STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555355	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Faire Nursing & Rehabilitation Center	3620 B Dale Rd. Modesto, CA 95356

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43071 Based on observation, interview, and record review, the facility failed to ensure residents' needs were accommodated promptly for 2 of 25 sampled residents(Resident 190 and Resident 63) when call lights were not answered in a timely manner. This failure resulted in needs not being met promptly and had the potential to cause psychosocial and/or physical harm for Resident 190, and Resident 63. Findings: 1. During a concurrent observation and interview on 4/22/24, at 9:18 a.m., Resident 190 was noted resting in bed in her room. Resident 190 stated she did not have her hearing aids on and could not hear well without her hearing aids. During a continued observation on 4/22/24, at 9:21 a.m., Resident 190 pressed her call light for staff to come help give her hearing aids from her nightstand drawer. During a continued observation and interview on 4/22/24, at 9:30 a.m., a staff member was heard talking outside the room in the hallway. Resident 190 stated in a frustrated tone that she wished she could get her hearing aids herself. During a continued observation on 4/22/24, at 9:37 a.m., staff were noted talking outside the room in the hallway. During a continued observation and interview on 4/22/24, at 9:40 a.m., Medical Records (MR) stood in the room doorway and asked Resident 190 if she needed help. Resident 190 told MR to give her hearing aids. MR informed Resident 190 that she was not her Certified Nursing Assistant (CNA) and she just saw the call light on from her office. MR stated she would send her CNA to help her with the hearing aids and then walked away. During a continued observation and interview on 4/22/24 at 9:42 a.m., CNA 1 came inside Resident 190's room and asked Resident 190 if she wanted her hearing aids while getting the hearing aids from Resident 190's bedside drawer. Resident 190 replied, You should have given to me earlier, so I didn't have to go through this. Give them when you bring the breakfast next time. CNA 1 apologized to Resident 190 and handed over hearing aids to Resident 190. Resident 190 placed her hearing aids in her ears and stated, Yeah, now I can hear. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/24, at 9:45 a.m., CNA 1 stated it would take her 10-15 minutes to answer the call light if she was assisting another resident in a room. CNA 1 further stated she was assisting another resident outside. CNA 1 stated she gave residents their hearing aids early in the morning around 6 am. CNA 1 further stated she did not offer Resident 190 her hearing aids earlier this morning. CNA 1 explained she should have offered Resident 190 to use her hearing aids this morning so Resident 190 could hear her while she was talking to her. During an interview on 4/22/24, at 9:50 a.m., Resident 190 stated she should have asked her CNA to give her hearing aids when she brought breakfast this morning. Resident 190 further stated she did not want to go through that again where she had to wait for a long time. Resident 190 added it was very upsetting to sit and wait for them to come help her. During an interview on 4/22/24, at 10:01 a.m., Resident 190 stated it always took them long time to answer her call light throughout the day. Review of Resident 190's care plan revised 4/12/24, indicated, At risk for falls and injuries . Interventions . Encourage use of call light . 2. During a concurrent observation and interview on 4/22/24, at 4:30 p.m., Resident 63 was observed lying in his bed and was noted with his bilateral lower extremities missing. Resident 63 stated he needed help to get up and pressed his call light. During a continued observation and interview on 4/22/24, at 4:37 p.m., Resident 63 was attempting to get up using his bedside rail. Resident 63 stated he wanted to get up and sit on the wheelchair (w/c) while pointing to the w/c at the foot of his bed. During a continued observation and interview on 4/22/24, at 4:39 p.m., when asked if staff always took long time to come help him, Resident 63 replied, Yeah, they don't come. Resident 63 continued to struggle to get up, holding his left side bed side rail with both hands. Resident 63 made multiple unsuccessful attempts to get up on his own. During a continued observation and interview on 4/22/24, at 4:41 p.m., Resident 63 stated, I want to sit down and go to bathroom. Resident 63 continued to try to get up on his own. During a continued interview on 4/22/24, at 4:46 p.m., Resident 63 stated in a louder tone, Come on help me .they are not gonna come. During a continued observation and interview on 4/22/24, at 4:49 p.m., CNA 2 came in the hallway with a coffee cart. CNA 2 came into Resident 63's room and asked him if he would like to get any coffee. During a continued observation and interview on 4/22/24, at 4:50 p.m., CNA 2 brought a cup of coffee for Resident 63 and asked Resident 63 if he needed something since his call light was on. CNA 2 then helped Resident 63 as per his request. During an interview on 4/22/24, at 4:57 p.m., CNA 2 stated sometimes it took her little bit longer to answer the call light if she was busy. CNA 2 stated sometimes it took her up to 20 minutes to answer a call light if she busy giving a shower to a resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 63's care plan revised 9/12/23, indicated, At risk for falls and injuries . Interventions . Encourage use of call light . During an interview on 4/25/24, at 10:45 a.m., the Director of Nursing (DON) stated staff should answer the call light as soon as possible. The DON stated call lights should be answered in less than 5 minutes. The DON stated a call light not answered for more than 5 minutes was not acceptable. The DON added if a resident had a critical situation such as choking and pressed the call light for help and waiting for 5 minutes would pose a life risk. The DON stated waiting for a call light to be answered for long time such as 15 - 20 minutes or longer was not acceptable. The DON stated it would cause a delay in care, would not meet resident needs in a timely manner and could put residents' safety at risk. Review of a facility policy titled, Call Lights: Accessibility and Timely Response dated October 2022, indicated, .Call lights will directly relay to a staff member or centralized location to ensure appropriate response .To facilitate timely call light response, all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 43943 Based on interview, and record review, the facility failed to ensure the Physician Orders for Life-Sustaining Treatment [POLST- a legal document communicating the resident's medical wishes for end-of-life care] was completed accurately for 7 of 25 sampled residents (Resident 22, Resident 62, Resident 79, Resident 491, Resident 3, Resident 63, and Resident 78), when: 1. Resident 22's POLST did not contain the resident representative (RR- the person who acts on behalf of the Resident) contact information, 2. Resident 62's POLST did not include Resident 62's contact information; and the date Resident 62 signed was missing, 3. Resident 491's POLST did not contain Resident 491's conservator (CON) 1 (a person who manages the resident's financial and healthcare issues when the resident is not able) contact information; and the date signed was missing, 4. Resident 3's POLST was signed by Resident 3, who did not have the capacity to sign for herself, 5. Resident 63's POLST was not dated when prepared, and the Advanced Directive (explains the type of health care you prefer in case you can't make your own decisions. It's used to appoint someone to speak for you to make sure your wishes are carried out- this person becomes your healthcare agent) section was not dated, and the healthcare agent was not verified from Resident 63's Advanced Directive; and, 6. Resident 78's POLST in Section D for Advanced Directive was left blank. These failures had the potential for the following: Incomplete contact information for Resident 22, Resident 62, and Resident 491 had the potential to delay emergency treatment or not honoring personal preferences for life-sustaining treatment; Resident 3's inability to understand her choices increased the risk medical treatment preferences would not be honored; Unverified healthcare agent information for Resident 63 increased the risk medical treatment preferences would not be honored; and, Advanced Directive information not collected for Resident 78 increased the risk medical treatment preferences would not be honored. Findings: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. A review of Resident 22's clinical record titled, Admission Record, indicated Resident 22's admitting diagnoses included heart failure, diabetes (inability to control blood sugar), and the presence of a cardiac pacemaker (implanted device in the heart that assists the heart in maintaining a steady heart rhythm). During a review of Resident 22's clinical record titled, POLST, dated 3/23/24, signed by the Medical Director (MD) and RR 1 indicated RR 1's mailing address and phone number were not listed. During a concurrent interview and record review on 4/23/24, at 3:02 p.m., with LN 2, Resident 22's document titled, POLST, dated 3/23/24, was reviewed. LN 2 verified the address and phone number of RR 1 was missing on the POLST form. LN 2 stated the legal document should have been completed in its entirety in order for the facility to easily reach RR 1 in case of an emergency. During an interview on 4/24/24, at 10:50 a.m., with the Admission Nurse (Admit Nurse- the nurse who completes the admission assessment and assists with paperwork) 1, Admit Nurse 1 stated it was the responsibility of the admission nurse to ensure the POLST form was initiated and completed. 2. During a review of Resident 62's clinical record titled, Admission Record, indicated Resident 62's admitting diagnoses included diabetes, heart failure, and history of a heart attack. A review of Resident 62's clinical record titled, POLST, dated 3/20/24, signed by the MD and Resident 62, indicated the POLST did not include the date the document was signed by Resident 62 or Resident 62's mailing address and phone number. During a concurrent interview and record review on 4/23/24, at 2:56 p.m., with LN 1, Resident 62's document titled, POLST, dated 3/20/24, was reviewed. LN 1 verified there was not a mailing address or phone number for Resident 62 listed on the POLST form. LN 1 stated the POLST form should not have had any blank areas. During an interview on 4/24/24, at 10:50 a.m., Admit Nurse 1 stated it was the responsibility of the admission nurse to ensure the POLST form was initiated and completed. 3. A review Resident 491's clinical record titled, Admission Record, indicated, Resident 491's admitting diagnosis included Chronic Obstructive Pulmonary Disease (COPD - a group of diseases that cause airflow blockage and breathing-related problems), heart failure, and respiratory failure. During a review of Resident 491's clinical record titled, POLST, prepared on 3/3/23, signed by Phys 1 and CON 1, indicated the POLST form did not include CON 1's mailing address, phone number, and the date the document was signed. During a concurrent interview and record review on 4/23/24, at 3:02 p.m., with LN 2 Resident 491's clinical record titled, POLST, prepared on 3/3/23, was reviewed. LN 2 acknowelged the POLST form did not include the CON 1's mailing address, phone number, and the date the document was signed. LN 2 stated the POLST was a legal document and should have been completed in its entirety. During an interview on 4/24/24, at 10:50 a.m., with Admit Nurse 1, stated it was the responsibility of the admission nurse to ensure the POLST was completed, and the document should have been completely filed out. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/24/24 at 8:45 a.m., with the DON, the P&P titled, Promoting the Right of Self-Determination for Healthcare Decisions and Advanced Healthcare Directives [a legal document that gives instructions on health care], dated 11/2016, was reviewed. The P&P indicated, .a completed, fully executed form is a legal physician order and is immediately actionable .staff should review documents for completeness . The DON acknowelged the POLSTs for Resident 22, Resident 62, Resident 79, and Resident 491 were not filled out in their entirely and stated the staff needed to be reeducated on the importance of completing all aspects of the POLST form. The DON stated, the P&P was not followed. 43071 4. Review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility in 2012 with multiple diagnoses including severe intellectual disabilities and a case worker was her responsible party for healthcare decisions (CON 2). Review of the MDS (Minimum Data Set: a standardized assessment tool that measures health status in nursing home residents) assessment, dated 10/26/12, indicated Resident 3 had severley impaired cognition. Review of Resident 3's POLST, dated 10/19/12, indicated Resident 3's POLST was discussed with Resident 3's legal decision maker, but was signed by Resident 3. During a concurrent interview and record review on 4/23/24, at 4:18 p.m., LN 14 stated a POLST was filled out with the resident or resident representative upon admission. LN 14 verified Resident 3's POLST prepared on 10/19/2012 was signed by Resident 3. LN 14 stated Resident 3 had a conservator and did not have the mental capacity to make her own decisions. LN 14 stated it should not have been signed by Resident 3 since she did not have the capacity. During a concurrent interview and record review on 4/24/24, at 9:44 a.m., Resident 3's POLST was reviewed with Minimum Data Set (a resident assessement tool) Nurse (MDS) 1. MDS 1 stated Resident 3 had a conservator and did not have the mental capacity to make her own decisions since being admitted to the facility. MDS 1 confirmed Resident 3's POLST was signed by Resident 3 herself. MDS 1 stated Resident 3's decisions were made by CON 2. During an interview on 4/25/24, at 8:23 a.m., CON 2 stated directors at the agency would make decisions on her behalf when needed. CON 2 stated Resident 3 was severely intellectually disabled ever since she was enrolled with their agency which was 1984. CON 2 stated Resident 3 did not have the mental capacity to make her own decisions. 5. Review of Resident 63's Admission Record indicated Resident 63 was admitted to the facility in 2024 with multiple diagnoses including encephalopathy (a group of conditions that cause brain dysfunction), and end stage renal disease (when kidneys no longer function well enough to meet a body's needs). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 63's POLST dated 4/15/24, indicated in section D, Advance Directive (describes a person's designation of a healthcare agent to make decisions on their behalf if they are no longer able) was marked as discussed with the legally recognized decisionmaker. The Advance Directive date was left blank. Resident 63's daughter's name was listed under the Health Care Agent if named in Advance Directive section. The date when the POLST form was prepared was left blank. During a concurrent interview and record review on 4/23/24, at 4:18 p.m., with LN 14 and LN 15, Resident 63's POLST was reviewed. LN 14 stated a healthcare agent was listed on Resident 63's POLST so Resident 63 must have an Advance Directive. LN 14 confirmed the date of the Advance Directive was missing and there was also no date when the POLST form was prepared. LN 15 stated Resident 63's daughter filled out the POLST. LN 15 further stated he went over the POLST form with Resident 63's daughter, but did not go over the Advanced Directive information. LN 15 stated he instructed the daughter to fill out Resident 63's RP's information in Section D of the POLST. LN 15 further stated he did not realize that the healthcare agent information was to be filled out as listed on the resident's Advance Directive. LN 15 stated he did not ask Resident 63's daughter anything about an Advance Directive and did not know if he had Advance Directive. LN 14 stated staff needed to see the Advanced Directive in order to enter the healthcare agent information. LN 14 stated it was important to know if a resident had an Advance Directive because an Advance Directive had their decision for treatment in life threatening situations and it should coincide with their POLST. LN 14 stated there was a possibility that the resident's life decision treatments/wishes might not be respected if a resident had an Advance Directive and it was not available. 6. Review of Resident 78's Admission record indicated Resident 78 was admitted to the facility in 2024 with multiple diagnoses including atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), portal vein thrombosis (PVT: a narrowing or blockage by a blood clot in the veins of the liver). Resident 78's POLST dated 2/11/24 was reviewed. Section D of the Advanced Directive on the POLST was left blank. During an interview on 4/23/24, at 11:21 a.m., when asked about her Advanced Directive, Resident 78 stated she had a power of attorney (POA) who would make healthcare decisions on her behalf, and she had given a copy to the facility. During a concurrent interview and record review on 4/23/24, at 4:56 p.m., LN 14 verified Resident 78's POLST was incomplete. LN 14 stated staff should have discussed the Advanced Directive information with Resident 78 and should have entered this on her POLST. LN 14 stated there was no Advanced Directive in Resident 78's record. LN 14 further stated they did not know if Resident 78 had an Advance Directive. During a concurrent interview and record review on 4/24/24, at 10 a.m., MDS 1 confirmed the Advanced Directive section on Resident 78's POLST was left blank and it meant that it was not discussed with Resdient 78. MDS 1 stated residents should be asked about an Advanced Directive in order to know what their wishes were for medical care in life threatening situations and who the decision maker was, in case they were unable. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/24, at 10:50 a.m., the Director of Nursing (DON) stated upon admission residents were asked about Advanced Directive, documented on the POLST, asked to provide a copy by the next day and uploaded in their chart. The DON further stated if a resident did not provide Advanced Directive they were asked again during care conference meeting. The DON stated staff should inquire about an Advanced Directive when filling out the POLST and document this. The DON stated Advanced Directives indicated a resident's living wishes towards end of life and had information of their healthcare agent who would be making decisions on their behalf if not able to. The DON stated if a resident had Advance Directive then the facility should have a copy in their record. Without a copy, the residents' life wishes might not be honored. The DON stated staff should not have a resident fill the POLST who did not have the mental capacity to make decisions, because the resident did not have enough understanding and could not make a good judgement. Review of the facility policy, titled Promoting The Right of Self-Determination For healthcare Decisions and Advanced Healthcare Directives, dated November 2016, indicated, .Residents will be informed upon admission, and periodically, of their rights concerning self-determination of preferred intensity of care and the process for creating and implementing advanced health care directives .Staff should document in the medical chart, the existence of an Advance Directive, Living Will, and/or standing physician order form . POLST .Staff should review documents for completeness and confirm with the resident and/or the legal healthcare decision maker that the documents are current .An Advance Directive can only be executed by the resident and the resident must have healthcare decision making capacity when executed .A resident's standing physician order form and Advanced Directives will be reviewed by the facility interdisciplinary team (IDT) with the resident/legal healthcare decision maker, on a periodic basis and as warranted by a change in the resident's health status, medical condition or preferences .The facility will implement existing Advance Directives when they have been created prior to admission to the facility .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47369 Based on observation, interview, and record review, the facility failed to ensure a clean, comfortable, and homelike environment for 4 out of 46 facility rooms (Room A, Room B, Room C and Room D) when: 1. The floor in Room A, under the nightstand, next to the first bed, contained stained, broken tiles and trash, 2. Room B had two areas of deep scratches in the drywall behind the first bed, 3. Room C had two deep scratches in the dry wall behind the second bed, the bathroom door had a broken, jagged edged striker plate (protective plastic disc used to prevent the bedroom doorknob breaking the bathroom door) partially covering a splintered, cracked area in the door, the bathroom sink was pulling away from the wall; and, 4. The toilet in Room D had been leaking for an unknown period of time. These failures resulted in the facility residents not being provided a clean, comfortable, and homelike environment with the potential to negatively impact the residents physical and psychosocial well-being. Findings: 1. During a concurrent observation and interview on 4/22/24, at 9:53 AM, in Room A, Housekeeper (HSK) 2 was observed moving a nightstand. HSK 2 confirmed there were three straws, several napkins, two medicine cups, a butter knife, a pen, a broken mirror, and a plastic lid on the floor under the cabinet. HSK 2 further confirmed five tiles were stained with dark brown and pink dried substances and two of the tiles were broken. HSK 2 stated, .This is not good for the residents . During an interview on 4/22/24, at 11 AM, the Maintenance Director (MDir) stated he was disappointed in the cleanliness of the floor in room A. The MDir further stated items and furniture should be pulled out daily and cleaned under. The MDir confirmed the broken tiles needed to be replaced. 2. During an observation on 4/22/24, at 10:17 AM, in Room B two deep scratches were noted in the dry wall behind the first bed. The area on the left measured approximately 12 inches (or in.) by 17 inches and the area on the right side measured approximately 12 in. by 7 in. both areas contained several areas of peeled drywall hanging off the wall. During an interview on 4/22/24, at 11 AM, the MDir confirmed the wall in Room B contained scratched areas and did not meet his expectations for a homelike environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 4/22/24, at 11 AM, in Room C, the MDir confirmed the bathroom sink was pulling away from the wall and there were gaps between the caulking material (flexible material used to seal leaks or gaps) and the wall and sink. The MDir stated when the sink was reset it was not fastened correctly and there was a separation of the brackets and the caulking material needed to be replaced. The MDir further stated repairing the sink was a high priority. The MDir stated the wall behind the bed in Room C looked poorly and needed to be repaired. The MDir confirmed the striker plate on the bathroom door was broken and had jagged edges and exposed a cracked area in the door underneath it. The MDir stated the broken striker plate was not safe and had the potential to injure the residents in the room. A review of a facility document titled, Work Order #817, dated 3/28/24, indicated, .Room [C} .SHEET ROCK BEHIND HEAD OF BED IS TORE UP, BASEBOARD IS ALSO DETACHED FROM WALL .Location BEHIND HEAD OF BED .COMMENTS Repaired . During a concurrent interview and review of pictures taken in Rooms A, B, and C, on 4/25/24, at 7:51 AM, the Director of Nurses (DON) confirmed the sink in Room C posed a safety risk for the residents who shared the bathroom. The DON stated it was her expectation that the issues in Rooms A, B, and C would have been addressed immediately. The DON further stated those rooms did not provide a homelike environment for the residents. A review of a facility policy and procedure (P&P) titled, Housekeeping Cleaning Schedule-Sample, dated 8/14, indicated, .To ensure that all areas receive standard levels of care .Document any repair needs and turn in to housekeeping supervisor .Clean resident rooms .Sweep and mop entire floor including under bed, nightstands, and dressers . A review of a facility P&P titled, Safe, Clean, Comfortable, and Homelike Environment, dated 6/2023, indicated, .In accordance with residents' rights, the facility will strive to provide a safe, clean, comfortable and homelike environment .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .Maintenance/Housekeeping Supervisor should conduct regular facility rounds and provide general monitoring/oversight of efforts to maintain a safe, clean, comfortable environment . 43943 4. During a review of Resident 79's clinical record titled, Admission Record, indicated Resident 79's medical diagnoses included muscle weakness and need for assistance with personal care. During an interview on 4/22/24, at 12:16 p.m., with Resident 79, stated the toilet in Room D had been leaking for three to four days. Resident 79 stated he told everyone that came in the room about the toilet and the facility staff looked and the toilet and then did not do anything to fix the problem. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Faire Nursing & Rehabilitation Center	3620 B Dale Rd. Modesto, CA 95356

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/22/24, at 12:21 p.m., with the Maintenance Director (MDir), the bathroom in Room D was observed. MDir took a few paper towels and wiped up the fluid that was around the toilet on the floor and the paper towels were saturated with fluid. MDir confirmed there was a large stain area around the toilet, and it appeared to be a result of a toilet that had been leaking for some time. MDir stated the staff should have informed him as soon as possible either verbally and/or by in putting an electronic work order in the computer. MDir stated there were not any current work orders listed for Room D. During an interview on 4/22/24 at 12:21 p.m., with Housekeeping (HSK) 1, HSK 1 stated the toilet in Room D was leaking yesterday. HSK 1 acknowledged she had not informed MDir that the toilet was leaking. During a review of the undated facility document titled, Job Description/Performance Evaluation .Supervisor Maintenance, indicated, .ensure that all patient and resident rooms are properly maintained (furniture, wall coverings, flooring, plumbing, lights, etc.) . During a concurrent interview and record review on 4/24/24, at 8:53 a.m., with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Safe, Clean, Comfortable and Homelike Environment, dated 6/2023, was reviewed. The P&P indicated, .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment . The DON acknowledged the leaking toilet did not provide a sanitary homelike environment and the P&P was not followed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47369 Based on observation , interview, and record review, the facility failed to ensure a comprehensive care plan was developed and revised for 3 of 25 sampled residents (Resident 6, Resident 8, and Resident 16), when: 1. A care plan was not developed for Resident 6 and Resident 16's oxygen therapy use; and, 2. Resident 8's nutrition care plan was not revised. These failures had the potential for Resident 6, Resident 8, and Resident 16's plan of care not being followed. Findings: 1a. A review of Resident 16's ADMISSION RECORD, indicated, she was readmitted to the facility in 2024 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD, long term lung disease that causes airflow blockage and shortness of breath). A review of Resident 16's MAR dated April 2024, indicated, .Oxygen at 2 LPM (Liter Per Minute) via nasal cannula (NC: a small, flexible tube that contains two open prongs intended to sit just inside the nostrils). continuous .Order Date 03/14/2024 . During a concurrent interview and record review on 4/24/24, at 9:22 AM, Licensed Nurse (LN) 12 confirmed Resident 16 did not have a care plan for oxygen use, and she should have. During a concurrent interview and record review on 4/24/24, at 9:33 AM, the Director of Nurses (DON) confirmed Resident 16 did not have a care plan for oxygen use. The DON further stated the purpose of the care plan was to direct the residents care, inform the nurses of the interventions specific to the resident, the complications to monitor for, and to ensure communication of the resident's short term and long-term goals. 43071 1b. Review of Resident 6's Admission Record indicated Resident 6 was readmitted to the facility in 2024 with multiple diagnoses including asthma (a condition that affects a person's airways and makes it difficult to breathe), acute respiratory failure with hypoxia (a condition when there is not enough oxygen in a person's body). During a concurrent observation and interview on 4/22/24, at 10:34 a.m., Resident 6 had oxygen on at a flow rate of 4 liters via NC. Resident 6 stated he was taking oxygen every night and sometimes during the day. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/22/24, at 12:31 p.m., LN 9 confirmed Resident 6 was receiving oxygen. LN 9 stated Resident 6 was readmitted from the hospital on 3/22/24 and had been using oxygen every day since then. During a concurrent interview and record review on 4/25/24, at 11:21 a.m., the DON stated if a resident received oxygen, then resident's care plan should reflect use of oxygen therapy. Resident 6's care plans were reviewed with the DON. The DON verified there was no care plan for Resident 6's use of oxygen therapy. The DON stated Resident 6 had acute respiratory failure, hypoxia, and asthma. The DON stated use of oxygen therapy was one of the interventions they were providing to Resident 6 and could affect Resident 6's care when not reflected on the care plan. 2. Review of Admission Record indicated Resident 8 was admitted to the facility with multiple diagnoses including dysphagia (difficulty swallowing food). During an observation on 4/24/24, at 1:07 p.m., Resident 8 was eating dinner with family at her bedside. Resident 8's meal tray card read, 1/2 dessert, sugar free condiment, fortified liquidized (smooth, liquified consistency). Preferences: 8oz [ounce: unit of measurement] fortified milk at all meals, add pudding or ice cream at lunch, extra sauce/gravies, serve meals in cups, small portions, soup x 3. Resident 8 had 4 cups of liquidized food, 1 glass of milk, and 1 glass of water. Resident 8 was drinking food with straw from a cup. Review of Resident 8's care plan revised 2/25/24, indicated, Altered nutrition and hydration risk . Interventions .Meal intervention per tray card: 1/2 portions desserts, SF [Sugar Free] condiments, extra gravy/sauce with meals, small portions . Review of Resident 8's care plan, revised on 2/20/24, indicated, Malnourished as evidenced by Nutritional Screening Tool. Care plan interventions did not reflect liquidized diet. During an interview on 4/24/24, at 4:26 p.m., the Dietary Services Supervisor (DSS) stated he had one resident, Resident 8 on a pureed liquidized diet as per family request. The DSS stated Resident 8's family spoke with him couple weeks ago that Resident 8 would not eat her puree (soft, pudding-like consistency) food but would drink with a straw. The DSS stated they decided to do a trial of puree liquidized diet to see if Resident 8 would eat more like that. The DSS stated he checked with Resident 8's family last week and was told Resident 8 was eating better with puree liquidized diet texture. The DSS stated Resident 8 had been eating better, drinking soups and taking more calories. Resident 8's nutrition care plan was reviewed with the DSS. The DSS verified Resident 6's nutrition care plans were not updated to reflect puree liquidized diet intervention. During an interview on 4/25/24, at 10:36 a.m., the DON stated resident's nutrition care plan should reflect diet interventions including trial of different diet or texture. The DON stated resident's care plan needed to be updated every time resident's diet change. The DON stated if resident's care plan not updated then it would not reflect the interventions being provided to the resident, might not get followed and could affect resident care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility's policy, titled Care Plan, Comprehensive, dated December 2017, indicated, .It is the policy of this facility to develop, in conjunction with the resident and/or representative, the Comprehensive Resident Care Plan. The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life .Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .Care Plans become a comprehensive tool for the IDT to utilize as a reference for identified concerns and approaches to establish guidance for meeting resident individual needs .Resident progress is regularly evaluated, and approaches revised or updated as appropriate .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 43071 Based on observation, interview, and record review, the facility failed to ensure necessary care and services were provided for 2 of 25 sampled residents (Resident 3 and Resident 8), when: 1. Resident 3 and Resident 8's nails were not cleaned and trimmed; and 2. Resident 3 did not receive showers as per her shower schedule. These failures had the potential for Resident 3 and Resident 8 to experience decreased self esteem from poor hygiene, poor skin integrity, and scratches which could lead to infection for Resident 8. Findings: 1a. Review of the Admission Record indicated Resident 8 was admitted to the facility in early 2023 with multiple diagnoses including hemiplegia with hemiparesis following cerebral infarction (paralysis of partial or total body function on one side of the body after stroke), need for assistance with personal care. During an observation on 4/22/24, at 10:22 a.m., Resident 8 had long fingernails with dirt in them. Resident 8 had scratch marks on her left forearm. During a concurrent observation and interview on 4/23/24, at 11:39 a.m., Certified Nursing Assistant (CNA) 4 confirmed Resident 8 had long fingernails and had dirt in them. CNA 4 stated Resident 8's fingernails needed to be trimmed and cleaned. CNA 4 stated residents' fingernails should be cleaned and trimmed, and stated residents could scratch themselves and break their skin. CNA 4 stated Resident 8 scratched herself and had scratch marks on her body. 1b. Review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility in 2012 with multiple diagnoses including severe intellectual disabilities. Review of Resident 3's care plan, revised 2/27/24, indicated Self Care Deficit As Evidenced by: Extensive assistance with most ADLs [Activities of Daily Living] d/t [due to] weakness and poor endurance with severe confusion and some behaviors .Interventions .Personal Hygiene: One person physical assistance required . Bathing: one person physical assistance required. During a concurrent observation and interview on 4/22/24, at 10:26 a.m., Resident 3 had long toenails with the small toenail on the right foot noted to be black. Resident 3 stated she did not like long toenails. Resident 3 stated she had asked staff to cut her long toenails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/23/24, at 11:30 a.m., CNA 4 stated nail care was done every Sunday and on residents' shower days. CNA 4 stated residents got showers twice a week. CNA 4 stated nail care included cleaning the dirt out, cut and file nails as needed. CNA 4 stated none of her residents requested to keep their fingernails long. CNA 4 added she trimmed their nails all the way. CNA 4 stated Resident 3 was scheduled to receive showers in the evening shift. CNA 4 stated she did not provide nail care for Resident 3. CNA 4 verified Resident 3's fingernails were long and had dirt in them. CNA 4 stated her nails needed to be cleaned and cut. CNA 4 stated CNAs were not allowed to cut residents' toenails and were done by podiatrist. CNA 4 stated they would notify charge nurse if resident needed toenail care. CNA 4 verified Resident 3's toenails were long. CNA 4 further stated those were too long. CNA 4 stated Resident 3's right little toenail looked like it was rotten or had fungus. During an interview on 4/24/24, at 1:42 p.m., the Director of Staff Development (DSD) stated staff should provide nail care during showers. The DSD stated she had also added the nail care task in residents' electronic record for staff do it every day. The DSD stated nail care included toenail care as well. The DSD stated CNAs were supposed to provide toenail care for non-diabetic residents. The DSD verified Resident 3 was non-diabetic (with no blood sugar disease). During an interview on 4/25/24, at 9:13 a.m., Licensed Nurse (LN) 9 stated all residents' toenail care was done by the Podiatrist (foot doctor), and she thought a podiatrist came to the facility on ce a month. LN 9 stated diabetic residents' fingernail care was done by the nurses. LN 9 stated nail care needed to be done at least twice a week. During a concurrent observation and interview on 4/25/24, at 9:37 a.m., Resident 3's toenails were observed with LN 9. LN 9 stated looking at the severity of Resident 3's toenails, a podiatrist should be taking care of them. LN 9 stated Resident 3's toenails were quite long and needed to be trimmed. LN 9 stated Resident 3's right little toenail was black and looked like old blood. LN 9 stated it needed to be taken care of. LN 9 stated she was not aware of Resident 3's toenails situation, no-one informed her and neither had she checked it. During an interview on 4/25/24, at 9:52 a.m., the Social Services Director (SSD) stated all long-term care residents were seen by the podiatrist every quarter. The SSD stated residents were seen by the podiatrist last time on 4/22/24. The SSD stated if a resident needed to be seen sooner or had an urgent need then she would reach out the podiatrist and he would come sooner. The SSD added if podiatrist was not able to come sooner then she would refer the resident out to receive the needed care. The SSD stated she did not remember receiving a request for any resident to be seen by the podiatrist this month. Review of the untitled facility provided document from outside podiatry provider, dated 4/25/24, the document indicated the list of residents seen by the podiatrist on 4/22/24. The list did not include any care provided to Resident 3. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent interview and record review on 4/24/24, at 10:50 a.m., Resident 3's shower task for the last 30 days was reviewed with LN 8. LN 8 stated per the electronic record, Resident 3 was scheduled to receive showers on Mondays and Thursdays on the morning shift. LN 8 verified there was no record of a shower offered or given to Resident 3 on her scheduled shower days on 4/11/24, 4/15/24, 4/18/24, and 4/22/24. LN 8 confirmed Resident 3's scheduled shower days 3/28/24, 4/4/24, and 4/18/24 were documented as not applicable. LN 8 stated CNAs followed a paper shower schedule kept at the nurses station. LN 8 verified the paper shower schedule indicated Resident 3 was scheduled to receive a shower on Wednesday and Saturday evening shift. LN 8 stated this conflicted with the electronic record. LN 8 verified there was no record of a shower offered/given to Resident 3 on her scheduled shower days as per the paper shower schedule on 4/3/24 and 4/6/24. LN 8 confirmed Resident 3's scheduled shower days per the paper shower schedule, 3/30/24, and 4/17/24 were documented as not applicable. LN 8 stated Resident 3 did not receive a shower according to either shower schedule. LN 8 stated Resident 3 missed showers because of conflicting shower schedules. LN 8 stated it was not good for Resident 3's hygiene and self-esteem. During an interview on 4/25/24, at 9:42 a.m., CNA 5 stated she documented residents' shower task in the electronic record. CNA 5 stated she would have choosen option not applicable under the shower task if it was not resident's shower day but was triggered to document. CNA 5 stated she would choose option refused under a shower task if a resident refused a shower, full bed bath and partial bed bath. CNA 5 stated she would choose the option not available under the shower task if resident was out of facility for an appointment or so and was not available for shower in her shift. During a concurrent interview and record review on 4/24/24, at 1:42 p.m., the DSD verified Resident 3 was scheduled to receive a shower on Wednesday and Saturday in the evening shift as per the paper shower schedule, and to receive a shower on Monday and Thursday in the morning shift per the electronic record. The DSD stated Resident 3 should have been receiving shower on Wednesday and Saturday per the paper shower schedule. During an interview on 4/25/24 at 10:03 a.m., the Director of Nursing (DON) stated CNAs were to provide nail care to non-diabetic residents over the weekend. The DON further stated nurses were responsible to provide toenail care to the residents unless a resident was diabetic and had thick or in grown toenails then it was done by a podiatrist. The DON stated residents' nails should be cleaned and trimmed for personal hygiene, safety, and dignity. The DON stated long, and dirty nails could pose a safety risk such as scratching that could lead to skin issues, long nails could get tangled with clothes, and dirt in nails could cause infection. The DON stated residents should receive a shower twice a week as per their schedule. The DON stated the facility was like their home and they should receive proper care. The DON stated showers were important for residents for their personal hygiene, respect, dignity, safety, and infection control. Review of Resident 3's care plan revised 2/27/24, indicated, Potential for pressure ulcer [Injury to skin and underlying tissue resulting from prolonged pressure on the skin] development r/t [related to] Impaired mobility .Interventions .Bathe/shower as scheduled and as needed . Review of a facility procedure, titled Bath, Bed, dated 2006, indicated, .PURPOSE .To cleanse, refresh and soothe the resident .To stimulate circulation .To inspect the body .Care of fingernails and toenails is part of the bath. be certain nails are clean. If toenails are difficult to cut, inform the charge nurse .Fingernails and toenails of diabetic residents are cut by the licensed nurse or podiatrist . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility procedure, titled Bath, Shower, dated 2006, indicated, .PURPOSE .To cleanse and refresh the resident .To observe the skin .To provide increased circulation .

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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. 43943 Based on observation, interview, and record review, the facility failed to administer parenteral fluids (fluids/medications administered through the vein, also known as IV or intravenous) within the professional standards of practice for two of five residents on IV therapy (Resident 22 and Resident 191) when: 1. Resident 22's IV tubing (plastic tubing that delivers the medication to the vein) did not have a cap (a covering device that covers the opening of the tubing and reduces the risk of infection to the resident) at the end of the tubing when the IV tubing was not in use; and, 2. Resident 191's PICC line (Peripherally Inserted Central Catheter: a long, thin tube that is inserted through a vein in the arm, neck or leg and passed through to the larger veins near the heart for long term intravenous (IV) antibiotics, nutrition, medication or blood draws) dressing was not changed. These failures could have resulted in Resident 22 acquiring an infection, and resulted in Resident 191's PICC line dressing not changed per physician order and increased the risk for infection at Resident 191's PICC line site. Findings: 1. A review of Resident 22's clinical record titled, Admission Record, indicated Resident 22's diagnoses included heart failure and anemia (low amount of hemoglobin the in the blood - hemoglobin carries oxygen to the body). During a concurrent observation and interview on 4/22/24, at 8:04 a.m., with Licensed Nurse (LN) 6, it was observed that Resident 22's IV tubing did not have a cap on the end of the tubing. LN 6 verified the IV line was connected to another port in the tubing, and did not have an IV cap in place. LN 6 stated this practice was against facility practice and put Resident 22 at risk for infection. During an interview on 4/22/24, at 3:34 p.m., with LN 4, stated Resident 22's IV tubing line was supposed to have a white cap at the end of the line to help prevent an IV line infection. LN 4 stated Resident 22 was placed at risk for infection. During a review of Resident 22's clinical record titled, Orders, dated 4/16/24, at 8:04 a.m., the orders indicated Resident 22 was receiving ceftriaxone (or Rocephin, medication used to treat infections) 1 gram (unit of measurement) intravenously one time a day for 10 days for the treatment of a urinary tract infection (infection of the bladder and/or kidneys). During a concurrent interview and record review on 4/24/24, at 11:36 a.m., with the Director of Nursing (DON), the policy and procedure (P&P) titled, Administration of an Intermittent Infusion, dated 6/1/21, was reviewed. The P&P indicated, . Administration sets used for more than one dose in a 24-hour period will have a new sterile end cap placed on the end of the administration set upon completion of each dose . The DON stated IV lines should have been changed every 24 hours and capped off with a new sterile end cap. The DON acknowledged the P&P was not followed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 191's Admission Record indicated Resident 191 was admitted to the facility in 2024 with multiple diagnoses including acute lymphangitis (an inflammation and infection of the lymphatic system, which is part of the immune system) of left arm, bacteremia (the presence of bacteria in the bloodstream), and for maintenance of a vascular access device. During an observation on 4/22/24, at 10:13 a.m., Resident 191 had a PICC line on the right upper arm. Resident 191's PICC line dressing was dated as 4/13 (4/13/24). During a concurrent observation and interview on 4/22/24, at 4:09 p.m., LN 4 stated PICC line dressings were changed upon admission the same day and then weekly. LN 4 stated the date on the PICC line dressing indicated the date the dressing was last changed. LN 4 stated Resident 191 was admitted a couple days ago and had a PICC line at his right upper arm. Resident 191's PICC line dressing was observed with LN 4. LN 4 verified Resident 191's PICC dressing was dated 4/13. LN 4 stated it meant the dressing was last changed on 4/13/24. LN 4 stated Resident 191 came with that dressing from the hospital. LN 4 added Resident 191's PICC line dressing had not been changed in the facility. LN 4 stated it should have been changed the day Resident 191 was admitted to the facility to make sure he did not get an infection, it was clean, and that there was no redness or swelling at the PICC line insertion site. LN 4 stated there was an order to change the PICC line dressing upon admission and weekly. During an interview on 4/25/24, at 11:18 a.m., the DON stated PICC line dressings should be changed every seven days. The DON stated if the physician order indicated to change upon admission, then it should be changed upon admission as well. The DON stated the importance of the PICC line dressing change was to prevent infection, and to observe the area for signs and symptoms of infection such as new redness and swelling. Review of Resident 191's physician order, dated 4/20/24, indicated, Change Catheter Site RUA [Right Upper Arm] Dressing with transparent dressing: On Admission, Q [every] week, and prn [as needed] complications; observe site. Measure external catheter length & document in supplemental documentation. Arm circumference .every day shift every Fri [Friday] . Review of Resident 191's IV Medication Administration Record (MAR), dated 4/2024, failed to show the PICC line dressing was changed. Review of Resident 191's care plan, dated 4/22/24, indicated, Potential for infection R/T [related to]: PICC Line .Interventions .change dressing to site q [every] 48 hours with gauze dressing . Review of a facility policy titled Central Vascular Access Device (CVAD) Dressing Change revised 6/1/21, indicated, .Central vascular access devices (CVADs) include .Peripherally inserted central catheter (PICC) . The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection . Perform sterile dressing changes using Standard-ANTT [Aseptic Non Touch Technique] .Upon admission .At least weekly .If the integrity of the dressing has been compromised (wet, loose, or soiled) .

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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. 43071 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided in accordance with professional standards of practice for 6 of 25 sampled residents (Resident 6, Resident 16, Resident 32, Resident 53, Resident 341, and Resident 491) when: 1. Resident 6 received oxygen without an order, 2. There was no oxygen safety signage posted outside Resident 6, Resident 341, and Resident 53's rooms, 3. Resident 53 and Resident 32's oxygen was not provided at the prescribed flow rate; and 4. Oxygen tubings were not changed for Resident 16 and Resident 6, and Nebulizer tubing was not changed for Resident 491. These failures had the potential to result in negative impacts on the health and safety of Resident 6, Resident 16, Resident 32, Resident 53, Resident 341, and Resident 491 including risks for ineffective oxygen therapy, respiratory distress, infection and fire safety. Findings: 1. Review of the Admission Record indicated Resident 6 was readmitted to the facility in 2024 with multiple diagnoses including asthma (a condition that affects a person's airways and makes it difficult to breathe), and acute respiratory failure with hypoxia (a condition when there is not enough oxygen in a person's body). During a concurrent observation and interview on 4/22/24, at 10:34 a.m., Resident 6 had oxygen on at a flow rate of 4 liters per minute (L/Min or LPM) via nasal cannula (NC: a small, flexible tube that contains two open prongs intended to sit just inside the nostrils). Resident 6 stated he was probably taking oxygen at a flow rate of 1 liter per minute. Resident 6 stated he was taking oxygen every night and sometimes during the day. During a concurrent observation, interview, and record review on 4/22/24 at 12:31 p.m., Licensed Nurse (LN) 9 confirmed Resident 6 received oxygen at a flow rate of 4 liters. Resident 6's active physician orders were reviewed with LN 9. LN 9 verified Resident 6 did not have an active order for oxygen therapy. LN 9 stated Resident 6 was readmitted from the hospital on 3/22/24 and had been using oxygen every day since then. LN 9 further stated Resident 6 used to receive oxygen as needed at a flow rate of 2 liters. LN 9 stated Resident 6 should have an order for oxygen therapy because technically without an order the facility could not administer oxygen, and they needed to know how much oxygen to administer, and how often. LN 9 added they did not want Resident 6 to have too much or too little oxygen. LN 9 stated if a resident received more oxygen than needed then it could cause hyperoxygenation [high level of oxygen that could lead to oxygen toxicity, shortness of breath, collapsed lungs, change of mental status] and if a resident received less oxygen than needed, then it would cause shortness of breath. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/24, at 11:21 a.m., the Director of Nursing (DON) stated oxygen should be administered per physician's order. The DON stated without a physician's order they would not know at what flow rate oxygen needed to be given to the resident which would put a resident life at risk. The DON stated if oxygen was given at higher flow rate than needed, then it could affect residents' lungs, lung capacity, could cause hypercapnia (too much carbon dioxide in the blood), hyperoxygenation, and brain damage. The DON further stated if oxygen was given at a lower rate than needed, then there was high risk of hypoxia (low oxygen level in blood), and a resident's organs would not get enough oxygen, which would put a resident's life at risk. Review of an undated facility policy, titled, Procedure-Oxygen Concentrator [a machine which filters air and provides air which has a high concentration of oxygen] indicated, .Verify physician's order for use .Adjust the flow meter control knob to the flow setting prescribed by the doctor . 2a. During a concurrent observation and interview on 4/22/24, at 12:31 p.m., LN 9 confirmed Resident 6 was receiving oxygen and an oxygen in use warning sign was not posted at Resident 6's room doorway. LN 9 stated an oxygen in use warning sign should have been posted at Resident 6's room doorway to alert others that the resident was on oxygen, and for safety to warn of no smoking near oxygen to prevent a fire hazard. During an interview on 4/25/24, at 11:21 a.m., the DON stated if a resident was receiving oxygen, then an oxygen in use sign should be posted at the resident's room doorway for safety, to alert others of no smoke and combustible substances near the room with oxygen use. 49823 2 b. Review of Resident 341's Admission Record indicated Resident 341 was admitted with diagnoses which included chronic respiratory failure (a disease that can cause shortness of breath, anxiety, and confusion due to a lack of oxygen to support body functions). During an observation on 4/23/24, at 12:15 p.m., Resident 341 was using supplemental oxygen at four liters by nasal cannula. Outside the room there was no oxygen in use safety sign. During an interview with LN 1 on 4/23/24, at 12:23 p.m., LN 1 stated that there should be an oxygen in use safety sign posted outside the rooms of all residents using supplemental oxygen. LN 1 confirmed that there was no oxygen safety signage outside Resident 341's room door. During a review of Resident 341's Order Summary Report, dated 4/19/24, the Order Summary Report indicated that Resident 341 was to receive oxygen at four to five liters per minute per nasal cannula. 50018 2c. A review of Resident 53's Admission Record indicated Resident 53 was admitted to the facility in 2024 with diagnoses including acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), acute respiratory failure with hypercapnia (excessive carbon dioxide in the bloodstream), and chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with (acute) exacerbation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/22/24, at 9:12 a.m., Resident 53 was observed lying in bed receiving oxygen at three LPM via nasal cannula via an oxygen concentrator. No oxygen in use signs were posted outside Resident 53's room. During a concurrent observation and interview on 4/22/24, at 10:49 a.m., with the DON, the DON stated there should be signs placed outside of the rooms to alert everyone that a resident was on oxygen. The DON further stated it was a safety concern if signs were not posted. The DON's expectation was for signs to be placed on all rooms for residents who had oxygen for safety reasons. During a review of the facility's policy and procedure titled, Oxygen Administration, dated 8/2014, in the section, PROCEDURE, indicated, .Place appropriate oxygen sign per facility procedure . 3a. During an observation on 4/22/24, at 9:12 a.m., Resident 53 was observed lying in bed receiving oxygen at three LPM via nasal cannula via an oxygen concentrator. During a concurrent observation and interview on 4/22/24, at 10:49 a.m., with the DON, the DON confirmed Resident 53 was receiving oxygen at three LPM via nasal cannula. During a concurrent observation and interview on 4/22/24, at 11:51 a.m., with Licensed Nurse (LN) 5, LN 5 observed Resident 53 was receiving oxygen at three LPM via nasal cannula. LN 5 stated that Resident 53 should be at two LPM and should not be at three LPM. LN 5 further stated that the order indicated for Resident 53 to be on two LPM and not three LPM. During a review of Resident 53's Order Summary Report, dated 3/25/24, indicated Resident 53 was to receive oxygen at two LPM via nasal cannula. 47369 3b. A review of Resident 32's ADMISSION RECORD, indicated she was admitted to the facility with diagnoses which included COPD. A review of Resident 32's Medication Administration Record, (MAR) dated April 2024, indicated .Oxygen at 2LPM [liters per minute, rate of flow] via NC [nasal cannula, small flexible tube that contains two open prongs intended to sit just inside the nose] . During a concurrent observation and interview on 4/22/24, at 11:09 AM, in Resident 32's room, LN 13 confirmed Resident 32's oxygen flow rate was set to 3 LPM via NC and it should have been set to 2 LPM. During an interview on 4/24/24, at 2:09 PM, LN 12 stated oxygen at the wrong flow rate could have a negative effect on the resident, especially a resident with COPD. A review of Resident 32's care plan initiated 2/18/22, indicated, The resident has altered cardiovascular [heart and blood vessel] status r/t [related to] critical high CO2 [carbon dioxide, a gas that is a waste product of respiration] .Administer oxygen as ordered . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/24, at 8:11 AM, the DON stated it was her expectation that physician orders for oxygen flow rates would be followed for all residents who received oxygen. The DON further stated oxygen at the wrong flow rate could negatively impact the resident's health. The DON stated a resident with COPD may retain carbon dioxide (excess carbon dioxide builds up in the blood which can cause serious symptoms and make it more difficult to breath) which could adversely affect their health and respiratory status. A review of an undated facility policy and procedure (P&P) titled, Procedure-Oxygen Concentrator, indicated, .Oxygen concentrators filter nitrogen out of the room air, collect the remaining oxygen and dispense it at prescribed liter flows .Procedure .Verify physician's order for use . 4a. A review of Resident 16's ADMISSION RECORD, indicated, she was readmitted to the facility with diagnoses which included COPD. A review of Resident 16's MAR dated April 2024, indicated, .Oxygen at 2 LPM via nasal cannula continuous . Order Date 03/14/2024 . During a concurrent observation and interview on 4/22/24, at 11:17 AM, in Resident 16's room, LN 13 confirmed Resident 16's nasal cannula was undated, and LN 13 was not sure when it had last been changed. During an interview on 4/24/24, at 8:11 AM, the DON stated it was her expectation that oxygen tubing's would be changed every Sunday. The DON further stated when tubings were changed, the MAR was signed to document completion of the task. During a concurrent interview and record review on 4/24/24, at 9:22 AM, LN 12 confirmed there was no documentation on Resident 16's MAR to indicate her tubing had been changed. LN 12 stated Resident 16 did not have an order to change her oxygen tubing and she should have. LN 12 further stated not changing the oxygen tubing routinely put Resident 16 at risk of infection. A review of an undated facility policy and procedure (P&P) titled, Procedure-Oxygen Concentrator, indicated, .Use tubing up to one month; and replace when visibly soiled or contaminated. Monitor tubing changes by either dating tubing at bedside or recording date of last change on TAR [treatment administration record] or MAR . 43943 4b During a concurrent observation and interview on 4/22/24, at 10:34 a.m., Resident 6 had oxygen on at a flow rate of 4 LPM via nasal cannula. Resident 6's oxygen tubing was not dated. Resident 6 stated he was using oxygen every night and sometimes during the day. Resident 6 stated staff was not changing his oxygen tubing that often. During a concurrent observation, interview, and record review on 4/22/24, at 12:31 p.m., LN 9 verified Resident 6's oxygen tubing was not dated. LN 9 stated oxygen tubing should be dated to ensure it got changed weekly. LN 9 stated oxygen tubing needed to be changed weekly to ensure it was clean, patent, and to prevent infection. LN 9 stated there should be an order to change Resident 6's oxygen tubing. Resident 6's physician orders were reviewed with LN 9. LN 9 verified Resident 6 did not have an order to change his oxygen tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/24, at 11:21 a.m., the DON stated oxygen tubing needed to be changed every 28 days and as needed as per their policy for tubing patency and infection prevention. The DON stated if a resident did not have an order, then the staff would not have known if oxygen tubing was being changed. Review of an undated facility policy titled, Procedure-Oxygen Concentrator, indicated, .Use tubing up to one month; and replace when visibly soiled or contaminated. Monitor tubing changes by either dating tubing at bedside or recording date of last change on TAR [Treatment Administration record or MAR [Medication Administration Record; section of the clinical record that indicated when medications were given and when medication related tasks were completed)] . 4c. During a review of Resident 491's clinical record titled, Admission Record, indicated Resident 491's medical diagnosis included respiratory failure, shortness of breath, and COPD. During a review of Resident 491's clinical record titled, Order Summary Report, dated 1/12/24, indicated Resident 491 was receiving formoterol inhalation nebulization solution (medication that treated COPD and was administered via a machine that made the medication into a breathable mist) two times a day for shortness of breath. During a concurrent observation and interview on 4/22/24, at 11:58 AM, with LN 4, the nebulizer tubing (tubing connected to a machine that delivers medication to the lungs) for Resident 491 did not contain a label indicating when the nebulizer tubing needed to be changed. LN 4 acknowelged the nebulizer tubing was not dated, and she was unsure how often the tubing needed to be changed. During a review of Resident 491's clinical record, there was not a physician's order on how often the nebulizer tubing needed to changed and there was not a section in the MAR for nursing to document when the nebulizer tubing was changed. During an interview on 4/24/24, at 9:30 a.m., LN 5 stated the nebulizer tubing was supposed to be changed weekly and documented in the electronic Heath Record (EHR) under the Medication Administration Record (MAR) section. During a concurrent interview and review of Resident 491's clinical record, on 4/24/24, at 8:59 a.m., with the DON, the DON acknowledged there was not a physician's order of how often the nebulizer tubing was supposed to be changed and there was not an area in the MAR to document tubing changes. The DON stated the expectation was that the tubing was changed once a week and the tubing changes would have been documented in the MAR. During a concurrent interview and record review on 4/25/24, at 3:00 p.m., with the Administrator (Admin), the undated facility document titled, Procedure - Small Nebulizer (SVN), was reviewed. The Procedure indicated, .Replace administration set up monthly (minimally), or as otherwise directed by MD . The Admin acknowledged the P&P was not followed when the nebulizer tubing was not dated with a change by date.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903 Based on observation, interview, and record review, the facility failed to ensure safe medication disposition practices for a census of 91 residents, when discontinued and discharged medications were stored and disposed of with no documentation and without cosignatory of the licensed staff. This unsafe practice could put the facility at risk of drug diversion and prescription medications mishandling. Findings: During a concurrent observation and interview with the Director of Nursing (DON), in the facility's medication room, at Station 1 and 2, on [DATE] at 9:44 AM, the discontinued prescription medications were piled up on a countertop in a corner next to the sink. The DON stated the pile of medications belonged to residents who were discharged , or medications discontinued by the doctor. The DON stated the nursing staff were responsible to destroy them when they had time. During an interview with Licensed Nurse (LN) 1, at station ,d+[DATE], on [DATE], at 9:56 AM, LN 1 stated she was not aware of any documentation on destruction of the prescription medications. LN 1 stated the discontinued narcotic medications were given to the DON to dispose, but the regular prescription drugs were not documented. During a concurrent observation and interview with LN 7, in the facility's medication room ,d+[DATE], on [DATE], at 10:54 AM, the medication room countertop on the corner next to the sink stocked a large pile of medications both in pill form and liquid form. The cabinet above the pile of medications was a storage place for staff belongings. LN 7 stated the medications on the countertop were discontinued or unusable medications that needed to be destroyed. LN 7 could not state how often the medications were destroyed or where it was documented. During a concurrent interview and second inspection of the facility's medication room ,d+[DATE], on [DATE], at 4:41 PM, the DON stated she helped destroy the discontinued medications and disposed of them in the pharmaceutical waste bin. The DON stated the facility did not document the destruction as there was no need to document. The DON stated every and any licensed nurse was responsible for destruction and disposition of medications. The DON stated the pharmacy provider never questioned them about not documenting the destruction. The DON was not sure how the hazardous medications were disposed of. The DON acknowledged that the staff were storing personal belongings including purses and backpacks in the medication room right next to where the discontinued medications were openly stored on the countertop. During a review of the facility's policy titled, Storage and expiration dating of Medications ., revised [DATE], the policy in Section 18 indicated, Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines . and in accordance with Policy 8.2 (Disposal/destruction of discontinued Medications). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Disposal/Destruction of Expired or Discontinued Medications, revised on [DATE], indicated, The facility should dispose of discontinued medication, outdated medication, or medications left in facility after a resident has been discharged in a timely fashion .The facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medication or marked to identify the medication are discontinued and subject to destruction. The policy in section 5 indicated, Facility should destroy non-controlled medications in the presence of a registered nurse and witnessed by one other staff member, in accordance with Facility policy or Applicable Law. The policy in section 6 indicated, .facility should enter the following information on a drug destruction form when medication are destroyed Resident name, name and strength of medication, prescription number, amount of medication (dosage unit) destroyed, date of destruction, signature of staff destroying medications, signature of witnesses; and method of disposition .by applicable Law.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903 Based on observation, interview, and record review, the facility failed to ensure safe medication use and monitoring in three out of seven residents (Resident 342, Resident 33, Resident 343) reviewed for unnecessary drug use when: 1. Resident 342's high risk blood thinner medication, called Apixaban (or Eliquis, drug used to prevent blood clot formation and can cause bleeding) was not monitored and care planned (Care Plan, a document that listss resident's medical issues and how the nursing staff should monitor and care for the resident) for safe use, 2. Resident 33's heart medication called metoprolol (a medication used to lower blood pressure and heartbeat) was not monitored according to hold parameters per doctor's order, 3. Resident 33's pain medication called Celebrex was continued upon admission without reassessment of its safe use and potential for side effects; and, 4. Resident 343's duplicate use of Vitamin D (a type of vitamin that could accumulate in the body when used in high doses) was not addressed and justification or diagnosis for use was not documented in the medical records. These failures could contribute to unsafe medication use in frail elderly and put them at risk of adverse consequences. Findings: 1. During a medication administration observation with Licensed Nurse (LN) 5 on 4/22/24, at 8:48 AM, in the hallway at station 3-4, LN 5 administered apixaban blood thinner along with 10 other pills to Resident 342. LN 4 did not name or explained the medication she was administering to Resident 342. During a review of Resident 342's medical record titled, Medication Administration Record, (MAR- a document used to list medications to be administered and how to monitor the drug use) dated 4/2024, the MAR indicated the order for blood thinner as follows: Eliquis Oral Tablet 5 MG; [MG- milligram, a unit of measure]; Give 1 tablet by mouth two times a day for Atrial Fibrillation [a type of heart rhythm problem]; Order Date- 1/22/24 Further review of the MAR did not show side effect monitoring parameters for nursing staff to monitor or address. During a review of Resident 342's electronic medical record, the Plan of Care dated 1/22/24, did not address Resident 342's use of blood thinner medication and how to monitor its potential adverse effects. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 342's electronic medical record, titled Minimum Data Set (MDS-a report provided by the facility that includes diagnosis and summarizes information for residents currently in nursing homes), dated 4/2024, the record did not include use of blood thinner or anticoagulant use by the resident. In a telephone interview with facility's Consultant Pharmacist (CP) on 4/25/24, at 10:15 AM, the CP stated she had not reviewed the records for Resident 342 and stated blood thinner medication posed a risk of bleeding, bruising, and should have been monitored. During a concurrent interview and record review with LN 4 on 4/25/24, at 11:32 AM, LN 4 acknowledged Resident 342's blood thinner medication apixaban was not monitored for sign and symptoms of bleeding, bruising and other adverse effects. LN 4 could not locate any care plan documentation for use of this high-risk medication (Drug that could pose more likelihood of harm with routine use). 2.During a review of Resident 33's MAR dated 4/2024, indicated a medication order as follows: Metoprolol Succinate .25 MG; Give 1 tablet by mouth one time a day for htn (hypertension- high blood pressure) hold for SBP [Systolic Blood Pressure; the amount of pressure experienced by the arteries while the heart is beating] < [less than] 110 or HR [heart rate] <60; -Order Date- 2/8/24. Further review of the MAR indicated the medication was administered when the heart rate was below the ordered parameter of less than 60 beats per minute on the following days: On 4/6/24 the HR was 56 and metoprolol was given, On 4/7/24, the HR was 55 and metoprolol was given, On 4/11/24, the HR was 57 and metoprolol was given, On 4/12/24, the HR was 56 and metoprolol was given, On 4/22/24, the HR was 56 and metoprolol was given, On 4/24/24, the HR was 58 and metoprolol was given. During a review of Resident 33's electronic [NAME] record titled, Progress Notes, with a date range of 4/4/24 to 4/25/24, the Progress Notes did not show any indication of why metoprolol was given when the heart rate was below the ordered parameter. During a concurrent interview and record review with LN 4 on 4/25/24, at 11:32 AM, LN 4 confirmed the hold parameters were not followed by nursing staff for Resident 33. LN 4 stated by not withholding the drug, this could contribute to heart stopping and the nursing staff should have notified the doctor so the drug could have been adjusted. During an interview with the Director of Nursing (DON) on 4/24/24, at 3:05 PM, the DON stated she expected the nursing staff to follow doctor's orders and notify the doctor if needed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of the Resident 33's electronic health record, the MAR dated 4/2024 indicated a medication order as follows: CeleBREX Oral Capsule 200 MG [or Celecoxib; a nonsteroidal anti-inflammatory drug or NSAID which relieves pain and swelling]; Give 1 capsule by mouth one time a day for SACRAL PAIN [pain in buttocks and lower back]-Order Date-2/9/24. The order did not specify a duration of use or a timeline to re-assess its use. During a review of the Resident 33's electronic medical record titled, Discharge Orders, from the hospital to the facility dated 2/8/24, the record indicated Resident 33 was treated for chest pain, low potassium level, and dehydration (not drinking enough water or fluids) in the hospital. Further review of the transfer medication list did not include Celebrex for treatment of the pain. In an interview with the facility's Consultant Pharmacist (CP) on 4/25/24, at 10:15 AM, the CP stated she had not reviewed Resident 33's records yet. In a telephone interview with Medical Doctor (MD) 2 on 4/25/24, at 10:52 AM, MD 2 stated Celebrex for long term use was not a good idea. MD 2 stated there could be risk of kidney damage, heart issues and stomach bleeding with use of Celebrex. MD 2 stated the resident did not have an arthritis diagnosis. MD 2 stated for new residents who came from the hospital, he would continue the hospital discharge orders. MD 2 stated he could not recall when he ordered Celebrex and could stop the use of the drug if needed. 4. During a medication observation with LN 5 on 4/22/24, at 9:33 AM, LN 5 administered a large dose of vitamin D products to Resident 343. During a review of Resident 343's electronic medical record, the MAR dated 4/2024, indicated two different orders for vitamin D as follows: Ergocalciferol Oral Capsule [a form of vitamin D2]; 1.25 MG [equivalent to 50,000 unit-MG or milligram and Units a measure of potency] Give 1 by mouth one time a day every Mon (Monday) for supplement -Order Date-4/19/24, Vitamin D3 Oral Tablet 20 MCG [equivalent to 800 units] [MCG- microgram a unit of measure]; Give 1 tablet by mouth one time a day for vitamin D deficiency -Order Date- 4/19/24. Further review of the MAR did not show any calcium product ordered for Resident 343. During a review of Resident 343's medical record titled, History and Physical, (H&P, a doctor's note describing a resident's overall medical condition and diagnosis), dated 4/22/24, the record written by MD 1 did not indicate any diagnosis related to vitamin D deficiency requiring high dosage of the medicine. Further review of the H&P did not indicate any blood level lab work indicating the need for high dosage vitamin D use. During a review of Resident 343's Plan of Care, dated 4/19/24, the record did not indicate a diagnosis or monitoring for vitamin D deficiency. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Faire Nursing & Rehabilitation Center	3620 B Dale Rd. Modesto, CA 95356

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with facility's Consultant Pharmacist (CP) on 4/25/24, at 10:07 AM, the CP stated she would ask the doctor to order a vitamin D level. The CP stated the pharmacy services first drug review was done upon admission for checking duplication or any medication issues. The CP stated taking vitamin D without a calcium supplement would make its use ineffective. In an interview with MD 1 on 4/25/24, at 12:32 PM, MD 1 stated the nursing staff put the new admission orders from the hospital in the computer, and if there was any discrepancy they clarified with his office. MD 1 could not recall if he reviewed the medication list, vitamin D use and duplicate orders. MD 1 stated he did not recall if he wrote an indication or diagnosis for vitamin D deficiency. MD 1 was aware of risk of vitamin D accumulation in the body and issues with effectiveness if not used with calcium supplement. Review of FDA (Food and Drug Administration; a federal entity that approves prescription drugs) drug labeling information Dailymed, last accessed on 5/1/24, the record indicated the following on ergocalciferol use: THE RANGE BETWEEN THERAPEUTIC AND TOXIC DOSES IS NARROW . DOSAGE MUST BE INDIVIDUALIZED UNDER CLOSE MEDICAL SUPERVISION. Calcium intake should be adequate. Blood calcium and phosphorus determinations must be made every 2 weeks or more frequently if necessary. Review of LexiDrug, a drug information resource, last accessed on 5/2/24, indicated, Treatment of vitamin D deficiency; Initial dosing: High-dose therapy: May be preferred in patients with a serum 25(OH)D [type of vitamin D] level <12 ng/mL [ng/mL or nanogram per milliliter, a unit of measure] or who are symptomatic [eg, bone fracture/pain, muscle weakness], or in patients with concomitant hypocalcemia [low calcium]. Oral: 50, 000 units (1,250 mcg) once weekly (or equivalent dose administered once daily) for 6 to 12 weeks, then recheck 25(OH)D level . Review of the facility's policy titled, General Dose Preparation and Medication Administration, last revised on 1/1/22, indicated, Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law . Review of FDA (Food and Drug Administration; a federal entity that approved prescription drugs) drug labeling information Dailymed on Celebrex, last accessed on 5/2/24 via https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=8d52185d-421f-4e34-8db7-f7676db2a226, the record indicated the following boxed warnings (serious and/or life-threatening adverse effect) on use of NSAID's WARNING: RISK OF SERIOUS CARDIOVASCULAR AND GASTROINTESTINAL EVENTS .Nonsteroidal anti-inflammatory drugs (NSAIDs) cause an increased risk of serious cardiovascular thrombotic (blood clot)events, including myocardial infarction(heart attack), and stroke, which can be fatal. This risk may occur early in the treatment and may increase with duration of use .NSAIDs cause an increased risk of serious gastrointestinal (GI) adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients and patients with a prior history of peptic ulcer disease and/or GI bleeding are at greater risk for serious GI events. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of LexiDrug, a drug information resource on use of Celebrex, last accessed on 5/2/24, indicated the following: Dosage guidance: Safety: Avoid or use with caution in patients at risk for or with existing cardiovascular disease, GI disease, kidney impairment, chronic liver disease, or a bleeding diathesis due to greater risk for adverse events. Consider administering in combination with a proton pump inhibitor [a drug that protects the stomach lining] in patients at risk for GI [gastro Intestinal or stomach] bleeding [eg, taking dual antiplatelet therapy or an anticoagulant-blood thinner or aspirin like drugs] , >[AGE] years of age more than [AGE] year old], high celecoxib doses; Dosing: Use the lowest effective dose for the shortest duration of time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40903 Based on interview, observation, and record review, the facility failed to ensure safe use and monitoring of psychotropic medications (drugs used to treat mental health such as anxiety, depression, or anger outburst) in four out of seven residents (Resident 33, Resident 342, Resident 343, and Resident 390) reviewed for unnecessary medication use (when medications are used without adequate monitoring or without adequate indication) when: 1. Resident 33's antidepressant medication called citalopram (or Celexa, a drug used to treat depression and anxiety) was not monitored for resident specific symptoms and behaviors that affected the mental health of the resident, 2. Resident 342's antidepressant medication called Effexor (or venlafaxine, a mood elevating drug that helps with depression and anxiety) was not monitored for resident specific behavior or symptoms of depression and anxiety, 3. Resident 343's antidepressant medication called escitalopram (or Lexapro, a medication used for treatment of depression) was not monitored for resident specific behavior or symptoms which accompanied depression; and, 4. Resident 390's anxiety and depression medications duloxetine (or Cymbalta, used to treat depressive mood) and Buspar (or buspirone, used to treat anxiety) were not monitored for resident specific symptoms and behaviors associated with the mental health disorder. These failures could contribute to unsafe use and monitoring of mental health medications and could hinder the assessment of medications for effectiveness. Findings: 1. During a review of Resident 33's electronic medical records titled, Medication Administration Record, (MAR) dated 4/2024, the MAR indicated an antidepressant medication order for citalopram as follows: Citalopram .Tablet 10 MG [MG or milligram; a unit of measure]; Give 1 tablet by mouth one time a day for depression; -Order Date-2/8/24. Further review of the MAR did not show daily nursing monitoring of the depression symptoms specific to Resident 33. During a telephone interview with facility's Consultant Pharmacist (CP), on 4/25/24, at 10:15 AM, the CP stated Resident 33's psychotropic medications were reviewed by the team of nurses, social worker, and the pharmacist. The CP stated they must have missed addressing the behavior monitoring parameters on this resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Director of Nursing (DON) on 4/25/24, at 2:09 PM, Resident 33's nursing Plan of Care (a plan for how the resident should be monitored) was reviewed. The DON stated the depression and anxiety care plan was completed by a social worker not a nursing staff. The DON stated the behavior monitoring was not included in the MAR for nursing staff to document and monitor. 2. During a medication pass observation with License Nurse (LN) 5, on 4/22/24, at 8:48 AM, LN 5 administered Resident 342's mood-altering medication called Venlaxafine (Effexor) along with 10 other medications without explaining the medication use or indication. During a review of Resident 342's MAR, dated 4/2024, the MAR indicated an order as follows: Venlafaxine .Tablet Extended Release .150 MG [MG milligram, a unit of measure]; Give 1 tablet by mouth one time a day for GAD [General Anxiety Disorder]; -Order Date- 1/22/24. Further review of the MAR did not show daily nursing monitoring for anxiety symptoms specific to Resident 342. During a review of the Resident 342's medical record for the nursing Plan of Care, last revised on 2/6/24, the Plan of Care document did not address use of mood-altering medication for Generalized Anxiety Disorder as ordered by the medical provider. During an interview with the DON on 4/25/24, at 2:09 PM, the DON stated the nursing staff should document any unusual behavior in their nursing notes. 3. During a medication pass observation with LN 5, on 4/22/24, at 9:33 AM, LN 5 administered Resident 343's mood-altering medication called escitalopram along with five other morning medications without explaining the medication use or indication. During a review of Resident 343's MAR, dated 4/2024, the MAR indicated an order for escitalopram as follows: Escitalopram .Tablet 10 MG; Give 1 tablet by mouth one time a day for Depression -Order Date 4/19/24. Further review of the MAR did not show daily nursing monitoring for depression symptoms specific to Resident 343. During a review of Resident 343's electronic medical record for nursing Plan of Care, last revised on 4/22/24 by Social Services, the Plan of Care for, mood problem r/t [related to] depression indicated, monitor for anti-psychotic medication (medication used for violent or unsafe behavior) side effects .Monitor for mood of isolation and provide assistance to a social activity if mood seen. The plan of care for behavior monitoring was not included in the MAR for nursing staff to document and monitor resident specific behaviors. 4. During a review of Resident 390's MAR dated 4/2024, the MAR indicated two mood altering medication order as follows: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	busPIRone HCl Oral Tablet 5 MG; Give 1 tablet by mouth two time a day for ANXIETY -Order Date- 4/10/24. DULoxetine HCl Capsule Delayed Release Particles 30 MG; Give 1 capsule by mouth one time a day for depression; -Order Date- 4/16/24. Further review of the MAR did not show daily nursing monitoring of the depression or anxiety symptoms specific to Resident 390. During a review of the Resident 390's medical record for nursing Plan of Care, last revised on 4/12/24 by Social Services, the record indicated Monitor for the mood of restlessness and provide a quiet/calm, environment if mood seen . The Plan of Care for depression indicated monitor for anti-psychotic medication side effects .Monitor for the mood of appetite loss and snack if mood seen. During an interview with the DON on 4/25/24, at 2:09 PM, the DON stated the depression and anxiety care plan were completed by a social worker staff and not a nursing staff. The DON stated the behavior monitoring was not included in the MAR for nursing staff to document and monitor. Review of the facility's policy titled, Psychotropic Medication Use, revised 10/24/22, indicated, Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. The policy in section 16 indicated, Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication . Facilities staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's respond to staff interventions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903 Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in three out of three medication rooms and two out of the four medication and treatment carts for a census of 91 when: 1. The Automated Dispensing Device (or ADD, an electronic medication storage device that controls access and usage of prescription medications) was stored in the same room as a hopper (a disposal and washing/rinsing device where bedpans [container used to collect urine or feces, shaped to fit under a person lying or sitting in bed], urinals [urine bottle, a bottle for urination for residents who find it impossible or difficult to get out of bed to urinate], and other body fluids were disposed), and the room was accessible to nursing assistants. The room's temperature log was not consistently monitored or documented, 2. Undated and unlabeled prescription medication was stored in the medication room active storage areas in Medication rooms at nursing station 1 & 2 (Med room [ROOM NUMBER]&2), 3. Undated and unlabeled prescription medications were stored in the active storage areas in the treatment cart; and, 4. The medication refrigerator inside the Medication room at station 3&4 (Med room [ROOM NUMBER]&4) stored opened and undated multi-dose vials of multi-dose injectable (inject into the skin) drugs, and the refrigerator was cluttered with excessive frosting where the insulin products (drug used to treat blood sugar disease and diabetes) and a vaccine were stored in direct contact with the frosted/frozen area on the top shelf. These failures could result in unsafe and unsanitary medication storage and the risk of residents receiving unusable or spoiled medications. Findings: 1. During a concurrent interview and inspection of the facility's ADD room, in the Station 3&4 hallway, on 4/22/24, at 11:14 AM, accompanied by Licensed Nurse (LN) 7, a room marked as utility room (a room that stored extra devices and supplies) stored patient care supplies such as clean urinals, a small refrigerator to store urine and specimen samples and the ADD device. Further observation indicated an open toilet like device with a flush and water spray system sitting on the corner next to the door with no sign around it. LN 7 stated the toilet like device was called a hopper and was used to dump urinals and resident waste by CNAs (Certified Nursing Assistants) and other staff. Further observation indicated the room temperature log was not consistently documented, and from 3/27/24 to 4/19/24 there were 10 markings for the room temperature documentation. LN 7 stated the nursing staff were responsible to check and document the temperature on a daily basis. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA 6, on 4/23/24, at 10:32 AM, at Station 3&4, CNA 6 stated she used the hopper to dump and clean the urinals. CNA 6 stated sometimes the urinals smelled and she had to flush and clean it. CNA 6 stated it was much easier to use the hopper rather than using the resident's bathroom. During a concurrent observation and interview with CNA 7, on 4/23/24, at 10:55 AM, at station 3&4 hallway, CNA 7 stated the utility room had a hopper she used to dump urinals and resident waste. LN 7 stated the resident's bathroom also could be used to dump the urinals. CNA 7 was able to open the utility room where the ADD and the hopper was located. The hopper had a note Out of Order which was not there the day before. During an interview with the Director of Nursing (DON), in her office, on 4/24/24, at 3:05 PM, the DON stated when the ADD was installed, pharmacy was concerned about infection control and cross contamination having the hopper and ADD in the same room. The DON stated they approved and licensed it last month for use. The DON stated the nursing staff should have been checking the room temperature on daily basis. The DON stated the CNA staff had an access code to the room, but they did not have ADD access. In a telephone interview with facility's Consultant Pharmacist (CP), on 4/25/24, at 10:16 AM, the CP stated the medications stored inside the ADD device were not exposed to infectious particles as a result of hopper use. The CP stated the assumption was that they were not using the hopper for human waste disposal in the utility room. The CP stated the facility should document the daily room temperature monitoring. A review of the facility's policy titled, Automated Medication Dispensing System or AMDS, revised 12/13/23, indicated, Facilities using AMDS should place it in a secure area of the facility and assure monitoring devices such as cameras are in working order, if applicable per state law. The AMDS should be always locked when not in use. Per applicable state law, the AMDS should be locked in an area behind locked doors . Temperature of the AMDS should be monitored daily and maintained at 59 to 77 F (degree Fahrenheit) for Medications. The storage area should be properly ventilated per manufacture requirement. 2. During a concurrent interview and inspection of the medication room in the facility's Med room [ROOM NUMBER]&2, on 4/22/24, at 9:37 AM, accompanied by LN 13, and the DON, an unlabeled prescription medication called SPS (or Sodium Polystyrene Sulfonate or Kayexalate; a medication used to treat high potassium levels) was stored in the same shelf as non-prescription medications. The DON stated if the bottle did not have a label, it was an OTC (Over the Counter) or non-prescription medication. During a concurrent interview and inspection of medication room in the facility's Med room [ROOM NUMBER]&2, on 4/22/24, at 10:04 AM, accompanied by LN 1, the refrigerator stored an opened vial of testing agent called Tuberculin Purified Protein (or Aplisol, a test injected under the skin for tuberculosis, a serious lung infection) with no marking when it was first opened. The label on the box of Aplisol indicated, Once entered, vial should be discarded after 30 days. The refrigerator stored a plastic zip lock bag with a faded/unreadable label, containing a controlled prescription medication called lorazepam (or Ativan in injection form, a drug used to treat anxiety or seizure). LN 1 stated the multi-use injectable medications should be dated when opened and stated the zip lock bag for lorazepam should have been relabeled as she suspected the resident was still on the drug although it had not been used for a long time. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent interview and inspection of the treatment cart, in the facility's Station 3&4 hallway, accompanied by LN 8, the following unlabeled and undated products were stored in the treatment cart: I. Nystatin topical Powder (anti-fungal drug) did not have a prescription label. The container label indicated RX Only (means available only by prescription written by a Doctor) II. Mupirocin Ointment (topical anti-infective drug) tube did not have a prescription label. The container label indicated RX Only. III. Normal Saline sterile irrigation solution (Salt Solution to clean wounds) bottle was half used; the label on the bottle indicated Do Not Reuse. IV. An open container of Iodoform packing strip (a sterile single use wound dressing) had expiration date of 3/2024. LN 8 acknowledged the findings. 4. During a concurrent interview and inspection of the medication room in the facility's Med room [ROOM NUMBER]&4, on 4/22/24, at 10:51 AM, accompanied by LN 7, the medication refrigerator was cluttered and had excessive frosting on the top shelf. The two sealed Emergency kits (Ekit, a small supply of insulins used for urgent needs) containing insulin products were touching the frosted areas. The top shelf of the refrigerator stored a resident's vaccine called Prevnar-20 (a pneumonia vaccine) in a zip lock bag and it was in close proximity to the frosted area. Further observation of the medication refrigerator indicated an open vial of testing drug called Aplisol that was not dated when it was first opened. LN 7 acknowledged the findings. LN 7 stated they will request a new Ekit from the provider pharmacy. LN 7 was not sure who was responsible to defrost the refrigerator. LN 7 stated the multi-dose vials should have been dated when first opened. Review of the facility's policy titled, Storage and Expiration Dating of Medications ., revised 4/11/18, indicated, Facility should ensure that only authorized facilities staff as defined by facility should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorize staff may include nursing supervisors, charge nurses, licensed nurses and other personnel authorized to administer medications in compliance with Applicable Law. Facility should ensure that medication and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerator/freezers of sufficient size to prevent crowding. Review of the facility's policy, titled Storage and Expiration Dating of Medications ., revised 4/11/18, the policy in section 5, 6 and 10 indicated, .Once any medication or biological package is opened, facility should follow manufacturer/supplier guideline with respect to expiration dates for open medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Facility staff may record the calculated expiration date based on date opened on the medication container. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels. Facility should ensure that resident medication and biological storage areas are locked and do not contain non-medication/biological items.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 47369 Based on observation, interview, and record review, the facility failed to ensure food preferences were honored for 3 of 90 residents (Resident 23, Resident 41, and Resident 344) receiving meals from the kitchen, when pasta was added to Resident 23's meal tray, salt packets were added to Resident 41's meal tray, and rice was served to Resident 344. These failures had the potential to result in unintended weight loss and other adverse health effects for Resident 23, Resident 41, and Resident 344. Findings: a. During a concurrent tray line observation and record review on 4/24/24, between 11:45 AM- 12:45 PM, Resident 23's tray card indicated, .Dislikes .Pasta . Dietary staff were observed adding pasta to Resident 23's tray. The tray was placed on the cart to be delivered to the residents. The Dietary Services Supervisor (DSS) confirmed pasta was added to Resident 23's plate and should not have been. A review of Resident 23's care plan indicated, .Focus .The resident is at risk for impaired nutritional status r/t [related to] at risk for wt [weight] fluctuations .Goal .encourage 76-100% meal intake .Interventions .Honor food/fluid preferences . b. A review of Resident 41's ADMISSION RECORD, indicated she was readmitted to the facility in 2023 with diagnoses which included hypertensive heart disease (heart disease caused by high blood pressure). A review of Resident 41's care plan, dated 9/29/23, indicated, .Focus .Altered Nutrition .Goal .Interventions . Meal intervention per tray card .No salt packet . During a concurrent tray line observation and record review on 4/24/24, between 11:45 AM- 12:45 PM, Resident 41's meal tray card indicated, .NO SALT PKT [packet] . Dietary staff were observed adding salt packets to Resident 41's tray. The DSS confirmed salt packets were provided on the meal tray for Resident 41 and should not have been. During an interview on 4/24/2024, at 1:32 PM, the DSS stated residents should receive their dietary preferences 100% of the time. The DSS further stated there was the potential for adverse health effects if residents received salt packets when they should not. c. During a concurrent observation and record review on 4/22/24, at 12:18 PM, in the dining room, Resident 344 was observed being served a meal tray that contained rice. A visitor at the table stated Resident 344 could not eat the food on his tray. A review of Resident 344's tray card indicated, .Dislikes .RICE . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 344's care plan, dated 4/14/24, indicated, .Focus .resident is at risk for impaired nutritional status .Interventions .Meal intervention per tray card .Honor food/fluid preferences . During an interview on 4/22/24, at 5:04 PM, the DSS stated he was not sure how the wrong tray was sent to Resident 344. The DSS further stated it was important to follow the resident's preferences for palatability and had the potential to diminish his appetite. During an interview on 4/24/24, at 2:37 PM, the Registered Dietitian (RD), stated resident's tray cards should be followed to ensure their personal preferences were met and to minimize potential adverse effects to residents' health. During an interview on 4/25/24, at 7:55 AM, the Director of Nurses (DON) stated not following resident preferences was a safety and dignity issue. The DON further stated it was her expectation that residents' preferences would be honored. A review of a facility policy and procedure titled, RESIDENT FOOD PREFERENCES, dated 11/2016, indicated, .Purpose .Satisfy resident's tastes and appetites by determining and providing their food preferences at meals .All food and dining services staff will be made aware of all preferences .the food and dining services staff will make every attempt to meet the resident's food preferences .

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 47369 Based on observation, interview, and record review, the facility failed to ensure the therapeutic diets prescribed by the physician were followed for 3 of 90 residents receiving meals (Resident 5, Resident 344, and Resident 8) when: 1. Salt packets were added to Resident 5's meal tray, 2. Resident 344 did not receive his prescribed diet texture; and, 3. Resident 8's therapeutic diet order change was not confirmed/obtained from the physician. These failures had the potential to adversely affect Resident 5 and Resident 8's health and well-being and put Resident 344 at risk of choking or decreased oral intake which could lead to weight loss. Findings: 1. A review of Resident 5's ADMISSION RECORD, indicated she was readmitted to the facility in 2024 with diagnoses which included hypertensive chronic kidney disease (high blood pressure caused by damage to the kidneys). A review of Resident 5's Order Listing Report, dated 4/24/24, indicated, .Regular diet .NO SALT PX [packet] for CARDIAC DIET . A review of Resident 5's care plan, dated 3/7/24, indicated, .Focus .The resident is at risk for impaired nutritional status .Interventions .Meal interventions per tray card .No Na [salt] packet .Diet as ordered . During a concurrent tray line observation and record review on 4/24/24, between 11:45 AM- 12:45 PM, Resident 5's meal tray card indicated, .NO SALT PKT [packet] . Dietary staff were observed adding salt packets to Resident 5's tray. The Dietary Services Supervisor (DSS) confirmed salt packets were provided on the meal tray for resident 5 and should not have been. During an interview on 4/24/2024, at 1:32 PM, the DSS stated there was the potential to adversely affect residents' health if they received salt packets when they should not. 2. A review of Resident 344's ADMISSION RECORD, indicated he was admitted to the facility in 2024 with diagnoses which included, hemiplegia and hemiparesis following cerebral infarction (weakness or inability to move a limb after a stroke -disrupted blood flow to the brain) During a concurrent observation and record review on 4/22/24, at 12:18 PM, in the dining room, Resident 344 was observed being served a meal tray which contained chicken cut into approximately one to two-inch (unit of measurement for length) pieces. A visitor at the table stated Resident 344 could not eat the food on his tray. A review of Resident 344's meal tray card indicated, .GROUND MEATS . (continued on next page)

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Vintage Faire Nursing & Rehabilitation Center	3620 B Dale Rd. Modesto, CA 95356

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 344's care plan dated 4/14/24, indicated, .Focus .resident is at risk for impaired nutritional status .dysphagia [difficulty swallowing] .therapeutic and mechanically altered diet .Interventions . Meal intervention per tray card .Monitor for Sign and Symptoms of aspirations [accidently inhaling food into the airway] . A review of Resident 344's Order Listing Report, dated 4/24/24, indicated .diet Soft & Bite sized texture . A review of an online document by the International Dysphagia Diet Standardization Initiative (IDDSI) titled, SOFT & BITE-SIZED, dated January 2019, last accessed on 5/2/24 via https://iddsi.org/IDDSI/media/images/ConsumerHandoutsAdult/6_Soft_Bite_Sized_Adult_consumer_handout_30Jan2019.pdf, indicated, .Meat cooked tender and chopped so pieces are no bigger than 1.5 cm [approximately 0.6 inches] x 1.5 cm lump size .To make sure the food is soft enough, press down on the fork until the thumbnail blanches white, then lift the fork to see that the food is completely squashed and does not regain its shape .If cannot serve soft and tender serve as minced and moist .AVOID these food textures that pose a choking risk for adults who need Level 6 Soft and Bite-Sized Food .meat .larger than 1.5 cm x 1.5 cm . During an interview on 4/22/24, at 5:04 PM, the DSS stated he was not sure how the wrong tray was delivered to Resident 344. The DSS further stated it was important to serve the correct food texture to prevent choking. During an interview on 4/25/24, at 10 AM, Licensed Nurse (LN) 12 stated nursing staff checked the meal trays prior to every meal to ensure residents received the right diet and texture, portion size, and utensils. LN 12 further stated therapeutic diets should be followed per physician orders due to the risk of choking or aspiration. During an interview on 4/24/24, at 2:37 PM, the Registered Dietitian (RD), stated it was her expectation that diet textures would be followed 100% of the time for resident safety. The RD further stated the tray cards should be followed to ensure residents personal preferences were met and to minimize potential adverse effects to residents' health. During an interview on 4/25/24, at 7:55 AM, the Director of Nurses (DON) stated it was her expectation that diet textures were treated as a high priority to prevent choking. The DON further stated diets needed to be followed per physician orders due to potential health risks. 43071 3. Review of Resident 8's Admission Record indicated Resident 8 was admitted to the facility in 2023 with multiple diagnoses including dysphagia (difficulty swallowing food). During an observation on 4/24/24, at 1:07 p.m., Resident 8 was eating dinner with family at her bedside. Resident 8's meal tray card read, 1/2 dessert, SF [sugar free] condiment, fortified liquidized [smooth, liquified consistency]. Preferences: 8oz [ounce: unit of measurement] fortified milk at all meals, add pudding or ice cream at lunch, extra sauce/gravies, serve meals in cups, small portions, soup x 3. Resident 8 had 4 cups of liquidized food, 1 glass of milk, and 1 glass of water. Resident 8 was drinking food with a straw from a cup. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8's active physician order, dated 2/25/24 indicated, .CCHO [Controlled Carbohydrate- to help manage blood sugar levels] diet Soft & Bite Sized texture, Regular/Thin consistency, Fortified Diet; 1/2 DESSERTS, SF CONDIMENTS . During an interview on 4/24/24, at 4:26 p.m., the DSS stated diet orders were sent to him through a dietary communication slip by the nurses and he also had access to the residents' records. The DSS stated once he received the dietary slip, he entered the diet order in his system where tray cards were printed from, and food was served as listed on the tray card. The DSS stated he had one resident, Resident 8 with pureed liquidized diet per family request. The DSS stated Resident 8's family spoke with him a couple weeks ago, to let him know Resident 8 would not eat her pureed (soft, pudding-like consistency) food but would drink with a straw. The DSS stated he suggested a trial of puree liquidized diet to see if Resident 8 would eat more, and Resident 8's family agreed. The DSS stated he entered the trial puree liquidized diet in his system. The DSS stated Resident 8's diet order should have been updated in her record as well. The DSS stated the charge nurse would update the diet order. The DSS stated he did not inform the nurse. The DSS stated he needed to tell the charge nurse that they were doing puree liquidized diet trial for Resident 8. The DSS stated the diet order should match the tray card and food served, so everyone knew what her current diet order was, that the diet order was being followed, and to make sure it was within the parameters. The DSS stated Resident 8 was on a pureed diet order before the trial of puree liquidized diet. The DSS stated Resident 8 had been eating better, drinking soups and taking more calories with the puree liquidized diet texture. Resident 8's current diet order was reviewed with the DSS. The DSS stated, Oh Wow and verified Resident 8's diet order indicated soft and bite sized texture. The DSS stated soft bite size and liquidized diets were two different types of diets by 3 levels. During an interview on 4/25/24, at 10:36 a.m., the DON stated the diet order in the resident's record and on the tray card should match to ensure the diet order was followed, such as diet texture and special therapeutic diet. The DON stated if it did not match, a resident might get food they were allergic to or a different diet texture that they might not be able to swallow, and their diet restrictions might not get followed. The DON stated even trial diet orders were needed to be updated in the residents' record. Review of a facility policy and procedure titled, THERAPEUTIC DIETS, dated 2/09, indicated, .A therapeutic diet is a diet ordered to manage problematic health conditions. Examples include .no added salt .A mechanically -altered diet is a diet specifically prepared to alter the consistency of food in order to facilitate oral intake .A physicians order is written for all therapeutic and mechanically altered diets .The facility prepares and serves all special diets as planned .

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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** 47369 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices for a total of 90 residents who received food from the kitchen when: 1. Food items available for use were stored in undated and unlabeled containers, 2 The unit snack/nourishment refrigerator contained ice buildup in the freezer, food debris, and stains, 3. The unit snack/nourishment refrigerator contained moldy foods and foods past their use by dates; and, 4. The unit snack/nourishment refrigerator did not have a temperature log. These failures had the potential to expose the facility residents to expired foods and placed these residents at risk of food borne illnesses (eating or drinking something that is contaminated with germs that can cause illness). Findings: 1. During a concurrent observation and interview on [DATE], at 8:24 AM, during the initial kitchen tour, three 5-gallon (unit of measurement for volume) containers were observed on the bottom shelf of a rack in the food storage room. The Dietary Service Supervisor (DSS) stated one bin contained flour, one contained rice and the other contained granulated sugar. The DSS confirmed none of the bins were labeled or dated and should have been. The DSS further stated if the bins were not labeled or dated, staff would not know what was in the container or when to use it by. The DSS stated the quality of the food could be affected if the items were expired. During an interview on [DATE], at 2:37 PM, the Registered Dietitian (RD) stated it was her expectation that all food items available for use would be dated and labeled to ensure they were not expired and to maintain resident safety. 2. During a concurrent observation and interview on [DATE], at 3:08 PM, the [NAME] President of Nursing Services (VPNS) confirmed the unit refrigerator used to store resident snacks and nourishments, contained a thick brown substance on the bottom shelf and the drawer above it was stuck to the debris. The VPNS further confirmed a thick build up ice from the freezer caused the containers on the shelf below it to be unmovable. The VPNS stated she was unaware the refrigerator was used for resident snacks. The VPNS further stated the cleanliness of the refrigerator should be maintained. 3. During a concurrent observation and interview on [DATE], at 3:08 PM, the VPNS confirmed the unit snack/nourishment refrigerator contained the following: a. An opened package of cheese with 3 green, moldy slices visible, and a use by date of [DATE]; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A packaged meal with a use by date of [DATE]; and, c. A container of milk with a use by date of [DATE]. The VPNS stated the expiration dates on food items should be checked and food should be thrown away if expired. The VPNS further stated staff should not serve expired or questionable foods to residents and moldy food was unacceptable. During an interview on [DATE], at 2:37 PM, the RD stated snacks stored in the unit refrigerator should all be labeled and dated correctly to ensure they were not expired. The RD further stated the unit refrigerator should be clean for sanitary purposes and to maintain infection control standards. 4. During a concurrent observation and interview on [DATE], at 7:47 AM, the Director of Nurses (DON) confirmed there was no temperature log for the unit snack/nourishment refrigerator and there should have been. The DON stated the refrigerator temperature should have been monitored for resident safety and to prevent the potential for food borne illness. A review of a facility policy and procedure (P&P) titled, FOOD SAFETY IN RECEIVING AND STORAGE, dated, ,d+[DATE], indicated, .Food is received and stored by methods to minimize contamination and bacterial growth .Expiration and use by dates will be checked to assure the dates are within reason .Food that is repackaged will be placed in a sanitary container .The container will be labeled with name of the contents and dated with the date it was transferred to the new container .Food will be stored in a manner to allow air circulation around food .The temperature of refrigerators shall be maintained to keep cold foods at 41 degrees F [Fahrenheit, measure of temperature] or below . A review of a facility P&P titled, Use and Storage of Food Brought in by Family or Visitors, dated ,d+[DATE], indicated, .It is facility policy to honor a Resident's Right to have food brought in .however, food must be handled and stored in a way to facilitate safety .Staff will monitor unit refrigerator temperatures daily and notify Maintenance Supervisor .when temperature is above 41 degrees F .Units will be assessed for temperature adjustment/repair needs and contents disposed of accordingly .Refrigerators will be cleaned weekly by designated staff .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50018 Based on interview, and record review, the facility staff failed to maintain complete and accurate medical records in accordance with accepted professional standards for 3 of 25 sampled residents (Resident 390, Resident 3, and Resident 8) when: 1. Resident 390's wound care was not documented in a timely manner on 4/14/24, 2. Resident 3 and Resident 8's records indicated nail care was provided, but Resident 3 and Resident 8 had long dirty nails; and, 3. Resident 3's shower schedule in the electronic and physical record did not match. These deficient practices had the potential to result in confusion in the care and services for Resident 390 and placed the resident at risk for not receiving appropriate care due to inaccurate and incomplete documentation, and resulted in inaccurate medical records for Resident 3 and Resident 8, and missed showers for Resident 3. Findings: 1. A review of Resident 390's Admission Record indicated Resident 390 was admitted to the facility with diagnoses including an open wound on the right and left thighs, and an infection of the skin and subcutaneous (beneath, or under, all the layers of the skin) tissue. During a concurrent interview and record review on 4/22/24, at 3:06 pm, Resident 390's Treatment Administration Record, (TAR) dated April 2024 was reviewed with Licensed Nurse (LN) 8. LN 8 confirmed the TAR indicated, on 4/14/24, the administration dates for the following four treatments were left blank without any licensed staff's initials: 1. Wound to Right Medial [situated in the middle] Thigh: Cleanse with normal saline [a mixture of sodium chloride and water] pat dry, apply medihoney [an all-natural way to treat open wounds] and cover with dry dressing every day and as needed on every day shift. 2. Wound to Left Buttock: Cleanse with normal saline, pat dry, apply medihoney and cover with dry dressing every day and as needed on every day shift. 3. Wound to Left Lateral Thigh: Cleanse with normal saline, pat dry, apply medihoney and cover with dry dressing every day and as needed on every day shift. 4. Wound to Right Lateral Thigh: Cleanse with normal saline, pat dry, apply medihoney and cover with dry dressing every day and as needed on every day shift. During a concurrent interview and record review on 4/23/24, at 11:50 a.m., with the Director of Nurses (DON), Resident 390's Treatment Administration Record (TAR), dated April 2024, was reviewed. The DON stated it looked like the wound care was not done when you see the empty white boxes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LN 7, on 4/24/24, at 1:14 p.m., LN 7 stated she forgot to document on 4/14/24 that the wound care was done for Resident 390. LN 7 stated the issue with not documenting timely was that you could forget what you did or what the wound looked like. LN 7 further stated that if it was not documented, it was not done and that she would question if the order was carried out if she saw empty white boxes on the TAR. 43071 2a. Review of Resident 8's Admission Record indicated Resident 8 was admitted to the facility in 2023 with multiple diagnoses including hemiplegia with hemiparesis following cerebral infarction (paralysis of partial or total body function on one side of the body after stroke), and need for assistance with personal care. During an observation on 4/22/24, at 10:22 a.m., Resident 8 had long fingernails with dirt in them. Resident 8 was noted with scratch marks on her left forearm. Review of Resident 8's Activities of Daily Living (ADL) task record titled, Nails Clean and Trimmed, for the past 14 days indicated Resident 8 received nail care at least once a day from 4/12/24 to 4/22/24. During a concurrent observation and interview on 4/23/24, at 11:39 a.m., Certified Nursing Assistant (CNA) 4 confirmed Resident 8 had long fingernails and had dirt in them. CNA 4 stated Resident 8's fingernails needed to be trimmed and cleaned. 2b. Review of Resident 3's Admission record indicated Resident 3 was admitted to the facility in 2012 with multiple diagnoses including severe intellectual disabilities. Review of Resident 3's care plan, revised on 2/27/24, indicated, Self Care Deficit As Evidenced by: Extensive assistance with most ADLs [Activities of Daily Living] d/t [due to] weakness and poor endurance with severe confusion and some behaviors .Interventions .Personal Hygiene: One person physical assistance required .Bathing: one person physical assistance required . During a concurrent observation and interview on 4/22/24, at 10:26 a.m., Resident 3 had long toenails with the small toenail on the right foot noted to be black. Resident 3 stated she did not like long toenails. Resident 3 stated she had asked staff to cut her long toenails. Review of Resident 3's Activities of Daily Living (ADL) task record titled, Nails Clean and Trimmed, indicated Resident 3 received nail care at least once a day from 4/12/24 to 4/22/24. During a concurrent observation and interview on 4/23/24, at 11:30 a.m., CNA 4 stated nail care was done every Sunday and on residents' shower days. CNA 4 stated residents got showers twice a week. CNA 4 stated nail care included cleaning the dirt out, cut and file nails as needed. CNA 4 stated none of her residents requested to keep their fingernails long. CNA 4 added she trimmed their nails all the way. Observed Resident 3's nails with CNA 4. CNA 4 stated Resident 3 was scheduled to receive showers in the evening shift. CNA 4 stated she did not provide nail care for Resident 3. CNA 4 verified Resident 3's fingernails were long and had dirt in them. CNA 4 stated those needed to be cleaned and cut. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/24, at 1:42 p.m., the Director of Staff Development (DSD), the DSD stated staff should provide nail care during showers. The DSD stated she had also added the nail care task in residents' electronic record for staff do it every day. The DSD stated the nail care task included toenail care as well. The DSD stated CNAs were supposed to provide toenail care for non-diabetic residents. The DSD verified Resident 3 was non-diabetic. During a concurrent observation, interview and record review on 4/25/24, at 9:13 a.m., Licensed Nurse (LN) 9 stated the nail care task was recorded in the residents' records. LN 9 verified the nail care task was scheduled for every shift for Resident 3 and Resident 8. LN 9 verified the record indicated nail care was provided to Resident 3 and Resident 8 at least daily for the last 7 days. LN 9 stated Resident 3 and Resident 8's nails were quite long and it would take at least a couple weeks for nails to get that long. LN 9 stated the nail care documentation was not correct. 3. During a concurrent interview and record review on 4/24/24, at 10:50 a.m., Resident 3's shower task for the last 30 days was reviewed with LN 8. LN 8 stated per the electronic record Resident 3 was scheduled to receive showers on Mondays and Thursdays on the morning shift. LN 8 verified there was no record of showers offered/given to Resident 3 on her scheduled shower days on 4/11/24, 4/15/24, 4/18/24, and 4/22/24. LN 8 confirmed Resident 3's scheduled shower days 3/28/24, 4/4/24, and 4/18/24, were documented as not applicable. LN 8 stated CNAs followed a paper shower schedule kept at the nurses station. LN 8 verified the paper shower schedule indicated Resident 3 was scheduled to receive a shower on Wednesdays and Saturdays during the evening shift. LN 8 stated the paper record conflicted with the electronic record. LN 8 verified there was no record of showers offered/given to Resident 3 on her scheduled shower days as per the paper shower schedule for 4/3/24 and 4/6/24. LN 8 confirmed on Resident 3's scheduled shower days per the paper shower schedule on 3/30/24, and 4/17/24, showers were documented as not applicable. LN 8 stated Resident 3 did not receive showers per either shower schedule. LN 8 stated the shower schedule in paper and electronic record should match so that there was no conflicting information and care could be provided as scheduled. LN 8 stated Resident 3 missed showers because of conflicting shower schedules. LN 8 stated it was not good for Resident 3's hygiene and self-esteem. During an interview on 4/25/24, at 9:42 a.m., CNA 5 stated she documented residents' shower task in the electronic record. CNA 5 stated she would choose option not applicable under the shower task if it was not a resident's shower day, but was triggered to document. CNA 5 stated she would choose option refused under the shower task to document if a resident refused a shower, full bed bath and partial bed bath. CNA 5 stated she would choose option not available under the shower task if a resident was out of the facility for an appointment or was not available for a shower on her shift. During a concurrent interview and record review on 4/24/24, at 1:42 p.m., the DSD stated residents' shower schedules were on paper at the nurses' stations and also in residents' electronic records. The DSD stated the shower schedule on both electronic and paper records should match so that it coincided with charting, to make sure showers were being done and not missed and to document that showers were given. The DSD verified Resident 3 was scheduled to receive showers on Wednesday and Saturday in the evening shift per the paper shower schedule, and to receive showers on Monday and Thursday in the morning shift per the electronic record. The DSD stated Resident 3 should have been receiving showers on Wednesday and Saturday per the paper shower schedule. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/24, at 10:03 a.m., the Director of Nursing (DON) stated CNAs were to provide nail care to non-diabetic residents over the weekend. The DON stated staff should document nail care accurately in residents' electronic records. Resident 3 and Resident 8's nail care documentation and pictures taken on 4/22/24 and 4/23/24 were reviewed with the DON. The DON verified Resident 3 and Resident 8's nails were not trimmed, were quite long, and had dirt in them. The DON stated Resident 3 and Resident 8's nail care documentation was not accurate. The DON stated their record should have reflected nail care not done, refused or accordingly. The DON stated it should have been documented correctly. The DON stated residents should receive shower twice a week as per their schedule for their personal hygiene, respect, dignity, safety, and infection control. The DON stated the shower schedule should match at both paper and electronic records for accuracy so that CNAs could follow it consistently. The DON stated if the paper and electronic shower record did not match, then it was inaccurate, could create confusion, and a resident might miss a shower. During a review of the facility's policy and procedure titled, LTC [Long Term Care] Health Information Practice and Documentation Guidelines, dated 8/2001 , in the section, Federal Regulations Pertaining to Clinical Records, indicated, must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49823 Based on observation, interview, and record review, the facility failed to follow their infection control policies and procedures when there was no signage posted on the door or the wall outside of Resident 64's room indicating the type of transmission-based precautions (TBP- precautions implemented based upon means of transmission to prevent or control the spread of germs) and required personal protective equipment (PPE- gowns, gloves, eye protection, facemasks or respirators used to prevent the spread of germs) needed prior to entering Resident 64's room. This failure could have resulted in the spread of infection and the need for additional medical interventions (medications/treatments) with a census of 91 residents. Review of Resident 64's Admission Record indicated Resident 64 was admitted to the facility with diagnoses which included a nephrostomy tube (a tube that lets urine drain from the kidney through an opening in the skin). During a concurrent observation and interview with Resident 64 on 4/22/24, at 9:20 a.m., Resident 64 stated, There are gowns and gloves outside the room, to visitors standing outside the door. There was no signage on the door or wall outside of Resident 64's room indicating the type of TBP and required PPE needed to enter the resident's room. Resident 64 stated, Yes; I have an infection in my urine, when asked why TBP were in place. During an interview with Certified Nursing Assistant (CNA) 3 on 4/22/24, at 9:24 a.m., CNA 3 stated Resident 64 had an infection in the urine. During an interview with Licensed Nurse (LN) 7 on 4/22/24, at 9:26 a.m., LN 7 stated she believed Resident 64 was on TBP for a multi-drug resistant organism (MDRO- infections that are resistant to three or more drugs that kill infection). LN 7 checked Resident 64's electronic medical record (EMR) and verified Resident 64 was on contact precautions (a type of TBP intended to prevent the spread of MDROs and other infections that are spread by direct or indirect contact with the resident or the resident's environment). LN 7 confirmed that there was no signage on the door or near the door of Resident 64's room, indicating the TBP needed prior to entering the room. LN 7 stated family and staff going into Resident 64's room without the proper PPE increased the risk of spreading the MDRO infection to other residents and staff in the facility. During an interview with the Director of Nursing (DON) on 4/23/24, at 8:50 a.m., the DON stated when there was a resident in the facility on TBP, signs indicating the type of TBP needed to be posted near the room door. The DON stated if someone went into a resident's room without the proper PPE, there was a risk of cross-contamination; staff could carry the organism (germs) to other resident rooms. During an interview with the Infection Preventionist (IP) on 4/23/24, at 11:40 a.m., the IP stated Resident 64 should have been on contact precautions on 4/22/24, and signage should have been in place near the room door alerting anyone who entered the room of the need for PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555355	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Faire Nursing & Rehabilitation Center	3620 B Dale Rd. Modesto, CA 95356

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of an undated facility policy and procedure titled, Infection Prevention Manual for Long Term Care, in the section titled Multi-Drug Resistant Organisms (MDROs), indicated, Purpose: To prevent transmission of multi-drug resistant organisms (MDROs) .Policy: Prevention, containment and eradication measures including use of contact precautions are indicated to prevent the spread of resistant microorganisms [germs] that have been identified within a facility . In the section II. Gloves and Hand Hygiene, indicated, .A. Hand hygiene should be completed prior to donning gloves. B. Gloves should be worn when entering the room .D. Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately . In the section .Gowns, indicated, .A gown should be donned prior to entering the room or resident's cubicle .The gown should be removed before leaving the resident's room . Review of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs), last reviewed dated 7/12/22, indicated, .Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) .Contact Precautions are intended to prevent transmission of infectious agents, like MDROs, that are spread by direct or indirect contact with the resident or the resident's environment .Contact Precautions require the use of gown and gloves on every entry into a resident's room . (https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html)