STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vacaville Convalescent & Rehab	585 Nut Tree Court Vacaville, CA 95687

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 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 46242 Based on observation, interview, and record review, the facility failed to ensure baseline care plans (instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) were developed and implemented within 48 hours of admission for one (1) out of 21 sampled residents (Resident 238) when Resident 238 had been ordered anti-seizure medication without related seizure monitoring and care plan. This failure had the potential to place Resident 238 at risk for unmet care needs. Findings: A review of Resident 238's admission record indicated Resident 238 was admitted to the facility in November of 2024, with diagnoses including a fracture of the left femur (a thigh bone) and a fall with subsequent encounter (aftercare). A review of Resident 238's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for November and December of 2024 indicated order initiated on 11/19/24 for Divalproex Sodium 250 MG (milligram, unit of mass) two times a day for seizure prevention, with medication marked as given daily per order with few occasional exceptions due to refusals. No orders for monitoring seizure symptoms were found in the record. A review of Resident 238's Care Plan History indicated no care plans specific to seizure monitoring. A review of Resident 238's Physician's Progress Note, dated 11/19/24, indicated, [Brand medication name] (Divalproex) 250 mg tablet, delayed release . Give 1 tablet by mouth two times a day for Seizure Prevention (Do not crush) During a concurrent interview and record review on 12/5/24 at 2:59 p.m. with the Licensed Nurse (LN 3, Unit Manager) Resident 238's orders and care plans were reviewed and LN 3 confirmed that Resident was on divalproex for seizures, had no seizure monitoring in place and no seizure specific care plan. LN 3 stated that she expected residents on anti-seizure medications to be monitored for seizures and to have a corresponding care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/6/24 at 12:06 p.m. with the Director of Nursing (DON), DON stated that for residents on anti-seizure medications, she expected seizure monitoring and a seizure-specific care plan to be implemented. A review of facility policy and procedure (P&P) titled, Seizures and Epilepsy- Clinical Protocol, dated November 2018, indicated, The physician and staff will help identify individuals who have a history of seizure or epilepsy, and individuals who are receiving antiepileptic medications for any reason; for example, seizure prophylaxis after a recent stroke or treatment for behavioral symptoms related to dementia . In addition, the nurse shall assess and document/report the following . Neurological assessment . Change in level of consciousness . Any seizure activity in detail (location, duration, severity, recurrence, etc.) . Injury occurring with seizure . Monitoring . The staff and physician will monitor the progress of individuals with a new seizure or a seizure disorder and will modify interventions accordingly. They should document periodically and objectively the presence or absence of seizure activity . For Individuals who have been seizure-free for an extended time, the physician will periodically consider tapering antiepileptic medications especially when their initial use was for idiopathic seizures, an underlying acute medical cause was corrected, or seizure prophylaxis had been initiated in the absence of an identifiable structural cortical [brain region] lesion. A review of facility P&P titled, Care Plans - Baseline, dated March 2022, 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. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders .

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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. 47465 Based on interview and record review the facility failed to provide services according to professional standards when anticoagulant (medications that prevent or reduce blood clotting) monitoring was not in place for Resident 63. This failure had the potential to put Resident 63 at risk for having complications related to excessive bleeding. Findings: A review of an admission record indicated Resident 63 was admitted to the facility in February 2023 with diagnoses including pulmonary embolism (blood clot in an artery in the lung), embolism and thrombosis of the left leg (a blood clot blocks or narrows an artery in the leg). During a review of Resident 63's, Medication Administration Record, on 12/4/24 at 10:04 a.m., the record indicated Resident 63 was receiving apixaban (medication that decreases the clotting ability of the blood) tablet twice a day. The record did not indicate an order to monitor side effects such as excessive bleeding or bruising. During a review of Resident 63's Care Plan, on 12/4/24 at 10:05 a.m., it did not indicate an anticoagulant monitoring care plan. During an interview and record review on 12/5/24 at 11:08 a.m., with Licensed Nurse 1 (LN 1), LN 1 confirmed that there were not any orders or a care plan for anticoagulant monitoring. She stated that not having the care plan can put the resident at risk for not being monitored for side effects of apixaban and any signs of bleeding may be missed. During an interview on 12/5/24 at 12:14p.m., with the Director of Nursing (DON), the DON stated that her expectations are that all residents on anticoagulants have orders to monitor side effects and an anticoagulant monitoring care plan, not having them can lead to residents not being monitored for bleeding. During a review of the facility's policy titled, Anticoagulation - Clinical Protocol, dated 2001, indicated, staff and physician will monitor for possible complications . and . If an individual on anticoagulation therapy shows signs of evidence of bleeding, the nurse will discuss the situation with the physician . During a review of the facility's policy titled, Care Plans, Comprehensive Person-Centered , revised March 2022, indicated, .care plan includes measurable objectives and .establishing the expected goals and outcomes of care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46242 Based on observation, interview, and record review, the facility failed to provide respiratory care services consistent with professional standards of care and facility policy, for one (1) resident (Resident 240), out of 21 sampled residents, when: 1. Resident 240's nasal cannula (NC- nasal cannula, special tubing that delivers gas to the nostrils) was unlabeled with a date it was changed; and 2. facility's orders and practices in changing humidifier bottle (a bottle of distilled water inserted into an oxygen delivery system to add moisture when being administered oxygen) and nasal cannula were not in agreement with facility's policy. These failures increased the risk for resident 240 to develop respiratory infections. Findings: A review of Resident 240's admission record indicated that Resident 240 was admitted to the facility in November of 2024 with diagnoses including respiratory failure with hypoxia (problems with breathing and low oxygen levels). A review of Resident 240's order summary report (OSR), dated 12/6/24, included the following active orders: O2 [oxygen gas] at 2 L/min [liters per minute, rate] via NC as needed for shortness of breath, chest pain, O2 saturation less than 90% .]. Initiated on 11/23/24. O2 at 2-3 L/min via NC continuously every shift. Initiated on 12/4/24. Change Humidifier Bottle &Tubing [NC] When O2 Used - Clean Filters of O2 Concentrators with Warm Soap Water, Pat Dry & Replace on O2 Concentrator when Changing Humidifier Bottle every night shift every 5 day(s). Initiated 12/4/24. During a concurrent observation and interview on 12/4/24 at 3:58 p.m., with the Infection Preventionist (IP), the IP stated NC and humidifier bottle should each be labeled with dates when first used/opened and changed on a weekly basis. IP entered Resident 240's room and confirmed that Resident 240's NC was not labeled, and the humidifier bottle was labeled with date 12/3. During an interview on 12/5/24 at 9:21 a.m. with Licensed Nurse (LN 3, Unit Manager). LN 3 stated the facility's practice was to change humidifier bottle and NC together and date only the bottle. LN 3 confirmed Resident 240 had an order to change the bottle and nasal cannula every 5 days. During concurrent observation and interview on 12/5/24 at 9:40 a.m. with Resident 240 lying in bed with NC applied and oxygen running at 2L/min. Resident 240 stated that she had been on continuous oxygen therapy via NC since she was admitted to the facility. There was still no date labeled observed on NC and the humidifier bottle was still labeled 12/3. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/5/24 at 9:46 a.m. with Licensed Nurse (LN 5), LN 5 stated that she was taking care of Resident 240, and the resident was on oxygen therapy via NC since admission. LN 5 also stated that she expected NC tubing and humidifier bottle to be changed every 3 days and they should be labeled with dates separately. During concurrent observation and interview on 12/6/24 at 9:50 a.m. with LN 5 in Resident 240's room. LN 5 confirmed observation that Resident 240's NC tubing was still not labeled with a date and the humidifier bottle was still labeled 12/3. LN 5 stated the bottle and tubing should be changed every 5 days, and they each should be labeled with dates. In an interview on 12/6/24 at 9:59 a.m. with the Director of Nursing (DON), the DON confirmed the humidifier bottle and NC are expected to each be labeled and the facility's practice of changing bottle and tubing as one unit was not in agreement with the policy that required bottle changes every 24 hours and tubing changes every 7 days. A review of facility policy and procedure titled, Departmental (Respiratory Therapy) - Prevention of Infection, undated, indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Distilled water used in respiratory therapy must be dated and initialed when opened, and discarded after twenty-four (24) hours . Infection Control Considerations Related to Oxygen Administration . [NAME] bottle with date and initials upon opening and discard after twenty-four (24) hours . Change the oxygen cannula and tubing every seven (7) days, or as needed .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48140 Based on observations, interviews, and record reviews the facility failed to ensure complete nurse staffing data was displayed and accessible for residents and visitors, for a census of 82 residents, when actual hours worked was not displayed. This failure had the potential to mislead residents and visitors of the actual hours worked by staff responsible for providing direct care to residents. Findings: During an observation on 12/4/24 at 2:50 p.m. at the North Nursing station, the Daily Staffing form was displayed. The form included the number of Licensed Nurses (LN) and Certified Nursing Assistants (CNA) scheduled for each of the facility's shifts. However, the form did not include the actual hours worked by the LNs and CNAs, who are directly responsible for resident care. During a concurrent observation and interview on 12/4/24 at 3:20 p.m., at the North Nursing station, with the Medical Records Director (MRD), the MRD confirmed the Daily Staffing form displayed did not include the total number and actual hours worked per shift for LNs or CNAs. The MRD stated, I never thought I had to post the actual hours .I've never posted it since I've been [working] here. During a concurrent interview and record review on 12/5/24 at 1:32 p.m., with the Administrator (ADM), the daily Staffing form was reviewed. The ADM confirmed the form did not include the actual hours worked per shift for LNs or CNAs providing direct care. During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, the P&P 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 . Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following .The actual time worked during that shift for each category and type of nursing staff . total number of licensed and non-licensed nursing staff working for the posted shift .

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 47465 Based on interview and record review, the facility failed to develop a comprehensive dementia (a progressive state of decline in mental abilities) care plan for one out of 21 sampled residents (Resident 57), when there was no dementia care plan for Resident 57. This deficient practice had the potential to delay dementia treatments and services needed for Resident 57. Findings: A review of Resident 57's admission record indicated the resident was admitted to the facility in October 2024, with diagnoses that include senile degeneration of the brain (decline in cognitive function) and dementia. A review of Resident 57's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/18/24, indicated the resident has moderate cognitive impairment and non-Alzheimer's (a disease characterized by a progressive decline in mental abilities) dementia. During a concurrent interview and record review on 12/5/24 at 1:54 p.m., with Licensed Nurse 1 (LN 1), Resident 57's care plans were reviewed. LN 1 confirmed there was not a dementia care plan for Resident 57. LN 1 stated that the care plan is important to assess the resident properly, informs staff how to interact with the resident, what behaviors to monitor and what are appropriate interventions for the resident. During an interview on 12/5/24 at 3:59 p.m., with the Director of Nursing (DON), the DON stated she expected that residents with dementia have a dementia care plan, so staff knows how to monitor and interact with the resident and implement proper interventions. During a review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, .care plan includes measurable objectives and timetables to meet the resident's psychosocial and functional needs . and, .services that are to be furnished to attain or maintain the resident's highest practicable mental, and psychosocial well-being .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47465 Based on observation, interview, and record review, the facility failed to ensure that medications were stored according to accepted professional principles for a census of 82 residents, when loose pills were found in a medication cart and medication refrigerators were not maintained. This deficiency had the potential for residents to have an increased risk of receiving compromised medications. Findings During a concurrent observation and interview on 12/4/24 at 2:07 p.m., with Licensed Nurse 2 (LN 2) of north hall medication cart A, 8 loose pills were found in the bottom of the medication drawer. LN 3 confirmed the presence of the loose pills and stated that loose pills could be accidently given to residents. During a concurrent observation and interview on 12/4/24 at 2:31p.m. of north station medication room with LN 1, LN 1 confirmed the medication refrigerator was: 1. noted to have thick ice buildup which prevented the freezer door to be opened, 2. puddles of water were seen at the bottom of the fridge and shelving, and 3. damage was noted on the external areas of the fridge. LN 1 stated that if the fridge is not working and maintained properly medications could be compromised and the residents could potentially receive ineffective medications or experience a reaction. During a concurrent observation and interview on 12/4/24 at 2:51 p.m., with LN 3 in the south station medication room. LN 3 confirmed the medication fridge thermometer indicated a temperature of 24 Fahrenheit (F - a unit of measure), and the medication fridge temperature expected range is 36-46 F. LN 3 stated that the medication fridge temperature is out of range which could potentially damage the medication and cause it to be ineffective. During an interview on 12/5/24 at 12:14p.m. with the Director of Nursing (DON), the DON stated loose pills shouldn't be in the cart and should be disposed of appropriately. The DON added, nurses are responsible for monitoring temperatures and general fridge maintenance such as cleaning and defrosting the fridge. During a review of the facility's policy and procedure titled, Medication labelling and storage, dated 2001, indicated, .the facility stores all medications .under proper temperature . and, .nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46242 Based on observation, interview, and record review, the facility failed to maintain infection prevention and control practices to help prevent the development and transmission of communicable diseases and infections when: 1. The wound treatment nurse (TN): took a container of medication from a resident's room and put back in the clean supply cart, failed to sanitize equipment between uses for different residents, and did not label wound dressings. 2. Housekeeping staff did not perform hand hygiene between cleaning different resident rooms and the same mop and sanitizing solution was used to clean multiple rooms. 3. Enhanced Barrier Precautions were not applied for residents with wounds and indwelling medical devices. These failures had the potential to result in infection spread among a facility census of 82 residents. Findings: 1. During wound treatment observation on 12/4/24 commencing at 1:55 p.m., the TN was observed providing wound care to Resident 141 and Resident 242. The TN brought supplies including scissors and an entire container of powdered nystatin (an antifungal medication) into Resident 141's room. The TN removed old dressings, that were not labeled with date or initials, from both knees of Resident 141. The TN used scissors to trim new dressings and applied new dressings to the knee wounds, but the TN did not label new dressings with a date or initials. The TN applied the nystatin powder to Resident 141's groin area, and then placed the nystatin container back in the treatment supply cart with other clean supplies. The TN took the scissors from Resident 141's room and placed them on the top of the treatment supply cart without disinfecting them. The TN removed four clean packages of dressings and placed them on top of the treatment supply cart where they touched the potentially contaminated scissors. The TN then took the four packages of dressings from the top of the treatment supply cart into Resident 242's to do a dressing change. The TN removed old dressings from Resident 242's right leg, old dressings were not labeled with date or initials, and then applied new dressings without labeling with date or initials. In an interview on 12/4/24 at 2:45 p.m., the TN admitted he took the entire nystatin powder container from Resident 141's room back to the clean cart. The TN acknowledged he was not supposed to bring the entire nystatin powder container into the resident's room and should have taken a small portion in a disposable medication cup for use inside the resident's room. The TN confirmed the old dressings, that were removed from both Resident 141 and 242, were not labeled with dates or initials, and he did not label new dressings as expected. The TN confirmed that he did not use readily available disinfectant wipes to sanitize the scissors that were brought from Resident 141's room nor did he sanitize the top of the treatment cart between providing treatments to two different residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/6/24 at 9:59 a.m. with the Director of Nursing (DON), the DON stated entire medication containers should not be taken into resident rooms but rather the needed dose must be taken into the room in a disposable medication cup. The DON added, medication containers that have been taken into the residents' rooms should not be brought back to the clean supply cart. The DON also stated she expected wound dressings to be labeled with date and initials and reusable equipment, including scissors and a treatment supply cart surface, must be sanitized between different residents with provided disinfecting wipes. A review of facility policy and procedure (P&P) titled, Dressings, Dry/Clean, undated, indicated, The purpose of this procedure is to provide guidelines for the application of dry, clean dressings . The following equipment and supplies will be necessary when performing this procedure . Clean dressing(s); Cleaning solution, as ordered; Tape; Scissors; and Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed) . Clean bedside stand, Establish a clean field . Label tape or dressing with date, time, and initials. Place on clean field. Using the clean technique, open other products . Apply the ordered dressing and secure it with tape or bordered dressing per order. (Note: Use nonallergenic tape as indicated.) Label with date and initials to top of dressing . 2. During an observation on 12/5/24 commencing at 8:21 a.m., Housekeeper 1 (HK 1) was observed cleaning resident rooms. HK 1 took the mop from the mop bucket with sanitizing solution and mopped the floor in rm 44. After moping room [ROOM NUMBER], HK 1 put the mop with the mop head back into the bucket with sanitizing solution. Then, without conducting hand hygiene or changing the mop head, HK 1 went to clean the floor in room [ROOM NUMBER]. HK 1 took the mop from the bucket with sanitizing solution, mopped the floor in room [ROOM NUMBER], and placed the mop back into the solution bucket. In an interview on 12/5/24 at 8:29 a.m. HK 1 confirmed that he did not perform hand hygiene when he moved from room [ROOM NUMBER] to room [ROOM NUMBER] and he used the same mop head and solution to clean both rooms. He stated that he routinely uses the same mop head and sanitizing solution to clean three to four rooms. During an observation on 12/5/24 commencing at 9:57 a.m. HK 2 was observed working in room [ROOM NUMBER]. HK 2 grabbed the mop with the wet mop head and mopped the floors in room [ROOM NUMBER]'s restroom. Then HK 2 placed the mop in a sanitizing bucket with a solution. HK 2 then grabbed gloves and the basket with cleaning supplies and went to room [ROOM NUMBER] to clean inside that restroom. In an interview on 12/5/24 at 9:57 a.m. HK 2 stated she uses the same mop head and solution to clean 5 restrooms before changing the solution. In an interview on 12/6/24 commencing at 9:59 a.m. DON agreed that using the same mop head and sanitizing solution in multiple rooms increases the risk of cross-contamination. She also stated she expected housekeeping staff to perform hand hygiene between different rooms. A review of facility P&P titled Cleaning and Disinfecting Residents' Rooms, dated August 2013, indicated, Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently . Floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60-minute intervals . Perform hand hygiene after removing gloves . Change mop solution water at least every three (3) rooms, or as necessary . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. In an interview on 12/4/24 at 3:58 p.m., the Infection Preventionist (IP) stated that Enhanced Barrier Precautions (EBP, a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms-MDROs during high contact care activities). Was used by the facility only on residents colonized or having a history of MDROs. During concurrent observation and interview on 12/6/24 at 9:09 a.m. in the facility's hallways with Licensed Nurse 3 (LN 3, Unit Manager). LN 3 stated that residents on EBP had a red dot against their name on the room entry signage. LN 3 provided a list of 10 residents with in-dwelling medical devices. Six (6) reviewed residents were not placed on EBP. LN 3 stated that she was not aware that these residents had to be placed on EBP. In an interview on 12/6/24 at 9:59 a.m. the DON confirmed EBP should have been implemented, but had not been, for residents with wounds and in-dwelling devices. A review of facility P&P titled, Enhanced Barrier Precautions, dated August 2022, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents . EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48140 Based on interviews and record reviews, the facility failed to ensure all Certified Nursing Assistants (CNAs) were provided mandatory abuse training when documentation for the required training was unavailable for the 13 CNAs assigned to the night (NOC) shift. This failure had the potential for all 82 residents in facility to experience physical, mental, or psychosocial harm. Findings: During an interview on 12/04/24 at 4:21 p.m. with the DSD, the DSD stated in-services were scheduled two times a week on Tuesday's and Thursday's from 2:30 p.m. to 3:30 p.m. When questioned if the DSD provided in-services to the NOC shift staff, the DSD did not provide a response. During an interview on 12/05/24 at 8:09 a.m. with the DSD, the DSD stated she tracked staff participation for required in-services by ensuring staff write their name and signature on a sign in sheet accompanying the in-service. The DSD confirmed the mandatory abuse prevention training had not been provided during 2024. During an interview on 12/05/24 at 10:58 a.m., When requested the NOC shifts training records, the DSD admitted , I don't provide in-services to the NOC shift staff .I make sure they get the information, but they don't sign a sign in sheet or attend in-services in person. During a review of the facility's policy and procedure (P&P) titled, In-Service Training, Nurse Aide, revised August 2022, the P&P indicated, All nurse aide personnel participate in regular in-service education . Required training topics for all staff (including nurse aides) included: c. abuse, neglect and exploitation of residents .Nurse aid participation in training is documented by the staff development coordinator, or his or her designee and includes: the date and time of the training, the topic of the training, the method used for training, a summary of the competency assessment and the hours of training completed.