaminated fish. Res 3- stated can receive an alternate, but had to request an hour or two. During a dining observation and interview on 07/31/24 at 10:30 A.M. to 12:00 P.M., with residents in their rooms due to a COVID outbreak at the facility. Resident food concerns addressed included: Pureed is not good its tasteless. Food is terrible . meat was Subgrade .had to eat it .to survive. Too many times they always serve chicken, but I eat it. Meals aren't that good really. I eat a lot when my daughter brings me food. Review of the facility's menu dated 7/31/24 indicated the Regular Diet was served pot roast, brown gravy, cheddar mashed potatoes, green peas, devils food cake, milk and beverage of choice. The Pureed Diet was served pureed pot roast, cheddar mashed potatoes with gravy, pureed carrots, pureed devils food cake, milk and beverage of choice. On 7/31/24 at 11:58 A.M., a test tray observation and interview was conducted with the Dietary Supervisor (DS), for two test trays (Pureed and Regular). The DS stated that pureed carrots did not taste like carrots because of the recipe they [kitchen staff] followed and was mixed with broth. The DS stated that the pureed pot roast tasted salty due to the ingredients. The DS agreed that the pureed and regular dessert was bland. On 8/1/24 at 10:43 A.M., an interview was conducted with the DS and the Registered Dietician (RD), in the kitchen. The DS stated that they would contact their nutritional consultant for a more streamlined menu for food options regarding resident complaints with the same menu items. The RD stated, Peas and pureed carrots both have different nutritional equivalency. The RD stated they would look at a different menu system that can provide a better nutritional menu equivalency for the different meal textures because residents should get what goes out on the monthly planned menu. The RD stated if residents are not eating enough because of palatability (tasteful) that this can cause a potential for weight loss amongst the residents. Per the facility's policy titled TASTE TESTING, dated 2017, the policy indicated .All food not passing the taste test due to seasoning, toughness, color, or other negative factors will not be served until the problem has been corrected.

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NAME OF PROVIDER OR SUPPLIER Stanford Court Skilled Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8778 Cuyamaca Street Santee, CA 92071	

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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. 48263 Based on observation, interview and record review the facility did not maintain or perform the sanitary (free of bacteria and other germs that is can be hazardous to humans) practices according to their policies and procedures of using a low-temperature dishwasher. This failure had the potential to cause widespread food borne illness among all 90 residents who received food from the kitchen. Findings: On 8/1/24 at 10:00 A.M., an observation and interview was conducted with the Dietary Assistant (DA) 1, in the kitchen. A low-temperature dishwashing machine was being used by DA 1 to clean two crates of dishes that contained trays, cups, dishes and utensils used by the residents in the facility. DA 1 stated that the temperature gauge for the low-temperature dishwashing machine read 111 F and stated, Anything below 120 F I would report to my boss. DA 1 stated, It would need to be 120 F due to germs and bacteria that can still be on the dishes. DA 1 continued to use the low-temperature dishwashing machine to wash another crate of dirty dishes and did not notify her supervisor. DA 1 stated that if the temperature was low and not reaching the right temperature that the low-temperature dishwashing machine should not be used. DA 1 stated using the low-temperature dishwashing machine was the only method they (kitchen staff) used to wash dirty dishes. On 8/1/24 at 10:12 A.M., an interview and observation was conducted with the Dietary Assistant (DA) 2, in the kitchen. DA 2 stated that the low-temperature dishwashing machine gauge read 111 F and that the low-temperature dishwashing machine needed to be at 120 F to remove, The stains and germs from dirty dishes. DA 2 stated if the temperature is not at 120 F they would need to wait until they fixed the, Issue to use the low-temperature dishwashing machine. DA 2 stated, People would get sick if not washed properly. DA 2 stated if the low-temperature dishwasher was broken he was unsure if they had another plan to clean the dishes. On 8/1/24 at 10:17 A.M., an interview was conducted with the Dietary Supervisor (DS). The DS stated that his expectations were for the staff to notify him when a machine was not working properly and that the staff was expected to know to use the three compartments sink to wash dirty dishes and air dried. The DS stated DA 1 did not properly sanitize the dirty dishes when the temperature read 111 F and should have stopped using the low-temperature dishwashing machine to continue washing dirty dishes. The DS further stated DA 1 should not have put the dishes away with the clean dishes because it was not fully sanitized and puts the residents at risk for foodborne illnesses. Per the facility's policy and procedure titled RESOURCE: SANITATION OF DISHES/DISH MACHINE dated 2017 indicated, .Low Temperature Dishwasher .Wash temperature 120 F .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews and record reviews the facility failed to store foods in a safe and sanitary manner according to their facility's policies and procedure for outside foods brought by family and visitors for two out of seven residents (Resident 59 and Resident 47) reviewed for food preference and homelike environment when: 1. Resident 59 had a bag of unlabeled apples and oranges placed at the bedside for a week or more. Cross reference F880 2. Resident 47 had three unlabeled food items with a brownish yellow banana, placed on top of a cluttered emesis basin, plastic wrapped chocolate pastries on top of a plastic container and a sandwich in an open plastic container unsecured without a lid at the bedside. This failure had the potential to attract pests (insects and rodents that carry harmful bacteria or viruses that could be passed on to humans), spoilage (the process in which food or other substances stop being good enough to eat or use) of food and risks of foodborne illnesses from food consumption. Findings: 1. Review of Resident 59's clinical record indicated Resident 59 was readmitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting left non-dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body). A record review of Resident 59's minimum data set (MDS: a nursing assessment tool) dated 6/3/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's mental status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 47 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits. On 7/30/24 at 9:26 A.M., an observation and interview was conducted with Resident 59. Resident 59 had a mesh bag that contained oranges and apples in a clear plastic bag beside fresh flowers on the nightstand to her right. Resident 59 stated she liked fruits and that her daughter had brought over the oranges and apples about a week ago and had been placed there for easy access for when she craved them. On 8/1/24 at 9:34 A.M., an observation and interview was conducted with Resident 59. Resident 59 stated that the facility had removed her oranges and apples because, They have State here [the facility] and was told by the nursing staff to keep the oranges and apples in the closet. Resident 59 stated that the nursing staff had placed her oranges and apples in her closet so that it was not left out in the open. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 1:34 PM an observation, interview and record review was conducted with licensed nurse (LN) 1. LN 1 stated that she was Resident 59's nurse for the past two days. LN 1 stated that all food items brought by outside visitors and family to residents should be stored, labeled with resident's name, date and time, and discarded within 24 hours. LN 1 stated the outside food from visitors were stored in the east wing refrigerator for all residents. An observation was conducted with LN 1 at the east wing refrigerator for personal food storage. Resident 59's oranges and apples were not stored in the residential refrigerator. LN 1 stated that they would have to disclose this policy for outside food to all residents and family. LN 1 stated that Resident 59's oranges and apples should not have been placed at Resident 59's bedside because the fruits needed to be refrigerated and should have been discarded since it had been over a week and not stored properly to prevent spoilage and consumption to prevent food borne illnesses. A record review was conducted with LN 1 regarding neutropenic (a decrease in white blood cells that help fight off infection) precautions (unwashed fruits and fresh flowers may contain harmful bacteria [tiny organisms found everywhere] and fungi [mold] that is harmful for people with neutropenia) for Resident 59's room. LN 1 stated Resident 59 was not on neutropenic precautions, but her roommate was on neutropenic precautions as to why the sign posted outside of Resident 59's room prior to entry. LN 1 stated that fruits and fresh flowers that were kept in Resident 59's room could potentially compromise Resident 59's roommates health because the room should not have fresh flowers or fruits due to the roommate's poor immune system to fight off infection. On 8/01/24 at 2:57 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated Resident 59's fruits should have been stored in the personal items' refrigerator for residents' [all facility residents] located in the east wing and properly labeled to prevent foodborne illness from consuming spoiled food. The DSD stated it should not be stored in the closet as this could attract pests and it should had been discarded since it was not properly stored in Resident 59's room for over two days. On 8/2/24 at 9:20 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations were for visitors to be informed regarding the facility's policies and procedures for bringing outside food and for the nursing staff to properly store the food items at the right temperature to prevent spoilage and to prevent foodborne illnesses from consuming spoiled foods. The DON stated that Resident 59's roommate was on neutropenic precautions and having fresh fruits and flowers should not be allowed in the room to prevent infection from harmful bacteria and mold that can grow on fruits and plants. Per the facility's policy and procedure titled FOOD BROUGHT by FAMILY/VISITORS dated, March 2022 indicated, . Policy and Interpretation and Implementation .4. Safe food handling practices are explained to the family/visitors in a language and format that they understand .5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food . 2. Review of Resident 47's clinical record indicated Resident 47 was readmitted on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting left non-dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body). (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 47's MDS dated [DATE], indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's mental status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 47 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits. On 7/30/24 at 9:19 A.M., an observation and interview was conducted with Resident 47, in Resident 47's room. Food items were observed at Resident 47's bedside which included unlabeled and undated food items such as a sandwich wrapped in a plastic wrap in a container without a lid, chocolate pastries stored outside of a plastic container wrapped in plastic and a brownish yellow banana on top of a cluttered emesis basin with resident belongings was observed placed on Resident 47's left nightstand. Resident 47 stated that he did not like the food at the facility and that his wife brought all the food items from home. On 8/01/24 at 1:34 P.M., an interview was conducted with LN 1, at the west wing nursing station. LN 1 stated that they store outside food items brought by visitors and family to a resident needed to be stored in a refrigerator located in the east wing. LN 1 stated it was not appropriate to have Resident 47's food items stored and unlabeled at his bedside. LN 1 stated that Resident 47's food items that were placed on the nightstand which included a sandwich, chocolate pastries, and a banana are all perishable (foods that can spoil easily without proper storage) and should have been labeled, stored in a refrigerator, or discarded. LN 1 stated since the food items were not labeled and not stored properly it was best to discard the food items to prevent any food-borne illnesses. On 8/1/24 at 2:57 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated Resident 47's sandwich and chocolate pastries should be stored in a tight-fitting container with a lid with a label and dated. The DSD stated that Resident 47's food items should be stored appropriately in the residents' fridge located in the East wing nursing station should the food be consumed at a later time. The DSD stated if food items are not labeled then the nursing staff would need to discard it right away to prevent attracting pests that can carry infection and the consumption of spoiled foods that could lead to food-borne illnesses. On 8/2/24 at 8:57 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated foods should not be on stored at Resident 47's bedside. The DON stated outside food items should be labeled to prevent spoilage and stored properly in tight fitting containers with lids to prevent attracting pests from contaminating food items that are harmful to all the facility residents and to prevent the consumption of spoiled foods to prevent food-borne illnesses. Per the facility's policy and procedure titled FOOD BROUGHT by FAMILY/VISITORS dated, March 2022 indicated, . Policy and Interpretation and Implementation .4. Safe food handling practices are explained to the family/visitors in a language and format that they understand .5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food a. Non-perishable foods are stored in re-sealable containers with tightly fitting lids b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date .

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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** 47466 Based on observation, interview and record review, the facility failed to ensure a neutropenic (low white blood cell count- part of the body's immune system) precautions room for one reviewed resident (Resident 58), was free of potential infection from raw foods. This failure had the potential outcome of endangering Resident 58's health condition and possible decline from exposed raw foods. Cross reference F813 Findings: Review of Resident 58's Admission Record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses that included Malignant Neoplasm of Endometrium (cancer of uterus). On 7/30/24 at 9:20 A.M., an observation of Resident 58's room was conducted. Resident 58's door had signage which indicated Resident 58 was on neutropenic precautions. On 7/30/24 at 9:25 A.M., an interview with Resident 58's roommate (Resident 59) was conducted. Resident 59's bedside table had a basket of raw fruits which consisted of apples and oranges. Resident 59 stated her daughter brought in the basket of fruits few weeks ago and left them on her bedside table. Resident 59 stated a supervisor from the facility took them out yesterday after the State saw the basket of raw fruits. Resident 59 stated she did not realize the raw fruits were not allowed in the room. On 8/2/24 at 9:30 A.M., an interview with Certified Nursing Assistant (CNA) 23 was conducted. CNA 23 stated Resident 58 was on neutropenic precautions to protect her from outside germs brought in by staff and visitors since Resident 58 was prone to infection. CNA 23 stated staff must gown up before entering Resident 58 's room and do hand hygiene. CNA 23 stated flowers were allowed in Resident 58's room, same with fruits and vegetables if they have been washed. CNA 23 stated visitors must gown up too but often they did not. On 8/2/24 at 9:57 A.M., an interview with licensed nurse (LN) 21 was conducted. LN 21 stated staff needed to wear mask, gown and gloves when entering Resident 58's room. LN 21 stated the facility does laboratory work to monitor Resident 58's white blood cell to ensure Resident 58 was protected from infection. On 8/2/24 at 10:02 A.M., an interview with LN 22 was conducted. LN 22 stated Resident 58 was on neutropenic isolation due a low white blood cell count. LN 22 stated staff needed to gown up and wear mask prior to entering Resident 58's room. LN 22 stated that was done to protect Resident 58 from infection. LN 22 stated there should be no fresh or raw fruits, vegetables, or flowers in Resident 58's room. LN 22 stated Resident 58's visitors were advised to gown up and are not allowed to bring fruits, vegetables, and flowers of any kind. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/24 at 10:30 A.M., an interview with the Infection Preventionist Nurse (IPN) was conducted. IPN stated IPN stated Resident 58 was bedbound but goes outside of her room at times with a mask to protect herself from infection from all sources. On 8/2/24 at 2:00 P.M., an interview with the Director of Nursing (DON) was conducted. DON stated she was made aware of the fruits found in Resident 58's room on 7/30/24. The DON stated she took the fruits off of Resident 59's bedside table. DON stated the staff should be following the neutropenic protocol to protect Resident 58 from contamination and infection. DON stated it was important for staff to know what kind of precautions Residents 58's required, and what personal protective equipment (PPE-protection from injury and infection) to use when inside Resident 58's room. A record review of Resident 58's Admission orders dated 9/23/2023 indicated .Neutropenic precautions related to malignant neoplasm of endometrium, indicated no outside food, plants, and flowers . A review of the facility's Neutropenic Precautions policy and procedure dated April 2018 .precautions continued .#4 plants and flowers shall be removed from the resident room . dietary concerns .#2 raw and partially cooked meat, vegetables and fruits are prohibited .miscellaneous .#3 family members and visitors may be required to wash their hands, put gown on and wear mask .