STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555333	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Meadows Care Center	1550 Third Street Lincoln, CA 95648

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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. 43258 Based on observation, interview, and record review, the facility failed to ensure self-administered medications kept at bedside for one of 23 sampled residents (Resident 189) were reviewed and approved by the physician. This failure had the potential for unsafe medication use, exposure to unwanted side effects and duplication of therapy. Findings: During an observation on 3/25/24 at 9:07 a.m. with Licensed Nurse 4 (LN 4), LN 4 was observed administering medications to Resident 189. To the left of Resident 189's bed was an albuterol (a medication to treat asthma) inhaler, without a pharmacy label, on a bedside table. Resident 189 stated she had been using the inhaler to help her breathe, but it was not providing her relief. She stated she had brought the inhaler with her to the facility from the hospital. During a concurrent interview and record review on 3/25/24 at 11:24 a.m. with LN 4, Resident 189's physician's orders were reviewed. LN 4 confirmed Resident 189 did not have an order for albuterol or an order that allowed the resident to self-administer medications. LN 4 stated a physician's order was required to safely allow residents to self-administer medications and the medication should have been stored in a lockbox. During an interview on 3/25/24 at 4:52 p.m. with Director of Nursing (DON), DON stated if residents came to the facility with medications, they were asked to give them to their family members or securely store them with herself. She stated a resident assessment and a physician's order was needed to allow self-administration of medication. DON stated the resident would then be encouraged to allow nursing staff to store the medication in the medication cart. During a review of the facility's policy and procedure (P&P) titled, Personal Medications, dated 3/2018, the P&P indicated, Procedures A. Medications brought in with residents on admission must be identified and approved by a physician or pharmacist to ensure correct contents and proper labeling . The nurse will document receipt of these medications in the admission nursing note or outside pharmacy log. (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 review of the facility's P&P titled, Administering Medications, dated April 2023, the P&P indicated, Policy Interpretation and Implementation . 17. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40841 Based on observation, interview, and record review, the facility failed to ensure resident's respect and quality of care were maintained for one of 23 sampled residents (Resident 62) when Resident 62 was not able to reach for the call light. This failure had the potential to increase the residents' fear of not able to reach for the call light when needing assistance. Findings: According to the Admission Record, Resident 62 was admitted to the facility in 2024 with diagnoses including asthma and left lower limb infection. During a concurrent observation and interview on 3/25/24 at 9:30 a.m. in Resident 62's room, Resident 62 reported she was not able to reach for the call light while in her wheelchair. The call light was located on the other side of Resident 62's bed. During an interview on 3/28/24 at 9:11 a.m., the Director of Nursing (DON) confirmed the call light should have been within reach of the resident. Review of the facility's policy titled, Answering the Call Light, dated 12/2022, indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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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** 44971 Based on observation, interview and record review, the facility failed to provide a comfortable and homelike environment for one of 23 sampled residents (Resident 37), when Resident 37's room was disorderly and cluttered with personal bags and boxes. This failure decreased the facility's potential to ensure residents' autonomy when using their personal belongings. Findings: A review of Resident 37's Admission Record, indicated Resident 37 was readmitted from hospital to the facility on [DATE] with diagnoses including urinary tract infection, major depressive disorder, and paraplegia (paralysis of the legs and lower body). A review of Resident 37's Minimum Data Set (MDS; an assessment tool), dated 1/6/24, indicated Brief Interview of Mental Status (BIMS, a cognitive assessment tool) score was 15 of 15 with good memory. MDS further indicated Resident 37 had impairment on bilateral lower extremities, used a wheelchair, and was dependent in transfer to and from bed to a chair or wheelchair. During a concurrent observation and interview on 3/25/24 at 9:59 a.m. with Resident 37 in her room, multiple personal belongings were stored as follow: four bags and three boxes under the wall-mounted television, two boxes under the sink, one big black bag on the floor at the bed's left side, and one box at the bedside table. Resident 37 stated no one helped her unpack her belongings since she returned back from hospital on 2/13/24. Resident 37 added the Social Services Assistant (SSA) kept telling her she will unpack her belongings over the weekend and did not do it. Resident 37 further stated keeping her belongings unpacked made her room not homelike, was unable to find her belongings, had below waist paralysis, and could not unpack her belongings by herself. During an interview on 3/25/24 at 10:25 a.m. with Housekeeper 1 (HK 1), HK 1 stated she could not reach Resident 37's head of bed and disinfect the bedside area because there was clutter around it. During an interview on 3/27/24 at 9:51 a.m. with Resident 37, Resident 37 stated last night the big black bag placed on the floor unplugged the bed's cord and she ended up sleeping on the bed frame because she was unable to adjust the bed. Resident 37 added she yelled for help because she was unable to use the call light which was not within reach. Resident 37 further stated housekeepers did not clean her room because there was clutter. During an interview on 3/27/24 at 10:01 a.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed Resident 37 had many boxes and bags. LN 1 stated Resident 37 expressed to her a concern about her need for someone to unpack her belongings. LN 1 further stated she did not report Resident 37's message to anyone. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 10:11 a.m. with SSA, SSA stated she packed Resident 37's belongings before hospital transfer. SSA further stated nurses and the Director of Staff Development (DSD) did not pass to her Resident 37's request to unpack her belongings. During an interview on 3/27/24 at 10:22 a.m. with Director of Staff Development (DSD), DSD stated Resident 37 told him when she returned back from hospital that her husband will not take her belongings back home and she needed help unpacking it. DSD further stated he did not pass Resident 37's request to SSA. A review of Resident 37's Care Plan, dated 7/5/23, indicated Resident 37 was at risk for falls related to paraplegia and gait/balance problems. Care plan further indicated Resident 37 needed a safe environment free from clutter and personal items within reach. During an interview on 3/27/24 at 10:36 a.m. with Director of Nursing (DON), DON confirmed Resident 37's belongings were packed in boxes and bags in her room and stated SSA should have filed a grievance form or resident concern form and followed-up until the problem was resolved. DON further stated unpacking Resident 37's belongings and ignoring her request could have increased her anxiety. A review of the facility's policy titled, Homelike Environment, dated 2/21, indicated Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .the characteristics of the facility that reflect a personalized, homelike setting .include: clean, sanitary and orderly environment .personalized furniture and room arrangements .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44971 45770 Based on observation, interview and record review the facility failed to ensure the Minimum Data Set (MDS, an assessment tool used to guide care) was accurate for three of 23 sampled residents (Resident 70, Resident 64 and Resident 88) when: 1. Resident 70's impaired vision was not reflected in his most recent quarterly MDS assessment; 2. Resident 64's MDS indicated she had no feeding tube; and, 3. Resident 88 was discharged to home and MDS indicated hospitalization . These failures had the potential for residents to not receive appropriate care and interventions. Findings: 1. A review of an admission record indicated Resident 70 was admitted to the facility in June 2023 with diagnoses including adjustment disorder with mixed anxiety and depressed mood. During an initial screening on 3/25/24 at 10:43 a.m. inside Resident 70's room, Resident 70 was observed lying in bed squinting while watching television and a pair of eyeglasses was on top of the table. Resident 70 stated the reading glasses were from the Activities Director and they gave him headaches whenever he used them. Resident 70 added he already told the staff he needed to see an eye doctor but he had not seen one yet. A review of Resident 70's MDS assessment Section B, dated 2/10/24, was coded that Resident 70 had no vision impairment and did not wear corrective lenses. A review of a social services note, dated 8/7/23, indicated Resident 70 was provided with a pair of reading glasses but requested to see an optometrist (eye doctor) due to left eye blurriness and Social Services Assistant (SSA) would arrange the referral. In an interview on 3/27/24 at 2 p.m. with the Activities Director (AD), AD confirmed Resident 70 used eyeglasses and had been requesting to see an eye doctor. AD stated she told the Social Services office of Resident 70's request because he complained the reading glasses given to him did not fit him. During a concurrent interview and record review on 3/27/24 at 2:15 p.m. with the Social Services Assistant (SSA) SSA stated if Resident 70's most recent quarterly MDS vision assessment indicated that his vision was adequate, it is considered inaccurate. According to the notes written by the other SSA in 8/7/2023, Resident 70 was provided with reading glasses and complained of blurred vision. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/28/24 at 10 a.m. with the Director of Nursing (DON) she stated assessments of residents should be done accurately and MDS assessment should be coded properly to reflect the resident's true condition, abilities and disabilities which can help develop the plan of care of residents. 2. A review of Resident 64's Admission Record, indicated Resident 64 was readmitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition and gastrostomy (external opening into stomach for feeding). During a concurrent observation and interview on 3/25/24 at 8:31 a.m. with Resident 64, a feeding tube was connected to her. Resident 64 stated she had a feeding via tube from 7 p.m. till 7 a.m. because she had stomach issues and during the day she ate a few bites and got full. A review of Resident 64's MDS, dated [DATE], indicated the Brief Interview of Mental Status (BIMS, a cognitive assessment tool) score was 15 of 15 with good memory. A review of Resident 64's Order Summary Report, dated 3/27/24, indicated Resident 64 had enteral feeding (tube feeding into stomach or intestine) and treatment orders since 11/12/23 to current report date. A review of Resident 64's Care Plan, dated 11/13/23, indicated Resident 64 required enteral nutrition related to gastrointestinal dysfunction. During a concurrent interview and record review on 3/27/24 at 1:24 p.m. with MDS Coordinator (MDSC), Resident 64's MDS, dated [DATE] was reviewed. MDSC confirmed Resident 64's MDS indicated she had no feeding tube on admission and while a resident of the facility. MDSC stated Resident 64's MDS nutritional assessment was inaccurate which could have impacted Resident 64's data collection, billing, and nurses' focus on delivering specific care areas. During an interview on 3/27/24 at 1:44 p.m. with DON, DON confirmed Resident 64's MDS nutritional assessment was inaccurate and stated if Resident 64's MDS was inaccurate, then her plan of care will be inaccurate. A review of the facility's policy titled, Certifying Accuracy of the Resident Assessment, dated 6/22, indicated Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. 3. A review of Resident 88's Admission Record, indicated Resident 88 was admitted on [DATE] with diagnosis of Pneumonia and discharged on [DATE]. A review of Resident 88's Order Summary Report, dated 1/19/24, indicated, Discharge resident home on 1/22/24 with daughter . A review of Resident 88's Discharge Summary, dated 1/19/24, indicated, Discharge disposition: Home . A review of Resident 88's Nurse's Notes, dated 1/22/24, indicated, discharged today. Daughter came to pick him up and transport him home . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 03/28/24 11:07 a.m. with MDS Coordinator (MDSC), Resident 88's MDS Section A2105, dated January 2024 was reviewed. MDS Section A2105 indicated, Discharge Status 04-Short-Term Care General Hospital . The MDSC reviewed Resident 88's Progress Notes and the MDS Coordinator's Notes, dated 01/22/24, which indicated, Resident discharged to home . The MDSC stated that Resident 88 was discharged home and discharged status in MDS Section A2105 should have indicate Resident 88 was discharged home and not to the hospital. During a concurrent interview and record review on 03/28/24 11:13 a.m. with DON, Resident 88's medical records was reviewed. The DON stated that Resident 88 was discharged to home and verified MDS Section A2105 was inaccurate. 48694

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44971 Based on interview and record review, the facility failed to develop and provide the baseline care plan (BCP) and written summary for one of 23 sampled residents (Resident 240) within 48 hours after admission. This failure decreased the facility's potential to address the residents' initial goals and current health needs. Findings: A review of Resident 240's Admission Record, indicated Resident 240 was admitted to the facility on [DATE]. A review of Resident 240's Baseline Care Plan Person-Centered Care Planning, indicated BCP was completed on 3/19/24. BCP further indicated a printed summary was not provided to Resident 240 or her representative. During an interview on 3/26/24 at 2:14 p.m. with Director of Nursing (DON), DON confirmed Resident 240's BCP was not completed within 48 hours of admission and stated it should have been done within 48 hours because there was a potential that nurses will not have a quick tool to identify what the resident's specific focus areas are that guide their provision of services. DON also confirmed Resident 240 was not provided with a printed summary and stated there was no evidence that Resident 240 received it. DON further stated the BCP summary should have been provided to Resident 240 or her representative in writing so she could understand the care she will receive at the facility. A review of the facility's policy titled, Baseline Care Plans, dated 3/22, indicated A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy also indicated The resident and/or representative are provided a written summary of the baseline care plan .

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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** 45770 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for one of 23 sampled residents (Resident 5), when Resident 5's care plan did not address the use of an incentive spirometer (a hand held device that helps people take slow, deep breaths) and compression stockings as ordered. This failure had the potential for the order to be missed and not implemented. Findings: A review of Resident 5's medical records indicated he was admitted in May 2022 with diagnoses including pulmonary dysfunction due to Chronic Obstructive Pulmonary Disease (COPD, lung disease causing restricted airflow and breathing problems) exacerbation. A review of Resident 5's Order Summary Report, for March 2024, indicated a physician's order, dated 3/17/24, for the use of an incentive spirometer three times a day for 10 days which also placed him on a respiratory program to improve lung function. A review of Resident 5's Order Summary Report, dated 2/22/24, indicated an order for Resident 5 to start using compression stockings for 10 hours daily, on in the morning and off at bedtime. During a concurrent interview and record review on 3/26/24 at 2:50 p.m. with Licensed Nurse (LN) 3, he confirmed Resident 5 had orders for the use of incentive spirometer and compression stockings. W,[NAME] asked if the orders were included in the care plan, LN3 affirmed there should be care plans done, after reviewing he stated he could not find the care plans for both orders. During an interview on 3/27/24 at 3:50 p.m. with the Medical Records Director (MRD), MRD stated there were no care plans for incentive spirometer and compression stockings she could find, that is the reason she could not provide copies of it. In an interview on 3/28/24 at 10 a.m. with the Director of Nursing (DON), DON stated she expects her staff to develop comprehensive care plans for the residents with identified areas of concern and be able to revise it if necessary. Care plans should be developed as soon as concerns are identified. A review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive revised 2/2022 it indicated A comprehensive care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change .The comprehensive person-centered care plan is developed within (7) days .

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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. 43258 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with acceptable professional standards of quality for one of five sampled residents (Resident 189) when nursing staff failed to expel air from a syringe to ensure the full dose of heparin (a medication to treat and prevent blood clots) was administered. This failure resulted in Resident 189 receiving an incorrect dose of heparin and potential for developing blood clots leading to complications of their clinical condition. Findings: During a medication pass observation on 3/25/24 at 9:07 a.m. with Licensed Nurse 4 (LN 4), LN 4 was observed preparing ten medications for Resident 189, including heparin 5000 units/milliliter (u/ml, a unit of measurement). She withdrew medication and pulled the plunger back to the 1 milliliter (ml, a unit of measurement) measurement marker. She held the syringe up and a large bubble was observed in the syringe. The heparin in the syringe was at the 0.88 ml measurement marker with the bubble on top. LN 4 confirmed she had finished preparing the dose and was ready to administer it to Resident 189. LN 4 administered the heparin into Resident 189's left lower abdomen without expelling the air from the syringe. A review of Resident 189's medical record indicated a physician's order, dated 3/9/34, for heparin 5,000 u/ml, inject 1 ml subcutaneously (under the skin) every 24 hours for DVT (deep venous thrombosis, a blood clot in a deep vein of the leg, pelvis, and sometimes arm). During an interview on 3/25/24 at 11:23 a.m. with LN 4, LN 4 stated she tried to remove the bubble from the heparin syringe to draw up the correct dose but was unable to. She acknowledged and agreed Resident 189 did not receive the correct dosage of heparin with a bubble in the syringe. During an interview on 3/25/24 at 4:47 p.m. with Director of Nursing (DON), DON confirmed correctly administering injectable medications to residents was an expectation and part of nursing staff's competency. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2023, the P&P indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 7. The individual administering the medication checks the label to verify . right dosage . before giving the medication. During a review of the facility's P&P titled, Subcutaneous Medication Administration, dated March 2018, the P&P indicated, Procedures A. Prepare medication as follows . 3) Prepare syringe and needle a. Swab rubber cap with alcohol sponge . c. Withdraw correct amount of medication . E. Expel air from syringe.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45770 Based on observation, interview, and record review the facility failed to assist one of 23 sampled residents (Resident 70) with the arrangement of an eye doctor consultation. This failure had the potential for a delayed delivery of care to help improve Resident 70's vision. Findings: A review of an admission record indicated Resident 70 was admitted to the facility in June 2023 with diagnoses including adjustment disorder with mixed anxiety and depressed mood (having emotional or behavioral symptoms within 3 months of a stressful event, including nervousness, worry, feeling sad, tearful, and hopeless). During an initial screening on 3/25/24 at 10:43 a.m. inside Resident 70's room, Resident 70 was observed lying in bed squinting while watching television and a pair of eyeglasses was on top of the table. Resident 70 stated the reading glasses were from the Activities Director and they gave him headaches whenever he used them. Resident 70 added he already told the staff he needed to see an eye doctor but he had not seen one yet. A review of a social services note, dated 8/7/23, indicated Resident 70 was provided with a pair of reading glasses but requested to see an optometrist (eye doctor) due to left eye blurriness and the Social Services Assistant (SSA) would arrange the referral. In an interview on 3/27/24 at 2 p.m. with the AD, she confirmed Resident 70 used eyeglasses and had been requesting to see an eye doctor. AD stated she told the Social Services office a month ago of Resident 70's request because he complained the reading glasses given to him did not fit him. In a concurrent interview and record review on 3/27/24 at 2:15 p.m. with the SSA, she acknowledged that according to the social services notes, the last time a follow up was made to Resident 70's request to see an eye doctor was in 8/2023 and no other documented evidence of an update was found. In an interview on 3/28/24 at 10 a.m. with the Director of Nursing (DON), DON stated she expected staff to be able to properly assess and identify resident's' needs like residents with impairments with hearing or vision. DON stated staff should be able to assist residents in obtaining needed services on time. A review of the facility's Policy and Procedure (P&P) titled, Sensory Impairments-Clinical Protocol, revised 3/2018, stipulated, The staff and physician will identify approaches to help the resident improve or compensate for sensory deficits for example, they may refer visually impaired individuals for a vision evaluation and/or corrective lenses. A review of the facility's P&P titled Social Services revised 5/2023, the P&P indicated, Medically-related social services is provided to maintain or improve each resident's ability to control everyday physical needs . The social services department is responsible for: Making referrals to social service agencies as necessary or appropriate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40841 Based on observation, interview, and record review, the facility failed to follow a physician treatment order for a stage 4 pressure ulcer (injury to skin and underlying tissue, exposing the tendon or bone) for one of 23 sampled residents (Resident 140) when staff did not follow the treatment order for the left posterior leg as physician prescribed. This failure had the potential for the resident's current pressure ulcers to worsen. Findings: According to the Admission Record, Resident 140 was admitted to the facility in 2024 with diagnoses including diabetes (issues regulating blood sugars; can delay wound healing) and stage 4 pressure ulcer. Review of the Order Summary Report, dated 3/28/24, indicated Resident 140 had a treatment order: stage 4 pressure injury (ulcer) to the left posterior leg, to cleanse with normal saline, pat dry, apply collagen, hydroferra blue (a powerful antibacterial wound dressing), triad (a cream to create a sterile coating for wound management) to the margin and silicone border foam dressing with skin prep (a wipe to protect the skin) to adhesive exposed skin every day shift every Monday, Wednesday, and Friday for wound care. Review of Resident 140's care plan, dated 3/25/24, indicated Resident 140 had a pressure ulcer to left leg. The care plan further indicated, Administered treatment as ordered . During a concurrent wound care observation and interview on 3/27/24 from 5:12 p.m. with Licensed Nurse 1 (LN1), LN 1 was performing a dressing change for the left posterior leg. LN 1 cleaned the wound with normal saline and gauze, applied triad cream to border of the wound, applied hydroferra blue to the wound bed, and covered with a foam border dressing. LN 1 confirmed he did not use skin prep and collagen during dressing change. During an interview on 3/28/24 at 8:44 a.m. with the Director of Nursing (DON), the DON confirmed she expected staff to follow physician orders for wound care. Review of the facility's policy titled, Pressure Ulcers, dated 4/2022, indicated, The physician/NP [nurse practitioner] will order pertinent wound treatment . wound cleaning . dressing and application of topical agents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45770 Based on observation, interview, and record review the facility failed to implement the proper checking of a roam signal device (a device that allows sensors on doors to alarm to keep track of wandering residents) for one of 23 sampled residents (Resident 56) when Licensed Nurses (LNs) took Resident 56 near a door to test its transmitter. This failure placed Resident 56 at an increased risk for elopement. Findings: A review of Resident 56's admission record indicated he was admitted in June 2022 with diagnoses including paranoid schizophrenia (mental illness with persistent false beliefs) and Alzheimer's disease (brain disorder that destroys memory, thinking skills, and the ability to carry out simplest task). During an initial screening on 3/25/24 at 11:28 a.m. inside Resident 56's room, observed Resident 56 wearing an alarm device to his left ankle while propelling himself out of the room towards the dining room to eat lunch. A review of an Order Summary Report, dated 12/15/23, indicated Resident 56 was ordered to use a roam signal device for exit seeking behavior. The order included checking the device for placement every shift and functionality every afternoon shift. During an interview on 3/27/24 at 2:38 p.m. with Licensed Nurse 2 (LN 2), LN 2 stated she was aware Resident 56 wore a roam signal device due to his behavior of trying to get out of the building alone. LN 2 confirmed the placement of the device is checked every shift, but she was not sure how to check the functionality and which staff was assigned to this task. LN 2, after checking in with the Director of Nursing (DON), stated the transmitter in the device is checked every afternoon shift. The LN assigned will take Resident 56 near the main door to check the functionality of the alarm. In an interview on 3/28/24 at 10 a.m. with the Director of Nursing (DON), she stated that Resident 56 had the roam signal device since she started working at the facility and still needed it due to his diagnosis. DON acknowledged that she's aware the nursing staff had been checking the transmitter device by taking Resident 56 near the main door but would find a proper way to check its functionality for the residents' safety. A review of the facility's Policy and Procedure (P&P) titled Assistive Devices and Equipment revised 5/2023 the P&P indicated the facility provides, maintains, trains, and supervises the use of assistive devices and equipment for residents.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40841 Based on observation, interview, and record review, the facility failed to implement fluid restriction orders for two of 23 sampled residents (Resident 139 and 77) when Resident 139's and Resident 77's water pitchers were at the bedside while on fluid restriction order. This failure had the potential for Resident 139 and Resident 77 not maintaining acceptable parameters of fluid intake. Findings: According to the Admission Record, Resident 139 was admitted to the facility in 2024 with diagnoses including heart failure. Resident 139 was his own responsible party. Review of the Order Summary Report, dated 3/26/24, indicated Resident 139 had a fluid restriction 1500 milliliters (ml, a unit of measurement) daily. During an observation on 3/25/24 at 11:03 a.m. in Resident 139's room, Resident 139 confirmed the water pitcher was at the bedside. During a concurrent observation and interview on 3/26/24 at 8:46 a.m., Certified Nursing Assistant 1 (CNA 1) confirmed the water pitcher was on Resident 139's bedside table. According to the Admission Record, Resident 77 was admitted to the facility in 2024 with diagnoses including atrial fibrillation (an irregular and often very rapid heart rhythm). Resident 77 was his own responsible party. Review of the Order Summary Report, dated 3/27/24, indicated Resident 77 had fluid restrictions of 1500 ml every 24 hours. During an observation on 3/25/24 at 10:25 a.m. in Resident 77's room, Resident 77 confirmed there was a water pitcher at the bedside. During an interview 3/27/24 at 10:56 a.m., Licensed Nurse 4 (LN 4) confirmed staff should not leave any water pitchers in the resident's rooms when they are on fluid restrictions. During an interview on 3/28/24 at 8:44 a.m., the Director of Nursing confirmed there should not be any water pitchers at the bedside for residents on fluid restriction. Review the facility's policy titled, Encourage and Restricting Fluids, dated 5/2022, indicated, .To provide the resident with the amount of fluids that meet his/her needs .Verify that there is an physician's order for any fluid restriction.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48694 Based on observation, interview, and record review, the facility failed to ensure the routine care practice and dressing change of the midline catheter (midline-a soft, long, and sterile tube inserted into a large vein in upper arm and used for administering medications into the bloodstream) for one of 23 sampled residents (Resident 76). This failure had the potential to result in serious blood stream infections causing hospitalization , organ failure, or death. Findings: During a concurrent observation and interview on 3/25/24 at 8:50 a.m. with Licensed Nurse (LN) 4, Resident 76 had a midline catheter with dressing dated 3/4/24 at 5 p.m. LN 4 stated the dressing should have been changed. A review of Resident 76's Physician's Orders, dated 3/4/24, indicated to insert a midline catheter for intravenous antibiotics treatment. A review of nurse's notes dated 3/4/24, the nurse's notes indicated, .a midline insertion at left upper arm . Sterile dressing applied. During a concurrent interview and record review on 3/28/2024 at 3:30 p.m. with Director of Nursing (DON), the Resident 76's active orders, medication administered records (MARs), and nurse's notes were reviewed. In active orders, there were no orders to flush and lock (a procedure to maintain the functioning status of the midline catheter), and change midline dressing. In the MARs, no documentation was found about midline flush and lock. In the nurse's notes, no documentation was found about midline dressing change and status. DON stated nurses should have added preset orders in Electronic Health Record (EHR) to the active orders, reviewed by physician, transcribed to MARs, and followed by nurses. DON further stated nurses did not add preset orders to active orders and missed the midline catheter care until the midline was removed on 3/25/24. DON also stated that failing to provide routine care and dressing change of midline catheter increased the risk of central line associated bloodstream infections. During a review of facility's policy and procedure (P&P) titled, Central venous Catheter Flushing and Locking, dated 2022, the P&P indicated, . Flush .to assess catheter function . Lock .after completion of the final flush . Monitor for any signs and symptoms of complications . Document .in resident's medical records .date and time .amount of flush administered . The condition of IV site before and after .signature and title of the person recording the data . Notify the supervisor, physician, and oncoming shift of any complications . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's P&P titled, Central venous Catheter Care and Dressing Changes, dated 2022, the P&P indicated, .Perform site care and dressing change .at least every 7 [seven] days for transparent semi-permeable membrane dressing .every 2 [two] days for sterile gauze dressing .or immediately if the dressing or site appears compromised . Label with initials, date, and time . The following information should be recorded in the resident's medical record .date and time dressing was changed .location and objective description of insertion site .any complications, interventions that were done .signature and title of the person recording the data . Report any signs and symptoms of complications to physician, supervisor, and oncoming shift .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44971 Based on observation, interview and record review, the facility failed to provide respiratory care services according to professional standards of quality for three of 23 sampled residents (Resident 39, Resident 240 and Resident 5), when: 1. Resident 39's and Resident 240's administered oxygen was not consistent with physician's order and care plan; and 2. Resident 5 was not provided with an incentive spirometer (a medical device used to help improve lung function) as ordered by the physician. These failures decreased the facility's potential to safely follow the physician's orders when providing respiratory services and increased the residents' risk of developing lung problems. Findings: 1. A review of Resident 39's Admission Record, indicated Resident 39 was readmitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary (lung) disease (COPD, lung disease that blocks airflow and makes it difficult to breathe) and acute respiratory failure (when the lungs cannot get enough oxygen into the blood). During an observation on 3/25/24 at 8:59 a.m., in Resident 39's room, Resident 39 was connected to oxygen at four liters (a unit of measurement) per minute via nasal cannula (delivers supplemental oxygen through a tube into the nose). During an interview on 3/25/24 at 2:55 p.m. with Licensed Nurse 3 (LN 3), LN 3 confirmed Resident 39 was connected to four liters of oxygen and stated it should have been two liters. A review of Resident 39's Physician Order, dated 8/8/23, indicated Resident 39 was on continuous oxygen at two liters per minute via nasal cannula for COPD exacerbation and shortness of breath. A review of Resident 39's Care Plan, dated 8/8/23, indicated Resident 39 required the use of continuous oxygen due to COPD and to administer oxygen therapy as ordered by the physician at two liters per minute via nasal cannula. A review of Resident 240's Admission Record, indicated Resident 240 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure, COPD, and pneumonia (lung infection). During an observation on 3/25/24 at 11:54 a.m., in Resident 240's room, Resident 240 was connected to oxygen at five liters per minute via nasal cannula. During an interview on 3/25/24 at 2:36 p.m. with LN 2, LN 2 confirmed Resident 240 was connected to five liters of oxygen and stated it should have been two liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 240's Physician Order, dated 3/19/24, indicated Resident 240 was on continuous oxygen at two liters per minute via nasal cannula for COPD. During an interview on 3/26/24 at 2:14 p.m. with Director of Nursing (DON), DON confirmed Resident 39's and Resident 240's oxygen orders were two liters and stated nurses should have followed the physician's order because both residents had the potential to develop carbon dioxide retention when administered four or five liters of oxygen instead of two due to their diagnoses. A review of the facility's policy titled, Oxygen Administration, dated 10/22, indicated Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 45770 2. A review of Resident 5's medical records indicated he was admitted in May 2022 with diagnosis including pulmonary dysfunction due to COPD exacerbation. During the initial screen on 3/25/24 at 10:10 a.m. inside Resident 5's room, Resident 5 was observed leaning forward to transfer from bed to the wheelchair. Resident 5 stated whenever he bends forward, he gets short of breath because he has COPD. A review of Resident 5's Order Summary Report, dated March 2024, indicated a physician's order dated 3/17/24 for the use of an incentive spirometer three times a day for 10 days which also placed him on a respiratory program to improve lung function. During a concurrent observation and interview on 3/25/24 at 1:11 p.m. with Resident 5, observed that there was no available incentive spirometer in the room for the resident to use. When asked about the device, Resident 5 stated he had never seen or used a breathing device other than the oxygen. During a concurrent observation, interview, and record review on 3/25/24 at 2:45 p.m. with LN 3, LN 3 verified Resident 5 had an order to use an incentive spirometer three times a day. LN 3 checked the room for the device but was not able to find it and asked Resident 5 for the device, but Resident 5 denied having seen it. LN 3 confirmed he did not check if Resident 5 had an incentive spirometer to use and stated he had never instructed Resident 5 how to use the device since it was ordered the week before. LN 3 steted LNs should have made sure Resident 5 had an incentive spirometer and was able to use it properly as ordered. During an interview on 3/28/24 at 10 a.m. with the DON, DON stated she expected the nursing staff to carry out and follow physician's orders accurately and be responsible for providing residents their needs and the order to be implemented completely and on time. A review of the facility's Policy and Procedure (P&P) titled, Physician Orders, dated October 2022, stipulated, Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order . The licensed staff shall carry out physician/nurse practitioner's orders as prescribed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Incentive Spirometry, revised May 2023, indicated this procedure ordered by an MD/Nurse practitioner is used to promote and maintain good respiratory health, staff should provide education to residents to follow incentive spirometry instructions properly.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44971 Based on observation, interview and record review, the facility failed to ensure staffing information was complete and posted on a daily basis at the beginning of each shift for a census of 90, when the Staffing Coordinator (SC) posted staffing information in the afternoon without the total number and actual hours worked per shift for licensed and unlicensed staff responsible for resident care. This failure decreased the facility's potential to post complete staffing information on a daily basis for residents and visitors. Findings: During an observation on 3/25/24 at 8:10 a.m. a document titled, Census and Direct Care Service Hours Per Patient Day (DHPPD), dated 3/23/24, was posted in the facility's main hallway beside the reception. During an observation on 3/25/24 at 11:39 a.m., the facility's staffing information for the current date was not posted. During a concurrent interview and record review on 3/27/24 at 11:10 a.m. with the SC, the facility's DHPPD forms dated, 3/23/24, 3/24/24, 3/25/24, 3/26/24, and 3/27/24 were reviewed. SC confirmed all DHPPD forms did not include the total number and actual hours worked per shift for licensed and unlicensed staff who were responsible for resident care. SC also confirmed staffing information was not posted on 3/24/24, and she posted staffing information in the afternoon on 3/25/24. SC stated staffing information should have been posted daily and early in the morning, so residents, visitors, and staff have access to the staffing report. A review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, dated 8/22, indicated Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43258 Based on observation, interview, and record review, the facility failed to ensure accurate accountability and effective storage of controlled medications (those with high potential for abuse or addiction) when random controlled medication audits for three out of four residents (Residents 6, 189 and 190) did not reconcile. The medications were signed out of the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications) but were not documented accurately on the Medication Administration Record (MAR) to indicate they were given to the residents. This failure resulted in the facility not having accurate accountability of controlled medications and potential for abuse or misuse of these medications. Findings: Resident 6 had a physician's order for tramadol (a medication to treat pain) 50 milligrams (mg, a unit of measurement), 1 tablet orally every 12 hours as needed for moderate to severe pain, dated 5/19/23. The CDR indicated 1 tablet was signed out on 2/9/24 and 2/28/24. The February 2024 MAR did not indicate their respective administrations to Resident 6 on these dates. Review of the February 2024 and March 2024 MARs indicated 1 tablet was administered to Resident 6 on 2/25/24 at 9:21 p.m., 2/29/24 at 9:24 p.m., and 3/12/24 at 9:23 p.m. but was signed out on the CDR. Resident 189 had a physician's order for hydrocodone/APAP (a medication to treat pain) 10/325 mg, 1 tablet by mouth every 4 hours as needed for moderate to severe pain, dated 3/10/24. The CDR indicated 1 tablet was signed out on 3/12/24 at 9:06 p.m., but its respective administration was not documented on the March 2024 MAR. Resident 190 had a physician's order for oxycodone (a medication to treat pain) 5 mg, 1 tablet by mouth every 6 hours as needed for moderate or severe pain, dated 3/11/24. The CDR indicated oxycodone 5 mg was signed out on 3/18/24 at 5:20 a.m., 3/19/24 at 4 a.m., 3/21/24 at 12:30 a.m., 3/24/24 at 5:30 a.m., 3/24/24 at 11:30 p.m., and 3/25/24 at 5 a.m. The March 2024 MAR did not indicate oxycodone was administered to Resident 190 on these dates or times. During an interview on 3/25/24 at 4:32 p.m. with Director of Nursing (DON), DON stated nursing staff were expected to document on both the MAR and CDR whenever a controlled medication was administered to a resident. During a review of the facility's policy and procedure (P&P) titled, Controlled Medications, dated 5/2022, the P&P indicated, Procedures . 4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration (MAR): a. Date and time of administration b. Amount administered c. Signature of the is actually administered.nurse administering the dose, completed after the medication

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 43258 Based on observation, interview, and record review, the facility had a 10.42% error rate when five medication errors out of 48 opportunities were observed during a medication pass for two out of five residents (Residents 5 and 189). This failure resulted in medications not given in accordance with the prescriber's orders, manufacturer specifications and potential to affect the residents' clinical conditions. Findings: During a medication pass observation on 3/25/24 at 8:04 a.m. with Licensed Nurse 1 (LN 1), LN 1 was observed administering medications to Resident 5, including a Trelegy Ellipta (a medication to treat asthma) 200/62.5/25 microgram (mcg, a unit of measurement) inhaler. Resident 5 inhaled 1 puff from the inhaler then sipped and swallowed his orange juice. A review of the manufacturer's specifications for the use of Trelegy Ellipta dated 12/2022 indicated, Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. During an interview on 3/25/24 at 11 a.m. with LN 1, LN 1 stated she normally instructed residents to rinse and spit after using Trelegy Ellipta, So they don't get any kind of fungus in their mouth. She confirmed she did not educate Resident 5 on the importance of rinsing and spitting after use of his inhaler. During a medication pass observation on 3/25/24 at 9:07 a.m. with LN 4, LN 4 was observed preparing ten medications for Resident 189 including insulin glargine (a long-acting insulin) pen, insulin lispro (a rapid-acting insulin) pen, multivitamin with minerals, and heparin (a medication to prevent and treat blood clots). LN 4 dialed the insulin glargine pen to 20 units and the insulin lispro pen to 5 units. LN 4 removed the flip cap from the vial and without swabbing the rubber cap underneath with an alcohol pad, inserted the needle. She then withdrew heparin from the vial with a syringe and pulled the plunger back to the 1 milliliter (ml, a unit of measurement) marker. She held the syringe up and a large bubble was observed in the syringe. The heparin in the syringe was at the 0.88 ml measurement marker with the bubble on top. LN 4 confirmed she had finished preparing the heparin and was ready to administer it to Resident 189. A review of Resident 189's medical record indicated physician's orders for the following: - Insulin glargine: Inject 20 units subcutaneously (under the skin) in the morning for DM-2 (diabetes type 2, a disease that occurs when blood sugar is too high), dated 3/9/24 - Insulin lispro: Inject 5 units subcutaneously before meals for DM-2, dated 3/9/24 - Multivitamin: 1 tablet one time a day, dated 3/9/24 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Heparin 5,000 u/ml (units/milliliter, a unit of measurement): Inject 1 ml subcutaneously every 12 hours for DVT (deep venous thrombosis, a type of blood clot), dated 3/9/24 During the same medication pass observation for Resident 189 with LN 4, LN 4 injected the prepared insulin lispro and glargine into the backs of Resident 189's right and left arms and counted to three each time before removing the needle. LN 4 then administered the heparin into Resident 189's left lower abdomen without expelling the air from the syringe. A review of the manufacturer's specifications for the use of insulin glargine pen revised July 2023 indicated, Step 3: Do a safety test. Always do a safety test before each injection to: Check your pen and the needed to make sure they are working properly. Make sure that you get the correct insulin glargine dose. 3A. Select 2 units by turning the dose selector until the dose pointer is at the 2 mark. 3B. Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly . Step 5: Injecting your insulin glargine dose . 5D. Keep the injection button held in and when you see '0' in the dose window, slowly count to 10 . This will make sure you get your full dose. 5E. After holding and slowly counting to 10, release the injection button. Then remove the needle from your skin. A review of the manufacturer's specifications for the use of insulin lispro pen revised July 2023 indicated, Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units . Step 8: Push the dose knob in until it stops, and '0' is seen in the dose window . Giving your injection . Step 11: Insert the needle into your skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle. During a concurrent interview and record review on 3/25/24 at 11:23 a.m. with LN 4, Resident 189's physician's orders were reviewed. LN 4 confirmed she did not prime either insulin pen before dialing the correct dose. She stated she counted to three after each injection of insulin before removing the needle because she did not want to make Resident 189 uncomfortable. She confirmed the insulin lispro was ordered to be administered before meals to control the blood sugar prior to a meal but it was not administered until after Resident 189 had eaten breakfast. LN 4 confirmed she prepared multivitamin with minerals instead of plain multivitamin for Resident 189. LN 4 confirmed she did not wipe the rubber cap of the heparin vial with an alcohol pad because there was a removable flip cap and thought it was not necessary. LN 4 stated she tried to remove the bubble from the heparin syringe to draw up the correct dose but was unable to. She acknowledged and agreed Resident 189 did not receive the correct dosage of heparin with the bubble in the syringe. During an interview on 3/25/24 at 4:47 p.m. with Director of Nursing (DON), DON confirmed correctly administering injectable medications to residents was expected and part of nursing staff's competency. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2023, the P&P indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 7. The individual administering the medication checks the label to verify . right dosage . before giving the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Subcutaneous Medication Administration, dated March 2018, the P&P indicated, Procedures A. Prepare medication as follows . 3) Prepare syringe and needle a. Swab rubber cap with alcohol sponge . c. Withdraw correct amount of medication . E. Expel air from syringe.

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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. 43258 Based on observation, interview, and record review, the facility failed to ensure medications were not stored on top of medication carts (med carts) when left unattended. The deficient practice had the potential for diversion or misuse of medications from not being stored securely. Findings: During an observation on 3/26/24 at 9:46 a.m. with Licensed Nurse 7 (LN 7), LN 7 was observed preparing medications at the med cart stationed in the hallway. LN 7 left the med cart in the hallway to attempt to locate a medication that was not inside the med cart. On top of the med cart was a bubble pack (a packaging system from the pharmacy for unit dosing medication) containing six hyoscyamine (a medication to treat excessive oral secretions) 0.125 milligram tablets. During an interview on 3/26/24 at 10:03 a.m. with LN 7, LN 7 confirmed the bubble pack that was left unattended on the med cart contained medication and was not securely stored when she had stepped away. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, dated April 2023, the P&P indicated, Policy Interpretation and Implementation . 13 . No medications are kept on top of the cart .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 40841 Based on observation, interview, and record review, the facility failed to ensure the competency of Food and Nutrition Services staff when: 1. Dietary Cook 1 (DC1) did not correctly know cooling down process; and, 2. DC1 did not know pureed consistency, did not use measurable tools/utensils, and did not use a recipe for pureed beef, vegetable, and starch. These failures to ensure staff competency for food related tasks had the potential to cause contamination of food and provide pureed food to residents with an inappropriate consistency for medical needs resulting in choking for 88 residents who received food from the kitchen out of a census of 90. Findings: 1. During an initial tour observation of the kitchen on 3/25/24 at 7:56 a.m. with Kitchen Dietary Manager (KDM), the KDM confirmed there were two pans of turkeys cooking in the oven for 3/26/24 lunch. Review the Cool Down Log, dated 3/25/24, indicated the turkey cooling down process was completed at 8 a. m. During a concurrent interview and record review of the cooling down log on 3/25/24 at 8 a.m. with DC1 and KDM, both staff confirmed the turkey cooling log was documented complete while the turkey was still cooking in the oven. The KDM confirmed the turkey should have been cooked first, then start the cooling down process. During an interview on 3/27/24 at 3:14 p.m. with Food Service Efficiency Consultant (FSEC), FSEC confirmed dietary staff should have competency with cooling down process. During an interview on 3/28/24 at 10:10 a.m., KDM confirmed there was no cooling down process training/in-service for DC1 in 2023. 2. During a concurrent observation of the pureeing process and interview on 3/27/24 at 9:18 a.m., DC1 was pureeing beef. DC1 used two hands to put 2 and a half hand-fulls of beef into the blender. Then, she added one pitcher (about 24 oz) of beef broth into the blender to mix and blend. There was no recipe used for pureed beef. DC1 confirmed she did not know the puree consistency for beef, did not use any measuring tools, and did not use a recipe for pureed beef. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation of the pureeing process and interview on 3/27/24 at 9:30 a.m., DC1 was pureeing vegetables (zucchini and carrots), she poured an unmeasurable amount of vegetable and vegetable juice into the blender to mix and blend. Then she added 1/4 cup of thickener into the blender. Next, DC1 start to puree sweet potatoes. She poured an unmeasured amount of canned sweet potatoes and sweet potatoes juice into the blender to mix and blend. DC1 confirmed she did not use a recipe nor any measuring tools/utensil and did not know the puree consistency for pureed starch and vegetable. During a concurrent observation of the pureeing process and interview on 3/27/24 at 9:45 a.m., DC1 was pureeing bread biscuits. DC1 put an unmeasured amount of biscuit and almond milk into the blender to mix and blend. DC1 confirmed she knew the puree consistency when pureeing starch, did not use any measuring tools/utensils, and did not use a recipe for pureed starch. During an interview on 3/27/24 at 10 a.m. and 3:14 p.m., FSEC confirmed dietary staff should have used recipes and measuring utensils when pureeing food. Review of the facility's policy titled, Demonstrating Food Safety and Job Competency for Food and Nutrition Services Employees, dated 5/2023, indicated, Each Food and Nutrition Services employee must be able to demonstrate competency in the food safety principles and job skills the facility requires.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40841 Based on observation, interview, and record review, the facility failed to prepare food in a manner to conserve nutritive value when recipes were not followed, and measurable tools/utensils were not used for pureed beef, pureed vegetable, and pureed starch. This failure had the potential to decrease the nutrients in food served and decrease food intake for five residents who received a pureed diet out of a facility census of 90. Findings: Review of the menu served for lunch on 3/27/24 and titled, Spring Cycle Menus indicated residents with a Regular texture diet received BBQ beef roast, sweet potatoes, fresh zucchini and carrots, and cheddar biscuit. Residents that were prescribed a pureed diet received pureed BBQ beef roast, sweet potatoes, fresh zucchini and carrots, and cheddar biscuit. During a concurrent observation and interview on 3/27/24 at 9:18 a.m., Dietary Cook 1 (DC1) was pureeing beef, she used two hands to put 2 and a half hand-fulls of beef into the blender. Then she added one pitcher (about 24 oz) of beef broth into the blender to mix and blend. There was no recipe used for pureed beef. DC1 confirmed she did not use any measuring tools and did not use a recipe for pureed beef. During a concurrent observation and interview on 3/27/24 at 9:30 a.m., DC1 was pureeing vegetable (zucchini and carrots), she poured an unmeasured amount of vegetable and vegetable juice into the blender to mix and blend. Then she added 1/4 cup of thickener into the blender. Next, DC1 start to puree sweet potatoes. She poured an unmeasured amount of canned sweet potatoes and sweet potatoes juice into the blender to mix and blend. There was no recipe used for pureed vegetable and starch. DC1 confirmed she did not use any measuring tools/utensil and did not use a recipe for pureed vegetable and starch. During a concurrent observation and interview on 3/27/24 at 9:45 a.m., DC1 was pureeing bread biscuit. DC1 put an unmeasured amount of biscuit and almond milk into the blender to mix and blend. There was no recipe used for pureed starch. DC1 confirmed she did not use any measuring tools/utensils and did not use a recipe for pureed starch. During an interview on 3/27/24 at 10 a.m. and 3:14 p.m. with Food Service Efficiency Consultant (FSEC), the FSEC confirmed dietary staff should have used recipes and measuring utensils when pureeing food to maintain nutritive value. Review of the facility's policy titled, Food Preparation, dated 5/2023, indicated, Food shall be prepared by method that conserve nutritive value, flavor, and appearance.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44971 Based on observation, interview and record review, the facility failed to provide a special eating utensil for one of 23 sampled residents (Resident 28), when Resident 28 was not provided with a rocker knife (a knife that can make it easier to cut food for one-handed individuals due to weakness or paralysis) during meals. This failure decreased the facility's potential to provide adaptive utensils designed to meet the clients' nutritional needs. Findings: A review of Resident 28's Admission Record, indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including left side hemiplegia (paralysis of one side of body), muscle weakness, and lack of coordination. A review of Resident 28's Minimum Data Set (MDS; an assessment tool), dated 12/30/23, indicated Brief Interview of Mental Status (BIMS) score was eight of 15 with some memory problems. MDS further indicated Resident 28 needed setup or clean-up assistance when eating. During an observation on 3/25/24 at 12:29 p.m. in the facility's dining room, Resident 28 was served her lunch tray without a rocker knife. Resident 28's meal ticket indicated Resident 28 had a rocker knife as adaptive equipment. Resident 28 was unable to cut her food using a regular knife. During a concurrent observation and interview on 2/25/24 at 12:42 p.m. with Resident 28 in the facility's dining room, Resident 28 was sitting in her chair and not eating her lunch. Resident 28 stated she could not cut the food using the regular knife. During a concurrent observation and interview on 3/25/24 at 12:43 p.m. with Restorative Nurse Assistant 1 (RNA 1) in the facility's dining room, RNA 1 confirmed Resident 28 had a regular knife instead of a rocker knife. RNA 1 stated if Resident 28 had a rocker knife then she might have been able to cut the food. During a concurrent observation and interview on 3/27/24 at 12:43 p.m. with Central Supply (CS) in Resident 28's room, CS confirmed Resident 28 received her lunch tray without a rocker knife. CS stated Resident 28 received a regular knife and her meal ticket, dated 3/27/24, did not indicate she needed a rocker knife. A review of Resident 28's Order Summary Report, dated 3/27/24, indicated Resident 28 should have a rocker knife as adaptive equipment. A review of Resident 28's Weight Summary, dated 3/27/24, indicated Resident 28's weight dropped from 158 pounds on 5/2/23 to 146 pounds on 2/24/24. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 28's Interdisciplinary (IDT) Conference Notes, dated 12/26/23, indicated to continue Resident 28's dietary plan of care. A review of Resident 28's Nutrition Care Plan, dated 11/9/22, indicated Resident 28 was at risk for altered nutritional status, malnutrition and dehydration related to hemiplegia affecting left non-dominant side that required the use of an adaptive equipment to increase Resident 28's self-feeding ability. A review of Resident 28's Care Plan, dated 10/26/23, indicated Resident 28 had adaptive equipment during feeding. A review of Resident 28's Nutrition Narrative Note, dated 11/15/22, indicated Resident 28 used a rocker knife and scoop plate to promote self-feeding independence. During an interview on 3/27/24 at 12:48 p.m. with Kitchen Dietary Manager (KDM), KDM stated Resident 28 never received a rocker knife because it was never available in the facility and kitchen never had a rocker knife utensil. During an interview on 3/27/24 at 2:26 p.m. with Director of Nursing (DON), DON confirmed Resident 28's order indicated to have a rocker knife and stated staff should have followed the physician order and should have notified the DON and Registered Dietitian when the rocker knife was unavailable. DON further stated Resident 28 had an increased potential for weight loss because staff did not provide her with a rocker knife to cut her food, and she could not maintain her motor skills by using the appropriate utensil which increased her dependence on staff. A review of the facility's policy titled, Adaptive Devices, dated 5/23, indicated Residents will receive adaptive devices to maintain or improve their ability to eat or drink independently .Residents needing devices will receive them as ordered. Tray cards and diet profile will record which device is needed .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40841 Based on observation, interview and record review, the facility failed to store food in a sanitary manner for a census of 90 when: 1. Dietary staff did not use hair nets and/or beard guards while in the kitchen; 2. Several food items were opened and not dated with their open date and expired food items were in the reach-in refrigerator and dry storage; and, 3. Expired left-over roast beef with used by date [DATE] was available to use on [DATE]. These failures had the potential to result in foodborne illness. Findings: 1. During a concurrent observation and interview on [DATE] at 7:45 a.m., the Dietary Aid (DA) was in the kitchen and was not wearing a hairnet. Later, the Kitchen Dietary Manager (KDM) entered the kitchen and was not wearing a hair net and beard guard. KDM confirmed hair net and beard guards are required while in the kitchen. Review of the facility's policy titled, Dress Code, dated 2023, indicated, Hair net for hair . beard and mustaches (any facial hair) must wear beard restraint. 2. During an observation in the reach-in refrigerator and dry storage on [DATE] at 7:45 a.m., there were 2 left-over loaves of bread and heads of lettuce without a date labeled, expired left-over beef puree, dated [DATE], and 6 opened bread bags without open date labeling. Review of the facility's policy titled, Labeling and Dating of Foods, dated 2023, indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. 3. During a concurrent observation in the kitchen and interview on [DATE] at 9 a.m. with Dietary Cook 1 (DC1), DC1 took out left-over roast beef with used by date [DATE] and was about to reheat it. DC1 confirmed she was not aware of the expired roast beef. Review of the facility's policy titled, Leftover Foods, dated 2023, indicated, Leftover food will be stored and served in a safe manner . Use refrigerated leftovers within 72 hours. During an interview on [DATE] at 10 a.m. and 3:14 p.m., Food Service Efficiency Consultant (FSEC) confirmed staff should not use expired food items, opened food items should have a date labeled, and staff should use hair net/beard guards while in the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40841 Based on observation, interview, and record review, the facility failed to follow infection control practices when: 1. Dietary Cook 1 (DC1) did not perform proper hand hygiene practice while in the kitchen for a census of 90; and, 2. Licensed Nurse 5 (LN 5) did not change gloves and perform hand hygiene during wound care for one of 23 sampled residents (Resident 140). These failures had the potential to spread infection in the facility. Findings: 1. During a concurrent observation in the kitchen and interview on 3/25/24 at 8 a.m., the DC1 entered the kitchen and performed hands washing and then pat drying using her clothes. Then DC1 washed her hands again without using hand soap, scrubbing hands less than 20 seconds. DC1 confirmed she should have washed hands with soap and water and dried with towels. During an interview on 3/27/24 at 3:14 p.m. with Food Service Efficiency Consultant (FSEC), FSEC confirmed staff must perform hand washing before providing food services. 2. According to the Admission Record, Resident 140 was admitted to the facility in 2024 with diagnoses including diabetes (the body's inability to manage blood sugars appropriately) and stage 4 pressure ulcer (injury to skin and underlying tissue, exposing the tendon and/or bone). During a concurrent observation and interview on 3/27/24 at 5:12 p.m. with LN 5, LN 5 was doing right leg wound care for Resident 140. LN 5 removed the old dressing, cleaned the wound with normal saline and gauze, and applied a new dressing and secured with tape using the same pair of gloves. There was no new gloves used and hand hygiene performed between removal of old dressing and application of the new dressing. During an interview on 3/28/24 at 8:44 a.m. with the Director of Nursing (DON), the DON confirmed staff are to change gloves from dirty to clean during wound care process. Review of the facility's policy titled, Hand washing Procedure, dated 2023, indicated, Hand washing is important to prevent the spread of infection . Hands need to be washed . Before starting work in kitchen. The policy further stipulated, Wet hands and forearms first. Add soap and rub hands together forming a lather . Rub . for 20 seconds.