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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555363	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Glen Skilled Nursing	2671 Plummer Avenue San Jose, CA 95125

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to treat the residents with dignity for one of two residents, (Resident 1), when Resident 1's urine drainage bag was not covered. This failure had the potential to cause embarrassment and feeling low self-esteem for the resident. Findings: Review of Resident 1's Admission Record indicated she was admitted to the facility on [DATE] with retention of urine diagnosis. Review of Resident 1's physician order, dated 11/26/24, indicated Resident 1 had a Foley catheter (a device that drains urine from the urinary bladder into a drainage bag outside of the body when the person cannot urinate on his/her own). During an observation and interview with licensed vocational nurse A (LVN A) on 3/17/25, at 9:28 a.m., Resident 1 was lying in her bed. Her urine drainage bag was hung on the bed side and was not covered. LVN A stated Resident 1's urine drainage bag should be placed in a cover bag. Review of the facility's policy, Dignity, dated 2/2021, indicated , 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered .

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42819 Based on observation, interview and record review, the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool and care screening tool) for pressure ulcers for one of 14 sampled residents (Resident 7). This failure could lead to an inaccurate resident assessment. Findings: A review of Resident 7's Treatment Administration Record (TAR) for January 2025 indicated the resident received daily treatment for a pressure injury on the sacrum. A review of the TAR for October 2024 also indicated daily treament for pressure injury on the sacrum. A review of Resident 7's Section M of the MDS dated [DATE] and 1/31/25 inidicated that Resident 7 was not coded as having a pressure injury on the sacrum (large, triangular bone located between the hip bones.) During an interview and record review on 3/20/25 at 10:38 a.m., the Minimum Data Set Coordinator (MDSC) reviewed Resident 7's TAR and other clinical records related to the pressure injury. The MDSC confirmed that Resident 7 received treatment during the look-back periods (refers to the timeframe used to capture residents' condition or status, typically 7 days) and stated that the pressure injury was not coded correctly on the MDS assessments for 11/1/24 and 1/31/25. A review of the facility's policy Resident Assessments, dated 10/2023, indicated, Information in the MDS assessments will consistenely reflect information in the progress notes, plans of care, and resident observation/interviews.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44185

Based on observation, interview and record review, the facility failed to ensure that the resident care plans were reviewed and updated for effectiveness in four of fourteen sampled residents, (Residents 6, 35, 43 and 44), when the activity care plans of these four residents were not reviewed and updated quarterly.

These failures had the potential to result in the residents not receiving the interventions necessary to maintain their highest level of well-being.

Findings:

1. During the observation of Resident 6 on 3/17/25 at 1:55 p.m., Resident 6 was laying in her bed, alert, calm, comfortable and verbally responsive.

Review of the admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) of Resident 6 indicated, Resident 6 was admitted to the facility on [DATE] with primary diagnosis of unspecified chronic obstructive pulmonary disease (COPD, group of lung diseases that block airflow and make it difficult to breathe).

Review of the physician orders of Resident 6 indicated, Resident 6 may participate in activity if not in conflict with treatment, ordered on 12/8/21.

Review of the activity care plan of Resident 6 indicated that it was not reviewed and updated quarterly for effectiveness.

During the concurrent review of the activity care plan of Resident 6 and interview with the activity director (AD) on 3/20/25 at 11:37 a.m., AD acknowledged that the activity care plan of Resident 6 was not reviewed and updated quarterly.

During the interview with the social service director (SSD) on 3/20/25 at 12:22 p.m., SSD verified that activity care plans should be updated quarterly and as needed.

During the concurrent review of the activity care plan of Resident 6 and interview with the director of nursing (DON) on 3/20/25 at 12:18 p.m., DON verified that activity care plans should be reviewed and updated quarterly and the activity care plan of Resident 6 was not reviewed and updated quarterly and will follow up on it.

2. During the observation of Resident 35 on 3/17/25 at 2:18 p.m., Resident 35 was laying in her bed, awake, confused and could not answer questions.

Review of Resident 35's admission record indicated, Resident 35 was admitted to the facility on [DATE] with primary diagnosis of Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) with dyskinesia (involuntary, abnormal movements) and with fluctuations (continual change in symptoms that come and go suddenly).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 35's physician orders indicated, Resident 35 may participate in activity if not in conflict with treatment, ordered on 2/7/23. Review of Resident 35's activity care plan indicated that it was not reviewed and updated quarterly for effectiveness. During the concurrent review of Resident 35's activity care plan and interview with the activity director (AD) on 3/20/25 at 11:22 a.m., AD acknowledged that Resident 35's activity care plan was not reviewed and updated quarterly. During the interview with the social service director (SSD) on 3/20/25 at 12:22 p.m., SSD verified that activity care plans should be updated quarterly and as needed. During the concurrent review of Resident 35's activity care plan and interview with DON on 3/20/25 at 12:15 p.m., DON verified that activity care plans should be reviewed and updated quarterly and the activity care plan of Resident 35 was not reviewed and updated quarterly and will follow up on it. 3. During the observation of Resident 43 on 3/17/25 at 12:38 p.m., Resident 43 was in her bed, confused and could not answer questions. Review of Resident 43's admission record indicated, Resident 43 was admitted to the facility on [DATE] with primary diagnosis of unspecified Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Review of Resident 43's physician orders indicated, Resident 43 may participate in activity if not in conflict with treatment, ordered on 10/10/23. Review of Resident 43's activity care plan indicated that it was not reviewed and updated quarterly for effectiveness. During the concurrent review of Resident 43's activity care plan and interview with the activity director (AD) on 3/20/25 at 11:10 a.m., AD acknowledged that Resident 43's activity care plan was not reviewed and updated quarterly. During the interview with the social service director (SSD) on 3/20/25 at 12:22 p.m., SSD verified that activity care plans should be updated quarterly and as needed. During the concurrent review of Resident 43's activity care plan and interview with DON on 3/20/25 at 12:13 p.m., DON verified that activity care plans should be reviewed and updated quarterly and the activity care plan of Resident 43 was not reviewed and updated quarterly and will follow up on it. 4. During the observation of Resident 44 on 3/17/25 at 12:35 p.m., Resident 44 was in the dining room eating lunch. Resident 44 was alert, calm and verbally responsive. Review of Resident 44's admission record indicated, Resident 44 was admitted to the facility on [DATE] with primary diagnosis of Parkinson's disease with dyskinesia, without mention of fluctuations. (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 Resident 44's physician orders indicated, Resident 44 may participate in planned activities, not in conflict with plan of care, ordered on 7/23/24. Review of Resident 44's activity care plan indicated that it was not reviewed and updated quarterly for effectiveness. During the concurrent review of Resident 44's activity care plan and interview with the activity director (AD) on 3/20/25 at 11:41 a.m., AD acknowledged that Resident 44's activity care plan was not reviewed and updated quarterly. During the interview with the social service director (SSD) on 3/20/25 at 12:22 p.m., SSD verified that activity care plans should be updated quarterly and as needed. During the concurrent review of Resident 44's activity care plan and interview with DON on 3/20/25 at 12:20 p.m., DON verified that activity care plans should be reviewed and updated quarterly and the activity care plan of Resident 44 was not reviewed and updated quarterly and will follow up on it. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure, the residents received the necessary care and services for one of 13 residents, (Resident 40), when there were no physician order and no care plan for Resident 40's skin discoloration on her left and right forearm. This failure had the potential to affect the resident's care and could jeopardize her health and well-being. Findings: Review of Resident 40's Admission Record indicated she was admitted to the facility on [DATE]. During observations on 3/17/25 at 10:30 a.m. and on 3/21/25 at 11:09 a.m., Resident 40 had skin discoloration on her left and right forearm, but there was no physician order and no care plan for the discolorations. During an interview with the director of nursing (DON) on 3/21/25, at 11:27 a.m., she reviewed Resident 40's clinical record and confirmed that Resident 40 did not have physician order and care plan for the discoloration on her left and right forearm. The DON stated, a physician order and care plan for Resident 40's skin discolorations should have been initiated. Review of the facility's policy, Change in a Resident's Condition or Status, dated 2/2021, indicated Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status . 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview, and record review, the facility failed to ensure provision of care and services related to pressure ulcers were consistent with professional standards of practice for one of fourteen sampled residents (Residents 35), when there were no wound measurements for Resident 35's three wound assessments. These failures had the potential for the residents with pressure ulcers, not being properly monitored and treated which could delay the healing or worsen the wound. Findings: During the observation of Resident 35 on 3/17/25 at 2:18 p.m., Resident 35 was laying in her bed, awake, confused, and unable to answer questions. Review of Resident 35's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident), indicated, Resident 35 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) with dyskinesia (involuntary, abnormal movements) and with fluctuations (continual change in symptoms that come and go suddenly), unspecified dysphagia (difficulty swallowing foods or liquids) and stage 2 pressure ulcer (involves partial-thickness skin loss with an exposed dermis or middle layer of skin) of sacral region (at the bottom of the spine and lies between the fifth segment of the lumbar spine or lower back and the coccyx or tailbone). Review of Resident 35's clinical records indicated, Resident 35 had a stage 2 pressure ulcer on her coccyx area. Review of Resident 35's wound assessments indicated, Resident 35 did not have wound measurements done for her 11/26/24, 12/10/24 and 12/11/24 wound assessments. During the concurrent review of Resident 35's clinical records and interview with licensed vocational nurse J (LVN J) on 3/20/25 at 1:00 p.m., LVN J acknowledged Resident 35 still had stage 2 pressure ulcer in the coccyx area. LVN J verified that wound assessments and wound measurements should be done weekly and as needed. LVN J further verified that there were no wound measurements on 11/26/24, 12/10/24 and 12/11/24 wound assessments. During the concurrent review of Resident 35's clinical records and interview with the director of nursing (DON) on 3/20/25 at 4:28 p.m., DON acknowledged that Resident 35 did not have measurements for her stage 2 pressure ulcer in her 11/26/24, 12/10/24 and 12/11/24 wound assessments. DON further verified that nurses should have documented the wound measurements, every time they did the wound assessments either weekly or as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Wound Care: Documentation, revised October 2010 indicated, The following information should be recorded in the resident's medical record, including . All assessment data such as wound bed color, size, drainage and other wound data are obtained when inspecting the wound . Notify supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of a bed) for 22 (Residents 35, 9, 24, 15, 14, 8, 19, 16, 10, 21, 7, 13, 29, 30, 33, 39, 253, 38, 37, 1, 50 and 11) of 22 residents who used side or bed rails when: 1. Twenty-two (22) of 22 residents who used side or bed rails were without care plans, 2. The risks of entrapment prior to the installation of side or bed rails were not assessed for 22 of 22 residents who used bed rails, and 3. The bed rail assessments were not updated in a timely manner for 18 of 22 residents (Residents 35, 9, 24, 15, 8, 19, 16, 10, 21, 7, 13, 29, 30, 33, 39, 38, 37 and 11). These failures had the potential to place the residents at risk for entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail) and injury. Findings: 1a. During the observation of Resident 35, on 3/17/25 at 2:18 p.m., Resident 35 was in bed, confused and could not answer questions. Resident 35's bilateral (both sides) side rails were up. During the concurrent observation of Resident 35 and interview with registered nurse C (RN C), on 3/21/25 at 4:22 p.m., Resident 35 was laying in her bed and her bilateral side rails were up. RN C verified that Resident 35's bilateral side rails were up. Review of Resident 35's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident), indicated, Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's physician orders indicated, Resident 35's side rails were ordered on 2/6/24. Review of Resident 35's care plans indicated, Resident 35 did not have a care plan for her side rails. 1b. During the observation of Resident 9 on 3/17/25 at 12:44 p.m., Resident 9 was in bed eating his lunch, and he was alert, calm, and verbally responsive. Resident 9's bilateral side rails were up. During the concurrent observation of Resident 9 and interview with RN C, on 3/21/25 at 4:25 p.m., Resident 9 was in his bed and his bilateral side rails were up. RN C verified that Resident 9's bilateral side rails were up, and Resident 9 was using those side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 9's admission record, indicated, Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's physician orders indicated, Resident 9's side rails were ordered on 2/29/24. Review of Resident 9's care plans indicated, Resident 9 did not have a care plan for his side rails. 1c. During the observation of Resident 24 on 3/17/25 at 1:48 p.m., Resident 24 was in her room, alert, comfortable and verbally responsive. Resident 24's bilateral side rails were up. During the concurrent observation of Resident 24 and interview with RN C on 3/21/25 at 4:27 p.m., Resident 24 was in her room and her bilateral side rails were up. RN C verified that Resident 24's bilateral side rails were up, and Resident 24 was using those side rails. Review of Resident 24's admission record, indicated, Resident 24 was initially admitted to the facility on [DATE]. Review of Resident 24's physician orders indicated, Resident 24's side rails were ordered on 3/14/24. Review of Resident 24's care plans indicated, Resident 24 did not have a care plan for her side rails. 1d. During the observation of Resident 15 on 3/17/25 at 1:48 p.m., Resident 15 was alert, comfortable and verbally responsive. Resident 15's bilateral side rails were up. During the concurrent observation of Resident 15 and interview with RN C on 3/21/25 at 4:30 p.m., Resident 15 was in her room and her bilateral side rails were up. RN C verified that Resident 15's bilateral side rails were up and were used by Resident 15. Review of Resident 15's admission record, indicated, Resident 15 was readmitted to the facility on [DATE]. Review of Resident 15's physician orders indicated, Resident 15's side rails were ordered on 8/24/24. Review of Resident 15's care plans indicated, Resident 15 did not have a care plan for her side rails. 1e. During the observation of Resident 14 on 3/17/25 at 1:54 p.m., Resident 14's bilateral side rails were up. During the concurrent observation of Resident 14 and interview with RN C on 3/21/25 at 4:32 p.m., Resident 14 was in her bed, confused and unable to answer questions. Resident 14's bilateral side rails were up. RN C verified that Resident 14's bilateral side rails were up. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 14's admission record, indicated, Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's physician orders indicated, Resident 14's side rails were ordered on 5/8/22. Review of Resident 14's care plans indicated, Resident 14 did not have a care plan for her side rails. 1f. During the observation of Resident 8 on 3/17/25 at 2:00 p.m., Resident 8's bilateral side rails were up. During the concurrent observation of Resident 8 and interview with RN C on 3/21/25 at 4:35 p.m., Resident 8 was in her bed, alert, calm, comfortable and verbally responsive. Resident 8's bilateral side rails were up. RN C verified that Resident 8's bilateral side rails were up and used by Resident 8. Review of Resident 8's admission record, indicated, Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's physician orders indicated, Resident 8's side rails were ordered on 2/6/24. Review of Resident 8's care plans indicated, Resident 8 did not have a care plan for her side rails. 1g. During the observation of Resident 19 on 3/17/25 at 2:05 p.m., Resident 19's bilateral side rails were up. During the concurrent observation of Resident 19 and interview with RN C on 3/21/25 at 4:38 p.m., Resident 19 was sitting in the chair, alert, comfortable and verbally responsive. Resident 19's bilateral side rails were up. RN C verified that Resident 19's bilateral side rails were up and used by Resident 19. Review of Resident 19's admission record, indicated, Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's physician orders indicated, Resident 19's side rails were ordered on 2/17/24. Review of Resident 19's care plans indicated, Resident 19 did not have a care plan for her side rails. 1h. During the observation of Resident 16 on 3/17/25 at 2:08 p.m., Resident 16's bilateral side rails were up. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the concurrent observation of Resident 16 and interview with RN C on 3/21/25 at 4:42 p.m., Resident 16 was sitting in the chair, alert, comfortable and verbally responsive. Resident 16's bilateral side rails were up, and RN C verified that Resident 16's bilateral side rails were up and used by Resident 16. Review of Resident 16's admission record, indicated, Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's physician orders indicated, Resident 16's side rails were ordered on 2/6/24. Review of Resident 16's care plans indicated, Resident 16 did not have a care plan for her side rails. 1i. During an observation on 3/17/25 at 9:33 a.m., Resident 10 was seated in a wheelchair, asleep, with bilateral upper bed rails raised. 1j. During an observation on 3/17/25 at 9:43 a.m., Resident 21 was lying in bed, asleep, with both upper bed rails raised. 1k. During an observation on 3/17/25 at 9:44 a.m., Resident 7 was lying in bed, asleep, with both upper bed rails raised. 1l. During an observation on 3/17/25 at 9:57 a.m., Resident 13 was awake, seated in a wheelchair, with both upper bed rails raised. 1m. During an observation on 3/17/25 at 9:58 a.m., Resident 29 was asleep in bed, with both upper bed rails raised. 1n. During an observation on 3/17/25 at 12:28 p.m., Resident 30 was seated in a wheelchair, eating lunch, with bilateral upper bed rails raised. 1o. During an observation on 3/17/25 at 12:30 p.m., Resident 33 was not in the room, but both bilateral upper bed rails were raised. 1p. During an observation on 3/18/25 at 11:16 a.m., Resident 39 was seated in a wheelchair, watching TV, with a caregiver in the room. Both upper bed rails were raised. A review of the clinical records for Residents 10, 21, 7, 13, 29, 30, 33, and 39 indicated that their care plans did not address the use of bed rails. 1q. During an observation on 3/19/25, at 3:09 p.m., Residents 253, 38, 37, 1, 50 and 11 had bilateral (two sides) bed rails. Review of the care plans of Residents 253, 38, 37, 1, 50 and 11 indicated, they did not have the care plans for their bed rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Glen Skilled Nursing	2671 Plummer Avenue San Jose, CA 95125

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the concurrent review of the resident care plans and interview with the director of nursing (DON) on 3/20/25 at 4:00 p.m., DON acknowledged that these 22 of 22 residents who were using side rails, (Residents 35, 9, 24, 15, 14, 8, 19, 16, 10, 21, 7, 13, 29, 30, 33, 39, 253, 38, 37, 1, 50 and 11), did not have care plans for their side rails and facility will update their care plans. 2a. Review of Resident 35's admission record indicated, Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's physician orders indicated, Resident 35's side rail was ordered on 2/6/24. Review of Resident 35's clinical records indicated, there was no documentation that Resident 35 was assessed for the risks of entrapment prior to the installation of her bed rails. 2b. Review of Resident 9's admission record, indicated, Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's physician orders indicated, Resident 9's side rail was ordered on 2/29/24. Review of Resident 9's clinical records indicated, there was no documentation that Resident 9 was assessed for the risks of entrapment prior to the installation of his bed rails. 2c. Review of Resident 24's admission record, indicated, Resident 24 was initially admitted to the facility on [DATE]. Review of Resident 24's physician orders indicated, Resident 24's side rail was ordered on 3/14/24. Review of Resident 24's clinical records indicated, there was no documentation that Resident 24 was assessed for the risks of entrapment prior to the installation of her bed rails. 2d. Review of Resident 15's admission record, indicated, Resident 15 was readmitted to the facility on [DATE]. Review of Resident 15's physician orders indicated, Resident 15's side rail was ordered on 8/24/24. Review of Resident 15's clinical records indicated, there was no documentation that Resident 15 was assessed for the risks of entrapment prior to the installation of her bed rails. 2e. Review of Resident 14's admission record, indicated, Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's physician orders indicated, Resident 14's side rail was ordered on 5/8/22. Review of Resident 14's clinical records indicated, there was no documentation that Resident 14 was assessed for the risks of entrapment prior to the installation of her bed rails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lincoln Glen Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2671 Plummer Avenue San Jose, CA 95125	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2f. Review of Resident 8's admission record, indicated, Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's physician orders indicated, Resident 8's side rail was ordered on 2/6/24. Review of Resident 8's clinical records indicated, there was no documentation that Resident 8 was assessed for the risks of entrapment prior to the installation of her bed rails. 2g. Review of Resident 19's admission record, indicated, Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's physician orders indicated, Resident 19's side rail was ordered on 2/17/24. Review of Resident 19's clinical records indicated, there was no documentation that Resident 19 was assessed for the risks of entrapment prior to the installation of her bed rails. 2h. Review of Resident 16's admission record, indicated, Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's physician orders indicated, Resident 16's side rail was ordered on 2/6/24. Review of Resident 16's clinical records indicated, there was no documentation that Resident 16 was assessed for the risks of entrapment prior to the installation of her bed rails. 2i. During an observation on 3/17/25 at 9:33 a.m., Resident 10 was seated in a wheelchair, asleep, with bilateral upper bed rails raised. 2j. During an observation on 3/17/25 at 9:43 a.m., Resident 21 was lying in bed, asleep, with both upper bed rails raised. 2k. During an observation on 3/17/25 at 9:44 a.m., Resident 7 was lying in bed, asleep, with both upper bed rails raised. 2l. During an observation on 3/17/25 at 9:57 a.m., Resident 13 was awake, seated in a wheelchair, with both upper bed rails raised. 2m. During an observation on 3/17/25 at 9:58 a.m., Resident 29 was asleep in bed, with both upper bed rails raised. 2n. During an observation on 3/17/25 at 12:28 p.m., Resident 30 was seated in a wheelchair, eating lunch, with bilateral upper bed rails raised. 2o. During an observation on 3/17/25 at 12:30 p.m., Resident 33 was not in the room, but both bilateral upper bed rails were raised. 2p. During an observation on 3/18/25 at 11:16 a.m., Resident 39 was seated in a wheelchair, watching TV, with a caregiver in the room. Both upper bed rails were raised. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the clinical records for Residents 10, 21, 7, 13, 29, 30, 33, and 39 showed that the facility did not assess the risk of entrapment before installing bed rails. 2q. During an observation on 3/19/25, at 3:09 p.m., Residents 253, 38, 37, 1, 50 and 11 had bilateral (two sides) bed rails. Review of the clinical records of Residents 253, 38, 37, 1, 50 and 11 indicated, there was no documentation that they were assessed for the risks of entrapment prior to the installation of their bed rails. During the concurrent review of the clinical records of the residents and interview with the DON on 3/21/25 at 4:47 p.m., DON verified that these 22 of 22 residents who were using side rails, (Residents 35, 9, 24, 15, 14, 8, 19, 16, 7, 21, 33, 30, 10, 29, 13, 39, 253, 38, 37, 1, 50 and 11), were not assessed for the risks of entrapment prior to the installation of side or bed rails. 3a. Review of Resident 35's admission record indicated, Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's physician orders indicated, Resident 35's side rails were ordered on 2/6/24. Review of Resident 35's bed rail assessment indicated, Resident 35's last bed rail assessment was done on 7/18/24. Resident 35's bed rail assessment was not updated quarterly. 3b. Review of Resident 9's admission record, indicated, Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's physician orders indicated, Resident 9's side rails were ordered on 2/29/24. Review of Resident 9's bed rail assessment indicated, Resident 9's last bed rail assessment was done on 7/18/24. Resident 9's bed rail assessment was not updated quarterly. 3c. Review of Resident 24's admission record, indicated, Resident 24 was initially admitted to the facility on [DATE]. Review of Resident 24's physician orders indicated, Resident 24's side rails were ordered on 3/14/24. Review of Resident 24's bed rail assessment indicated, Resident 24's last bed rail assessment was done on 7/18/24. Resident 24's bed rail assessment was not updated quarterly. 3d. Review of Resident 15's admission record, indicated, Resident 15 was readmitted to the facility on [DATE]. Review of Resident 15's physician orders indicated, Resident 15's side rails were ordered on 8/24/24. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 15's bed rail assessment indicated, Resident 15's last bed rail assessment was done on 11/24/24. Resident 15's bed rail assessment was not updated quarterly. 3e. Review of Resident 8's admission record, indicated, Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's physician orders indicated, Resident 8's side rails were ordered on 2/6/24. Review of Resident 8's bed rail assessment indicated, Resident 8's last bed rail assessment was done on 7/19/24. Resident 8's bed rail assessment was not updated quarterly. 3f. Review of Resident 19's admission record, indicated, Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's physician orders indicated, Resident 19's side rails were ordered on 2/17/24. Review of Resident 19's bed rail assessment indicated, Resident 19's last bed rail assessment was done on 7/18/24. Resident 19's bed rail assessment was not updated quarterly. 3g. Review of Resident 16's admission record, indicated, Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's physician orders indicated, Resident 16's side rails were ordered on 2/6/24. Review of Resident 16's bed rail assessment indicated, Resident 16's last bed rail assessment was done on 7/18/24. Resident 16's bed rail assessment was not updated quarterly. 3h. During a concurrent observation and interview with the Licensed Vocational Nurse B (LVN B) on 3/21/25, at 4:27 p.m. in Resident 10's room, Resident 10 had bilateral upper bed rails raised. The LVN confirmed that Resident 10 was using the bed rails. A review of Resident 10's bed rail assessment indicated that it was last completed on 7/18/24. 3i. During a concurrent observation and interview with the LVN B on 3/21/25 at 4:30 p.m. in Resident 33's room, resident was sitting in a wheelchair, watching TV. Resident 33 had bilateral upper bed rails raised. The LVN B confirmed that Resident 33 was using the bed rails. A review of Resident 33's bed rail assessment indicated that it was last completed on 7/18/24. 3j. During a concurrent observation and interview with the LVN B on 3/21/25 at 4:31 p.m. in Resident 30's room, resident was seated in a wheelchair, watching TV. Resident 30 had bilateral upper bedrails raised. The LVN B confirmed that Resident 30 was using the bed rails. A review of Resident 30's bed rail assessment indicated that it was last completed on 7/19/24. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3k. During a concurrent observation and interview with the LVN B on 3/21/25 at 4:32 p.m. in Resident 13's room, Resident 13 was seated in a wheelchair, watching TV. Resident 13 had bilateral upper bed rails raised. The LVN B confirmed that Resident 13 was using the bed rails. A review of Resident 13's bed rail assessment indicated that it was last completed on 7/10/24. 3l. During a concurrent observation and interview with the LVN B on 3/21/25 at 4:33 p.m. in Resident 29's room, Resident 29 was seated on a couch, listening to music. Resident 29 had bilateral upper bed rails raised. The LVN B confirmed that Resident 29 was using the bed rails. A review of Resident 29's bed rail assessment indicated that it was last completed on 7/19/24. 3m. During a concurrent observation and interview with the LVN B on 3/21/25 at 4:35 p.m. in Resident 21's room, Resident 21 was awake, lying in bed. Resident 21 had bilateral upper bed rails raised. The LVN B confirmed that Resident 21 was using the bed rails. A review of Resident 21's bed rail assessment indicated that it was last completed on 10/25/24. 3n. During a concurrent observation and interview with the LVN B on 3/21/25 at 4:36 p.m. in Resident 7's room, resident was asleep, lying in bed. Resident 7 had bilateral upper bed rails raised. The LVN B confirmed that Resident 7 was using the bed rails. A review of Resident 7's bed rail assessment indicated that it was last completed on 7/21/24. 3o. During a concurrent observation and interview with the LVN B on 3/21/25 at 4:43 p.m. in Resident 39's room, Resident 39 had bilateral bed rails raised. The LVN confirmed that Resident 39 was using the bed rails. A review of Resident 39's bed rail assessment indicated that it was last completed on 11/20/24. 3p. During an observation on 3/19/25, at 3:09 p.m., Residents 38, 37 and 11 had bilateral (two sides) bed rails. Review of the bed rail assessments of Residents 38, 37 and 11 indicated, they did not have quarterly bed rail assessments. The only bed rail assessments Residents 38, 37 and 11 had were dated 7/28/24. During the concurrent review of the bed rail assessments of the residents and interview with the DON on 3/20/25 at 4:00 p.m., DON verified that the bed rail assessments of these 18 of 22 residents who were using side rails, (Residents 35, 9, 24, 15, 8, 19, 16, 10, 21, 7, 13, 29, 30, 33, 39, 38, 37 and 11) were not updated quarterly and facility will check on them. Review of the facility's Bed Rail Assessment, printed on 3/20/25 indicated that bed rail assessments were to be done quarterly. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy and procedure titled, Bed Safety and Bed Rails, revised August 2022, indicated, The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit . The resident assessment to determine the risk of entrapment includes, but is not limited to medical diagnosis, conditions, symptoms . size and weight, sleep habits, medications, acute medical or surgical interventions, underlying medical conditions . cognition . mobility and risk of falling. The resident assessment also determines potential risks to the resident associated with the use of bed rails . Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan, includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Assessments of the residents are ongoing, and care plans are revised as information about the residents and the residents' condition change .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37409 Based on interview and record review, the facility failed to ensure the effective use of medications for one of 13 residents (1) when Resident 1 received ferrous sulfate (iron, for prevention/treatment of iron deficiency) and Calcium+D3 (a medication used to prevent or treat low blood calcium levels) at the same time. This failure had the potential for the resident to not receive the amount of prescribed iron supplement. Findings: Review of Resident 1's Admission Record indicated she was admitted to the facility on [DATE] with anemia (a condition that develops when the blood produces a lower-than-normal amount of healthy red blood cells) diagnosis. Review of Resident 1's clinical record indicated, she had physician orders for ferrous sulfate 325 milligrams (mg, a metric unit of mass) every other day for anemia at 9 a.m., started on 11/28/24, and for Calcium+D3 600-20 mg-microgram (ug, a metric unit of mass) two times a day, at 9 a.m. and 6 p.m., started on 2/19/25. Thus, since 2/19/25, ferrous sulfate and Calcium+D3 were given at the same time at 9 a.m. every other day. During an interview with the clinical pharmacist consultant (CPC) on 3/21/25, at 9:32 a.m., she reviewed Resident 1's clinical record and confirmed that ferrous sulfate and Calcium+D3 were given to Resident 1 at the same time at 9 a.m. every other day since 2/19/25. The CPC stated that ferrous sulfate and Calcium+D3 should be administered at least two hours apart due to drug-to-drug interaction that decreases the absorption of iron, and she would change the time of the administration. According to Lexicomp (www.[NAME].com), a nationally recognized drug information resource, the concurrent use of calcium and ferrous sulfate led to a drug-drug interaction (DDI) of Risk Rating D, which was a significant interaction and required therapy modification. The effect of the DDI was that the calcium may decrease the absorption of oral preparations of iron salts. It indicated the iron absorption was decreased an average of 60% when given as ferrous sulfate and co-administered with calcium. Lexicomp also indicated to separate the administrations of these medications so it may minimize the potential for significant interaction. Review of the facility's policy, Medication/Food Interaction, dated 7/2013, indicated, . 1. The consultant pharmacist, nurses, and physician shall review medications ordered for each resident to determine if medications interact with food, beverages, or another medication that has been prescribed for the resident.

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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** 37409 Based on observation, interview, and record review, the facility failed to ensure medications were stored appropriately when: 1. Opened medications without open date were found in Station 1 and Station 2 medication carts, and one expired medication was found in Station 1 medication cart. This had the potential for residents to be given expired or past open-period medications. 2. A medication cart with medications was left unlocked. This had the potential for access to medications by unauthorized persons such as unauthorized staff, residents, and visitors. Findings: 1a. During an observation on Station 1 medication cart with registered nurse D (RN D) on [DATE], at 12:43 p.m., an opened bottle of docusate sodium (stool softener) 250 milligrams (mg, a metric unit of mass) and an opened bottle of guaifenesin (cough and cold medication) 100 mg/5 milliliters (ml, a metric unit of volume) did not have and open date for each bottle; and one container of hyoscyamine sulfate (treats the symptoms of condition that affects the stomach and intestines) 0.125 mg for Resident 24 had a discard after [DATE] date. During a concurrent interview with RN D, she stated that expired medication should not be in the medication cart, and opened medications should have open date. 1b. During an observation on Station 2 medication cart with licensed vocational nurse E (LVN E) on [DATE], at 1:40 p.m., an opened bottle of ibuprofen (treats mild to moderate pain) 200 mg, an opened bottle of acetaminophen (treats mild to moderate pain) 500 mg, an opened bottle of Vitamin B-12 (treats vitamin B-12 deficiency) 1000 micrograms (ug, a metric unit of mass), an opened bottle of Melatonin (treats sleep disorder) 5 mg, and an opened bottle of Vitamin C (essential for wound healing and the formation of nutrient responsible for healthy joints and skin) 250 mg did not each have an open date. During a concurrent interview with LVN E, she stated that opened medications should have open dates. Review of the facility's policy, Medication Labeling and Storage, dated ,d+[DATE], indicated, . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 2. During an observation on medication administration on [DATE], at 10:18 a.m., licensed vocational nurse E (LVN E) pushed her medication cart to the nurse station, did not lock the medication cart, and went in Resident 13's room to answer his call light. (continued on next page)

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	555363	A. Building B. Wing	03/24/2025

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Lincoln Glen Skilled Nursing	2671 Plummer Avenue San Jose, CA 95125

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with LVN E on [DATE], at 10:20 a.m., she confirmed her medication cart was left unlocked. LVN E stated that she should have locked her medication cart before going to Resident 13's room. Review of the facility's 2007 policy, Storage of Medication, indicated, Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42819 Based on observation, interview, and record review, the facility failed to keep the exterior of the kitchen's ice machine free of dust. This failure placed all 51 residents at risk of food contamination (unintended presence of potentially harmful substances such as microorganisms, chemicals, or physical objects in food.) Findings: During an observation and interview with the Food Service Manager (FSM) on 3/20/25 at 2:00 p.m. in the facility's kitchen, the exterior side panel of the ice machine was covered in dust. Clean plates were also placed next to the dusty side of the ice machine. The FSM confirmed the observation and stated that the area was dusty. During a concurrent interview and review of the facility's Cleaning Assignments Checklist, provided by the FSM, indicated that staff were responsible for sanitizing the ice scoop, scoop holder, and exterior of the ice machine. The FSM stated that kitchen staff clean the exterior of the ice machine every evening shift. During an interview on 3/20/25, at 2:10 p.m., the Director of Support Services (DSS), who was also present in the kitchen, acknowledged the dust on the ice machine and asked a maintenance staff member to clean it. The DSS stated that he would remind the kitchen staff to thoroughly clean the exterior of the ice machine. A review of the ice machine manufacturer's Installation, Use & Care Manual under the Maintenance section indicated: Exterior Cleaning: Clean the area around the ice machine as often as necessary to maintain cleanliness and efficient operation . Sponge any dust and dirt off the outside of the ice machine with mild soap and water.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37409 Based on observation, interview, and record review, the facility failed to ensure staff followed proper infection control procedures when: 1. Certified Nursing Assistant F (CNA F), Certified Nursing Assistant G (CNA G), and Activities Leader H (AL H) delivered meal trays to Resident 6, Resident 21, and Resident 24 without sanitizing their hands; 2. Licensed Vocational Nurse E (LVN E) used paper towel to wipe the first drop of blood on Resident 4's finger; 3. Employee food was placed on Resident 27's overbed table; 4. Resident 40's filter of oxygen concentration was dusty, and her humidifier bottle was not changed within 5 days; 5. Home Health Aids I (HHA I) walked out of Resident 46's room without sanitizing her hands; and, 6. For Resident 7, LVN E did not perform proper hand hygiene practices during wound care. These failures had the potential to increase the risk of spreading infections in the facility. Findings: 1. During a lunch observation on 3/17/25, at 12:08 p.m., certified nursing assistant F (CNA F) pushed the meal cart then brought the lunch tray to Resident 6 without sanitizing her hands. During a concurrent interview with CNA F, she acknowledged she should sanitize her hands before delivering the lunch tray to Resident 6. During a lunch observation on 3/17/25, at 12:13 p.m., certified nursing assistant G (CNA G) pushed the meal cart then brought the lunch tray to Resident 21 without sanitizing her hands. During a concurrent interview with CNA G, she acknowledged she should sanitize her hands before delivering the lunch tray to Resident 21. During an observation in the dining room on 3/17/25, at 12:24 p.m., activities leader H (AL H) brought the lunch tray to Resident 24 without sanitizing her hands. During a concurrent interview with AL H, she acknowledged she should sanitize her hands before delivering the lunch tray to Resident 24. During an interview with the infection preventionist (IP) on 3/21/25, at 3:59 p.m., she stated that staff should sanitize their hand before delivering meal trays to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Lincoln Glen Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2671 Plummer Avenue San Jose, CA 95125	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Nursing Department Responsibilities at Mealtime, dated 8/31/18, indicated, . Nursing should wash their hands between touching a resident, themselves, soiled items and clean items in order to prevent cross contamination. 2. During an observation with the medication administration on 3/19/25, at 11:46 a.m., licensed vocational nurse E (LVN E) used a lancet to prick Resident 4's finger to get a drop of blood drop to check her blood sugar. LVN E wanted to use Resident 4's second blood drop for the blood sugar check, so she wiped away Resident 4's first blood drop with a paper towel. During a concurrent interview with LVN E, she acknowledged she should not use the paper towel to wipe the first blood drop on Resident 4's finger. During an interview with the IP on 3/21/25, at 4:30 p.m., she stated that when checking the residents' blood sugar, the licensed nurse should use something cleaner such as a cotton ball to wipe away the residents' first drop of blood instead of a paper towel. Review of the facility's policy, Obtaining a Fingerstick Glucose Level, dated 10/2011, indicated . 12. Wipe the fingertip with a cotton ball to seal the puncture site. 3. During an observation with licensed vocational nurse A (LVN A) on 3/17/25, at 10:18 a.m., a bowl of three boiled eggs was placed on Resident 27's overbed table. During a concurrent interview with LVN A, she stated the bowl of three boiled eggs belongs to a certified nursing assistant (CNA), and it should not be placed on Resident 27's overbed table. During an interview with the IP on 3/21/25, at 3:53 p.m., she stated, the employee food should be stored in the employee break room and not in the resident's room. 4. During an observation with LVN A on 3/17/25, at 10:01 a.m., Resident 40 was on 6 liter (L, a metric unit of volume) per minute of oxygen. The humidifier bottle was dated 3/9/25, and the filter of the oxygen concentrator was dusty. During a concurrent interview with LVN A, she confirmed that the filter of the oxygen concentrator was dusty, and it should be cleansed every week. LVN A stated she would check on within how many days the humidifier bottle should be changed. During an interview with the IP, she stated that the filter of the oxygen concentrator should be cleansed every week, and the humidifier bottle should be changed every 5 days. Review of the facility's policy, Oxygen Administration, date 10/2010, indicated Change oxygen humidifier bottle every 5 days. Check and clean oxygen concentrator filter every Friday when oxygen in use. 5. During an observation on 3/17/25, at 10:35 a.m., home health aids I (HHA I) walked out of Resident 46's room without sanitizing her hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with HHA I, she stated that she was preparing Resident 46 for bed bath in her room. HHA I acknowledged that she should sanitize her hands when walking out of Resident 46's room. During an interview with the IP on 3/21/25, at 3:51 p.m., she stated that staff should wash or sanitize their hands when exiting the residents' rooms. 42819 6. During an observation of Resident 7's wound dressing change on 3/19/25 at 11:03 a.m., LVN E was observed wearing gloves while removing the old dressing, cleanse the sacrococcyx area (tailbone), applied wound treatment to the wound on the sacrococcyx, and applied cream to Resident 7's buttocks. LVN E then placed a clean dressing over Resident 7's sacrococcyx wound. However, LVN E did not perform hand hygiene after removing the soiled gloves or when moving from dirty to clean areas during the dressing change. During an interview with the IP on 3/21/25 at 11;25 a.m., who was present during Resident 7's wound care, IP was informed of the observation and he acknowledged that LVN E should have performed hand hygiene after removing gloves and when touching from dirty to clean areas during dressing change. Review of the facility's policy, Handwashing/Hand Hygiene, dated 10/2023, indicated, . Hand hygiene is indicated . d. after touching a resident . g. immediately after glove removal.