STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555391	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freedom Village Healthcare Center	23442 El Toro Road Lake Forest, CA 92630

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure whether it was safe to self-administer the medications for one of 14 final sampled residents (Resident 24). * Resident 24 was observed to have two Voltaren (topical pain medication) gel tubes at bedside. Resident 24 did not have the physician's order or care plan problem addressing the self-administration of medications. This failure had the potential for Resident 24 to administer the medications inaccurately. Findings: Review of the facility's P&P titled Self-Administration of Medications revised 6/5/24, showed the facility should comply with facility policy, applicable law, and the State Operations Manual with respect to resident self-administration of medications. Facility, in conjunction, with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition. Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer. Facility should document the self-administration and self-storage of medications in the resident's care plan. On 10/21/24 at 1059 hours, an observation was made at Resident 24's bedside. Two Voltaren gel tubes were observed inside an open drawer of the resident's nightstand. On 10/21/24 at 1101 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified the above findings and stated she was not aware of the medications at the resident's bedside. On 10/23/24 at 0843 hours, an interview was conducted with Resident 24. Resident 24 stated she would apply the Voltaren gel herself for the right knee pain. Medical record review for Resident 24 was initiated on 10/22/24. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24 H&P examination dated 10/22/24, showed Resident 24 had the capacity to understand and make medical decisions. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 24's Self-Administration of Medications assessment dated [DATE], showed Resident 24 was not a candidate for safe self-administration of medications. Further review of Resident 24's medical record failed to show documented evidence of the physician's order and care plan problem addressing Resident 24's self-administration of the medications. On 10/23/24 at 1001 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 24 was not a candidate for self-administration of the medications and did not have a physician's order or care plan in place.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539 Based on interview, medical record review, and facility P&P, the facility failed to ensure the advance directive information was documented and/or the information on how to formulate an advance directive was offered to three of 14 final sampled residents (Residents 22, 24, and 25). * The facility failed to ensure the copies of the advance directives were obtained and placed in the medical records for Residents 22 and 24. * The facility failed to ensure the POLST for Resident 25 was updated to show the advance directive was formulated. These failures had the potential for the facility to provide the treatments and services against the residents' wishes. Findings: Review of the facility's P&P titled Advance Directive revised 11/16/23, showed the following: - Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment to formulate an advance directive if he or she chooses to do so; - Information about whether or not the resident has executed an advance directive, the advance directive shall be displayed prominently in the medical records; and - The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. 1. Medical record review for Resident 22 was initiated on 10/21/24. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's POLST dated 2/17/24, showed Resident 22 had an advance directive dated 12/2019, and had a legally recognized decision maker. On 10/23/24 at 1640 hours, an interview was conducted with the SSD. When asked regarding the facility's process for advance directive, the SSD stated she asked the residents or family if they had advance directive. The SSD verified Resident 22's POLST showed the resident had an advance directive. On 10/23/24 at 1649 hours, a follow-up interview and concurrent medical record review was conducted with the SSD. The SSD stated there was no copy of the advance directive in Resident 22's medical record and stated she did not contact the family for a copy of the advance directive. 46787 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 24 was initiated on 10/22/24. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's H&P examination dated 10/22/24, showed Resident 24 had the capacity to understand and make medical decisions. Review of Resident 24's POLST dated 10/27/23, showed Resident 24's advance directive was not available. Review of Resident 24's Social Services assessment dated [DATE], showed Resident 24 had an advance directive. Review of Resident 24's Social Service Quarterly assessment dated [DATE], showed Resident 24's family member would bring in a copy of the advance directive. On 10/23/24 at 0936 hours, an interview and concurrent medical record review for Resident 24 was conducted with the SSD. The SSD acknowledged Resident 24's advance directive was not available in the medical record and should have been followed up. 48844 3. Medical record review for Resident 25 was initiated on 10/24/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's POLST, Section D (advance directives), dated 10/19/23, showed Resident 25 had no advance directive. Review of Resident 25's Power of Attorney for Healthcare dated 10/30/23, showed Resident 25 had formulated an advance healthcare directive. Further review of Resident 25's medical record failed to show the resident's POLST was updated to show an advance directive was formulated. On 10/24/24 at 1103 hours, an interview and concurrent medical record review for Resident 25 was conducted with the SSD. The SSD verified Resident 25 had formulated an advance healthcare directive; however, the POLST was not updated to show an advance healthcare directive was formulated.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview and record review, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNOC) after the termination Medicare Part A services for two nonsampled residents (Resident 45 and 47). This failure had the potential for violating the residents' rights to be informed of changes for coverage. Findings: 1. Review of Resident 45's Admission Record showed the resident was admitted to the facility on [DATE], and the last covered day of Medicare Part A Services was on 8/3/24. Review of Resident 45's SNF Beneficiary Protection Notification Review dated 5/17/24, showed the resident's representative was notified regarding the resident's last covered Medicare day. However, the representative was provided copy of the CMS 20052 SNF Beneficiary Protection Notification Review as the ABN (Advance Beneficiary Notification). 2. Review of Resident 47's Admission Record showed the resident was admitted to the facility on [DATE] and readmitted on [DATE]; and the last covered day of Medicare Part A Services was 5/15/24. Review of Resident 47's SNF Beneficiary Protection Notification Review dated 5/13/24, showed the resident's representative was notified regarding the resident's last covered Medicare day. However, the representative was provided copy of the CMS 20052 SNF Beneficiary Protection Notification Review as the ABN. On 10/22/24, at 0842 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated Residents 45's and 47's representatives were informed of the notification of the residents' last covered day for Medicare. The SSD stated they did not give the residents or their representatives a copy of the ABN.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51423 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the timely intervention for one of three final sampled residents (Resident 22) reviewed for weight loss. * Resident 22 experienced a 5.32% weight loss in one month. There was no assessment from nutritional services, RD intervention, care plan, and notification to the MD and family regarding the weight loss. This failure had the potential to result in continued nutritional decline and negative outcomes. Findings: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1. 18.11 dated 10/2023 showed if a resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status. Review the facility's P&P titled Weight Management Guidelines revised 2/2022 showed a weight change is significant per RAI manual definition with a weight loss of 5% and/or 5# in one month. The P&P also showed the following tasks at the time of identification of weight loss: - A Nutrition at Risk Review should be completed and should be initiated by the Dietary Manager and completed and assessed by the Dietitian. - Nursing should notify the physician and family of significant weight loss. - Weight loss should be care planned and have nutritional goals and approaches. Medical record review for Resident 22 was initiated on 10/21/24. Resident 22 was admitted on [DATE]. Review of Resident 22's Weights and Vitals Summary dated 10/21/24, showed the following weights: - On 5/3/24, 100 lbs - On 6/3/24, 97 lbs - On 7/3/24, 98 lbs - On 8/1/24, 96 lbs - On 9/3/24, 94 lbs - On 10/2/24, 89 lbs (a -5.32 % and 5 lbs weight loss from 9/3/24) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 22's medical record failed to show an assessment from nutritional services or RD intervention was completed after the weight loss was identified. Further review of Resident 22's medical record failed to show a care plan for weight loss was initiated and the MD/family were notified of the significant weight loss. On 10/24/24 at 1508 hours, a concurrent interview and medical record review was conducted with RN 2 and LVN 1. RN 2 stated the RNAs took the weights and reported weight changes to the DON and charge nurses. If there was a weight loss, the meal percentages would be checked. If the dietary intake was poor, the MD would be notified and asked for medications to increase appetite. RN 2 further stated the RNA would report the significant weight changes of five lbs in a week or month to the charge nurse or RN. Then, the RN would notify the physician, put the change of condition for three days, and document the oral intake. RN 2 stated the new admitted residents would be weighed weekly for four weeks and then monthly. LVN 1 stated the interventions would be documented in the change of condition and the resident was monitored for 72 hours. The nurses used a communication board on the electronic health record system to document changes of condition, weight loss changes and to alert the RD of a change. The care plan was also updated to reflect the weight loss. RN 2 and LVN 1 both confirmed there was no care plan in place for weight loss nor was there a progress note to document the MD or family was notified for Resident 22's weight loss. RN 2 and LVN 1 further verified a change of condition was not initiated for Resident 22.

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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 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 14 final sampled residents (Resident 22) and one nonsampled resident (Resident 17) reviewed for respiratory care were provided with the appropriate respiratory services. * The facility failed to ensure Resident 17's nasal cannula was stored in a sanitary manner when not in use. *The facility failed to ensure Resident 22's nasal cannula tubing and respiratory storage bag were dated. These failures had the potential to affect the respiratory health and well-being of the residents received respiratory care in the facility. Findings: 1. Medical record review for Resident 17 was initiated on 10/21/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report dated 10/24/24, showed a physician's order dated 5/29/24, to administer oxygen two liters per minute via nasal cannula as needed for shortness of breath and oxygen saturation level less than 90%. During an initial tour of the facility on 10/21/24 at 0927 hours, Resident 17's nasal cannula tubing was observed hanging on the concentrator and not stored in a bag when not in the use. On 10/21/24 at 0935 hours, a concurrent observation and interview for Resident 17 was conducted with LVN 3. LVN 3 acknowledged the oxygen tubing was dated 10/21/24, was just hanging on the concentrator and not stored in a Ziploc/set-up bag when not in use. LVN 3 verified the above findings. On 10/24/24 at 1340 hours, the DON was informed and acknowledged the above findings. 51539 2. Review of the facility's P&P titled Oxygen Administration dated 11/16/23, showed to change and date oxygen tubing, mask, or cannula every Sunday by night shift staff. Medical record review for Resident 22 was initiated on 10/21/24. Resident 22 was admitted to the facility on [DATE]. Review of the Order Summary Report dated 9/29/24, showed a physician's order dated 3/19/24, for oxygen at 3 liters per minute via nasal cannula as needed for SOB. (continued on next page)

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	On 10/21/24 at 0931 hours, an observation for Resident 22 was conducted. Resident 22 was observed lying in bed watching the television. Resident 22's nasal cannula and respiratory storage bag were observed hanging on the oxygen concentrator undated and unlabeled on the right side of Resident 22's bedside. On 10/21/24 at 1044 hours, an observation and concurrent interview for Resident 22 was conducted with LVN 2 at Resident 22's bedside. LVN 2 verified there was no date on Resident 22's nasal cannula and respiratory storage bag.

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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 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. 51539 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate reconciliation and disposal of medications. * The facility failed to ensure the count performed for all controlled medications in the Omnicell (automatic drug delivery system) as per the facility's P&P. This failure posed the risk for diversion of medications. Findings: Review of the facility's P&P titled Automatic Drug Delivery Systems (ADDS) CA- Omnicare revised 2022 showed the following: - The Pharmacy tracks the AADS and generates complete and accurate user records of all transactions including all medications and other inventory added to or removed from the ADDS. - Authorized facility shall count each controlled substance and verify their count against the count according to the ADDS system. - The two authorized facility stall will each sign the ADDS daily temperature and cycle count log after the cycle count is completed. On 10/23/24 at 1620 hours, and interview was conducted with Pharmacy Staff 1. When Pharmacy Staff 1 was asked how the nurses verified the count for the controlled narcotics (class II-class VI medications) in the Omnicell, Pharmacy Staff 1 stated that the nurses were to conduct an Omnicell count at least daily. When Pharmacy Staff 1 was asked what the meaning of the Cycle-Count Non-Compliant Report was, he stated the facility was not compliant because there was a discrepancy when the controlled medications were checked. On 10/23/24 at 1448 hours, a concurrent facility documents review and interview was conducted with the DON. Review of the facility document titled ADDS Daily Temperature and Cycle Log dated September 2024 and October 2024 with the DON regarding the Omnicell was conducted. When the DON was asked how the medications in the Omnicell were accounted for, the DON stated the night shift nurses were only counting the controlled medications categorized as touched. The DON stated if the controlled medications were not touched on the day of the count, the nurses did not have anything to account for. However, the log showed the controlled medications were reconciled from 7 AM-7 PM, and 7 PM-7 AM daily. When the DON was asked why the Cycle Count log showed, non-compliant, the DON stated and verified it was because the facility was not compliant with counting the controlled medications daily. The DON verified the findings. Review of the facility document titled Cycle Count Non-Compliant Report dated 10/23/24 at 0600 hours, showed the following medications were listed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- acetaminophen-cod #3 tablet (treats mild to moderate pain) with the last cycle counted on 9/17/24. - alprazolam 0.25 mg tablet (treats anxiety and panic disorder) with the last cycle counted on 10/2/24. - hydrocodone-acetaminophen 10-325 mg tablet (treats severe pain) with the last cycle counted on 9/11/24. - hydrocodone-acetaminophen 7.5-325 mg tablet (treats severe pain) with the last cycle counted on 10/1/24. - hydromorphone 2 mg tablet (treats pain) with the last cycle counted on 7/12/24. - lorazepam 0.5 mg (treats anxiety) with the last cycle counted on 7/12/24. - lorazepam 1 mg tablet (treats anxiety) with the last cycle counted on 10/6/24. - morphine Sulfate ER 15 mg tablet (pain medication with extended release) with the last cycle counted on 8/14/24. - morphine Sulfate IR 15 mg tablet (pain medication with immediate release) with the last cycle counted on 8/14/24. - oxycodone immediate 5 mg tablet (pain medication with immediate release) with the last cycle counted on 10/15/24. - oxycodone-acetamin 5-325 mg tablet (treats mild to moderate pain medication) with the last with the cycle counted on 10/15/24. - oxycodone-acetamin 10-325 mg tablet (treats moderate to severe medication) with the last cycle counted on 7/12/24. - oxycontin ER 10 mg tablet (moderate to severe pain) with the last cycle counted on 7/12/24. - pregabalin 50 mg capsule (treats nerve pain, prevents seizures) with the last cycle counted on 10/15/24. - pregabalin 75 mg capsule (treats nerve pain, prevents seizures) with the last cycle counted on 10/15/24. - temazepam 15 mg capsule (controlled medication to treat inability to sleep) with the last cycle counted on 10/15/24. - temazepam 7.5 mg capsule (controlled medication to treat inability to sleep) with the last cycle counted on 7/12/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- tramadol HCL 50 mg tablet (treats moderate to severe pain) with the last cycle counted on 8/14/24. - zolpidem tartrate 5 mg tablet (controlled medication to treat inability to sleep) with the last cycle counted on 9/18/24. On 10/24/24 at 1615 hours, an interview and concurrent document review was conducted with the DON. The DON was informed and verified the findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 12) was properly monitored for the stool softener medications. This failure had the potential to negatively impact the resident's health condition. Findings: Review of the facility's P&P titled Medication Administration revised 11/16/23, showed the following: - The facility policy regarding medication administration in accordance with Applicable law and the State Operations Manual when administering medications. - The licensed nurse should confirm the MAR reflects the most recent medication order. Medical record review for Resident 12 was initiated on 10/21/24. Resident was admitted to the facility on [DATE]. Review of Resident 12's Order Summary Report dated 9/29/24, showed Colace 100 mg (stool softener) one capsule by mouth two times a day for bowel management and to hold for loose stool. On 10/22/24 at 0916 hours, a medication administration observation of Resident 12 was conducted with LVN 2. LVN 2 administered Colace to Resident 12 without inquiring if the resident was having any loose stools. On 10/22/24 at 1349 hours, an interview was conducted with LVN 2. When asked about the process of administering stool softeners, LVN2 stated the facility would print out a list of all the residents with loose stool. When asked for the list, LVN2 stated it was not given to her today. LVN 2 was asked if she checked the point click care dashboard to assess for Resident 12's stool pattern, she stated no. LVN 2 was asked if she checked what the resident stool pattern was with the CNA today, she stated no. LVN 2 verified she did not check if the resident had loose stools prior to administering the medication. On 10/24/24 at 1615 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified the findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 25) reviewed for unnecessary medications was free from the unnecessary psychotropic medications (medication that affects the mind, emotions, and behavior). This failure had the potential for Resident 25 to have adverse complications from the medication. Findings: Review of the facility's P&P titled Antipsychotic Medication and Informed Consent Policy updated June 2024 showed antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavior symptoms have been identified and addressed. The policy interpretation and implementation include among others the following: - The attending physician and other staff will gather and document information to clarify a resident's behavior, mood function, medical condition, specific symptoms, and risks to the residents and others; - Diagnoses alone do not warrant the use of antipsychotic medication. The antipsychotic medication will generally only be considered if behavioral interventions have been attempted and included in the plan of care; - Pertinent non-pharmacological interventions must be attempted. Medical record review for Resident 25 was initiated on 10/24/24. Resident 25 was admitted to the facility on [DATE]. Resident 25 had diagnoses including Parkinson's disease (a chronic brain disorder that causes movement problems and mental health issues) and unspecified dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering and reasoning). Review of Resident 25's Order Note dated 10/9/24, showed an obtained clarification of manifestation for Nuplazid (antipsychotic medication) 34 mg tablet by mouth for psychosis (a condition that causes a person to lose touch with reality) related to Parkinson's disease manifested by paranoid ideation (a pattern of thinking characterized by persistent feelings of suspicion and distrust). Review of Resident 25's MAR for October 2024 failed to show for behavioral monitoring of the episodes for paranoid ideation. There was no documented evidence of any non-pharmacological interventions provided for Resident 25. Review of Resident 25's progress notes for the months of September and October 2024 failed to show documentation regarding Resident 25's manifestation of paranoid ideation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 25's care plan problems addressing the use of Nuplazid medication failed to show it was for the manifestation for paranoid ideation and documentation of interventions for the nonpharmacological implementation for the use of the Nuplazid medication. On 10/24/24 at 1004 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated Resident 25 was ordered Nuplazid on 10/9/24, for psychosis related to Parkinson's disease manifested by paranoid ideation. However, the DON was unable to show documentation of Resident 25's episodes of paranoid ideation. Furthermore, the DON was unable to find any monitoring of episodes and documentation for the nonpharmacologic intervention provided to Resident 25. The DON also verified there was no care plan for the use Nuplazid medication for psychosis related to Parkinson's disease manifested by paranoid ideation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed ensure proper storage and label of medications in Medication Cart 1 and medication storage room when: * Resident 7's eye drop medication in Medication Cart 1 was not kept in the refrigerator as per the medication instruction. * Resident 22's cough medication was stored with the topical ointment medication in Medication Cart 1. * Resident 686's inhalation medication in Medication Cart 1 was not labeled with an opened date as per the facility's policy . * The bottom drawer of Medication Cart 1 was not kept clean and free from spill residue. * The expired medication was stored in the medication storage room. In addtion, the licensed nurse left the medications for Resident 27 unattended while performed other tasks. These failures had the potential for the medications misuse, medication ineffectiveness, and potential exposure to harmful pathogens (bacteria, viruses, fungi) from expired medications for the residents. Findings: Review of the facility's P&P titled Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles revised on 8/1/24, showed the following: - Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding. - Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals. - Topical (external) use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration. - Medications with a manufacturer's expiration date expressed in month and year will expire on the last day of the month. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Medication Administration Revised 11/16/23, showed the following: - Licensed Nurse should enter the date opened on the label of medications with shortened expiration dates. - Licensed Nurse should not leave medications or chemicals unattended. 1. On 10/22/24 at 0850 hours, a medication observation was conducted with LVN 2. A bottle of aspirin (blood thinner) 81 mg was observed without an open date in Medication Cart 1. On 10/22/24 at 1403 hours, a medication cart inspection for Medication Cart 1 was conducted with LVN 2. The following was observed: - One opened box of latanoprost 0.005% (treats glaucoma and high eye pressure) eye drops for Resident 7 was placed in a plastic bag which had instructions to refrigerate until opened. The latanoprost eye drops were kept in the top drawer of the medication cart. LVN 2 verified the medication was to be stored in the refrigerator. - One guaifenesin DM (cough medication) 10-100 mg/5 ml oral solution bottle for Resident 22 was placed in the bottom drawer of Medication Cart 1 along with topical ointment cream: Diclofenac (treats pain) 1%. - One opened box of ipratropium-albuterol (used for difficulty breathing) inhalation aerosol 0.5-3 mg/3 ampoule for Resident 686 was observed without an open date. - The bottom drawer of Medication Cart 1 was observed with paper lining stained with green residue and dried medication debris. LVN 2 verified the above findings. 2. On 10/23/24 at 1039 hours, an observation and concurrent inspection of the Medication Storage Room was conducted with the DON and RN 1. One bottle of aspirin EC (blood thinner) 325 mg was observed with the expiration date 1/2024. The DON and RN 1 verified the findings. 3. On 10/23/24 at 0833 hours, a medication administration observation for Resident 27 was conducted with LVN 1. LVN 1 was observed leaving two eye drop medication bottles: brimonidine tartrate (treats glaucoma) solution 0.1% and dorzolamide HCL-Timolol Mal PF (treats glaucoma) Ophthalmic solution 22.3-6.8 mg/ml unattended on Resident 27's overhead table to wash her hands in the bathroom. At 0836 hours, LVN 1 was observed for the second time stepping out of Resident 27's room and leaving the two eye drops (brimonidine tartrate and dorzolamide HCL) unattended on Resident 27's overhead table to call for assistance. Medical record review was was intiated for Resident 27 on 10/21/24. Resident 27 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 27's Order Summary Report dated 10/23/24, showed a physician's orders as follows: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- brimonidine tartrate solution 0.1% instill one drop in the left eye two times a day for glaucoma. - dorzolamide HCL-Timolol Mal PH ophthalmic solution 22.3-6.8 mg/ml (dorzolamide HCL-timolol maleate) instill one drop in both eyes two times a day for glaucoma. On 10/23/24 at 1421 hours, an interview was conducted with LVN 1. LVN 1 acknowledged Resident 27's eye drops were left unattended. When asked where Resident 27's eye drops were when she stepped out of the room, LVN 1 stated she left them unattended at Resident 27's overhead table.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46787 Based on interview and facility document review, the facility failed to ensure the DSS who was responsible to oversee the satellite kitchen which produced food for the skilled nursing facility was qualified in managing the day-to-day functions of the food services department. This failure had the potential to negatively affect the health and well-being of 42 residents who received the food prepared in the kitchen. Findings: Review of the facility's matrix showed 42 residents who consumed food prepared in the kitchen. According to the California Code, Health, and Safety Code - HSC S 1265.4, a licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. On 10/23/24 at 0802 hours, an interview was conducted with the DSS. The DSS stated she was responsible to manage the SNF satellite kitchen. The DSS stated the food for the SNF residents was prepared in the main kitchen and transported to the SNF. The DSS stated the main kitchen was managed by the executive chef. The DSS stated the RD was employed part-time and would work two days a week. During the recertification survey from 10/21/24 to 10/24/24, multiple issues were found in the main kitchen and satellite kitchen, including kitchen utensils and equipment were not clean and in good working condition, kitchen equipment not cleaned and dried properly, and failure to ensure there was an air gap for a juice machine. Review of the facility's documents for qualifications of the DSS failed to show evidence she met the qualifications under the California Code, Health and Safety Code - HSC S 1265.4. On 10/23/24 at 1400 hours, an interview was conducted with the Administrator. The Administrator acknowledged the above findings. Cross references to F812 examples #1, #2, and #3.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the main menus were followed for 42 of 42 residents who consumed food prepared in the kitchen. This failure had the potential for the residents to not receive the menus as planned. Findings: Review of the facility's matrix showed 42 residents consumed food prepared in the facility's kitchen. Review of the facility's P&P titled Menu Alternatives dated 2018 showed the Director of Food and Nutrition Services is responsible for supervising meal preparation and service to ensure the menu is followed and served as planned. Residents/patients who do not like the menu entree will be given the menu alternative. Review of the facility's document titled Daily Spreadsheet Tuesday Day 17, showed the following items were to be served for the lunch main menu on 10/22/24: - Burgundy Beef Tenderloin Tips - Parslied Noodles - Seasoned Spinach - Choice of Bread - Margarine Review of the facility's document titled Daily Spreadsheet Tuesday Day 17, showed the following items served for lunch alternate menu on 10/22/24: - Turkey Pot Pie - Seasoned Spinach - Choice of Bread - Margarine On 10/22/24 at 1130 hours, an observation was conducted of the lunch meal tray line with the DSS. The alternate menu was observed being prepared in the kitchen. The DSS stated the alternate menu was being followed today and not the main menu. (continued on next page)

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the facility's documents failed to show evidence the residents were notified of the menu change. On 10/23/24 at 0802 hours, an interview and concurrent facility document review was conducted with the DSS. The DSS acknowledged and verified the main menu was not followed and the residents were not notified of the menu change.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, and facility document review, the facility failed to ensure the food allergy item was not served to one of 14 final sampled Residents (Resident 27). This failure had the potential for the resident's medical complication. Findings: Medical record review of Resident 27 was initiated on 10/21/24. Resident 27 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 27 Dietary Communication dated 4/12/24, showed the resident had allergies to cucumber. On 10/21/24 at 1210 hours, Resident 27 was observed eating his lunch independently and was served cucumber in his main plate. On 10/21/24 at 1230 hours, an interview and concurrent diet card review was conducted with the Dietary Service Supervisor. The DSS was asked if the resident had allergies to cucumber. The DSS stated yes and asked why the resident was served with the cucumber. The DSS stated, I will replace it now. The DSS verified the findings. On 10/24/24 at 1457 hours, an interview was conducted with Resident 27. Resident 27 stated he had allergy with cucumber and if he ate it, he would throw up and got sick.

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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. 46787 Based on observation, interview, and facility document review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen when: * The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions. * The facility failed to ensure the kitchen equipment were cleaned properly. * The facility failed to ensure a juice machine had an air gap for back flow prevention. These failures had the potential to pose the risk for exposure to food-borne illnesses in a medically vulnerable population of 42 residents received food prepared in the kitchen. Findings: Review of the facility's matrix showed 42 residents consumed food prepared in the facility's kitchen. 1. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 10/22/24 at 1405 hours, during an observation of the main kitchen with the supervision of the DSS and Executive Chef, the following items were observed: - Multiple metal sheet trays stacked flat wet with dripping water - Multiple metal sheet trays and rectangular baking pans with solid black residue on outer and inner surfaces (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One whisk with burnt handle - One melted spatula with red handle - One cracked spatula with brown handle - Multiple heavily marred cutting boards - One gray plastic bin holding clean and dried kitchen tools with water and black particles on inner bottom surface 2. On 10/22/24 at 1405 hours, during an observation of the main kitchen, Dietary Aide 1 was observed to be handling clean plates with the same gloves used to handle dirty dishes. Dietary Aide 1 was observed to not change gloves or wash hands in between changing of the gloves. 3. According to the USDA Food Code 2022 5-402.11 Backflow Prevention, (A) a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 10/21/24 at 0814 hours, during an initial tour of the kitchen, a juice machine was observed without an air gap. On 10/22/24 at 1448 hours, an observation and concurrent interview was conducted with the Maintenance Technician. The Maintenance Technician verified the finding and stated the juice machine was used to provide juices for the residents. On 10/24/24 at 1500 hours, the Administrator, DON, and DSS were notified and acknowledged the above findings. Cross reference to F801.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 46787 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the education was provided to the staff and family/visitors on safe food handling of outside food. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from outside sources. Findings: Review of CMS S&C-09-39 dated 5/29/09, showed the residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. The CMS guideline further showed the facility has the responsibility under the food safety regulation to help the visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Review of the facility's P&P titled Foods Brought by Family/Visitors revised 11/16/21, showed the food brought by the visitors and family is permitted. The facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The family/visitors are asked to prepare and transport food using safe food handling practices. On 10/23/24 at 0802 hours, an interview and concurrent medical record review was conducted with the DSS. The DSS was about her role when the food was brought from the outside for the residents to consume. The DSS stated she educated the residents, responsible parties, and visitors regarding how long the food would be kept in the refrigerator at the facility. When asked about the education provided to the visitors and responsible party regarding the safe food handling practices, the DSS stated she instructed the family/visitors to ensure for proper cool down of food intended for storage. When asked about the specifics of the education provided, the DSS stated she did not address for the proper cooking and cooling temperatures of the foods. When asked if she provided the family/visitors with any literature regarding safe food handling practices, the DSS stated she did not. On 10/23/24 at 0827 hours, an interview and concurrent facility document review was conducted with the DSD/IP. When asked about the education/in-services were provided to the staff regarding safe food handling practices, the DSD/IP stated she reminded staff to ensure the food items were labeled properly and they were appropriate according to the resident's diet. The DSD/IP stated she only provided in-services to the CNAs and not the licensed staff regarding outside food policy. The DSD/IP stated she did not provide education to the staff regarding safe food handling practices for the preparation of food or educate about safe cooking and cooling temperatures. The DSD/IP stated the licensed staff reheat food for the residents. On 10/23/24 at 1411 hours, an interview was conducted with LVN 2. When asked about what education she provided to the resident's family regarding the food brought from outside, LVN 2 stated she did not provide education to the visitor/responsible party about safe food handling practices. LVN 2 stated reheating of the food was done by the cooks in the kitchen and not the licensed staff or aides. On 10/24/24 at 1500 hours, the Administrator, DON, and DSS were informed and acknowledged the above findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of 14 final sampled residents (Resident 22) reviewed for hospice services. * The facility failed to ensure Resident 22 received hospice aide visit one time per week as ordered by the physician. * The facility failed to ensure the hospice log showed documentation regarding the CHHA visit. * The facility failed to ensure the hospice RN was included in Resident 22's Care Conference/Care Plan Meeting on 9/27/24. These failures had the potential for not providing necessary care and services to the resident recievieng hospice services. Findings: Review of the facility's P&P titled Hospice Services revised 11/16/24, showed the following: - Hospice providers who contract with this facility are held responsible for meeting the same professional standards and timelines of service as any contracted individual or agency associated with the facility. - In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions including changing the level of services provided when it is deemed appropriate. - In general, it is the responsibility of the facility to meet the resident's the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. This includes communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. Medical record review for Resident 22 was initiated on 10/21/24. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Physician Order Summary Report dated 10/24/24, showed SN visits 2x/week (two visits a week), CHHA 1x/week, SW and SC for evaluation. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 0338 hours, an interview and concurrent facility document review was conducted with the DON. Review of the document titled California Hospice Proposed calendar visit Schedule dated September and October 2024, showed there were no visitations from a CHHA. When the DON was asked if the CHHA's signature should be reflected on the visitation schedule, she stated yes. The DON verified the CHHA visit was to be once a week. In addition, review of the document titled California Hospice Interdisciplinary Note and Vital dated 3/19/24 to 10/17/24, showed the visits were completed by a CHHA and was documented on 5/8, 5/14, and 5/22/24. The DON verified there was no additional visits completed by the CHHA on the California Hospice Interdisciplinary Notes and Vitals from 3/19/24 to 10/17/24. Further review of the IDT Note dated 9/27/24, showed the Hospice Case Manager was unable to attend the meeting and would be calling the POA. Review of the Care Conference sign-in sheet dated 9/27/24, showed the hospice was unable to attend the meeting and would call the POA. Review of the document failed to show the hospice's involvement in Reside 27's care conference. On 10/24/24 at 1538 hours, the DON was informed and verified the above findings.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility documentation review, the facility failed to ensure the QA committee identified and developed action plans to address the focused areas from the last recertification survey. The QA committee failed to have documented evidence to show they identified and developed action plan to correct the identified concern of the respiratory care and medication storage. This failure had the potential to result in residents at risk for possible infection and causing adverse side effects for expired medication. Findings: Review of the facility's previous recertification survey completed on [DATE], showed the following deficient practices were cited: respiratory care (F695) and medication storage (F761). These deficient practices were the repeated deficient practices cited during this Recertification Survey. During the QAA interview with the Administrator and DON on [DATE] at 1320 hours, the DON was asked how the QAA committee identified current and ongoing issues for actions to improve care and performance related to respiratory care and medication storage. The DON stated for the respiratory care, the CNAs were trained to label the respiratory tubings or equipment, dated, and put them in the bag. They changed the tubing on Sundays. When asked about the documentation, the DON was unable to provide the documentation. The DON was asked for the medication strorage improvement performance process. The DON stated the charge nurse checked the medication chart and medication storage room daily every shift. The DON was asked to provide the log or documentation; the DON was unable to provide the documentation. The DON verified the findings. On [DATE] at 1431 hours, an interview was conducted with LVN 3. LVN 3 stated he would check his medication chart once a week but not daily. LVN 3 stated he only check the morning medication that he would administer and not checking the whole cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the safe and sanitary environment to help prevent the development and transmission of infection when: * The facility failed to maintain the accurate infection surveillance program for September and October 2024. * The facility failed to ensure the infection control practices were implemented in the facility's laundry room. * The facility failed to ensure the licensed nurse (LVN 1) performed hand hygiene in between changing gloves during the medication administration observation for Resident 27. * The facility failed to ensure Foley catheter care for Resident 686 was done in the safe and sanitary manner. These failures posed the risk for not identifying the residents' infections and thereby, preventing the implementation of interventions to control the potential transmission of communicable diseases to other residents in the facility. In addition, these failures posed the risk for transmission of disease-causing microorganisms. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Guidelines revised 11/16/23, showed guidelines for general infection prevention and control for caring for resident includes methods of preventing their spread and how to recognize and report signs and symptoms of infection. Standard precautions will be used in care of residents regardless of suspected or confirmed presence of infectious disease. Review of CDC's Core Infection Prevention Practices for Safe Healthcare Delivery in All Settings dated 4/12/24, showed the following: - Identify and monitor adherence to infection prevention practices and infection control requirements; and - Monitor the incidence of infections that may be related to care provided at the facility and act on data and use information collected through surveillance to detect transmission of infectious agents in the facility. a. Review of the Infection Surveillance Report for the week 8/30/24 to 9/5/24, showed Resident 20 was on ciprofloxacin 500 mg (an antibiotic medication) for urinary tract infection for five days. Medical record review for Resident 20 was initiated on 10/23/24. Resident 20 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of Resident 20's Infection Screening Evaluation dated 8/25/24, under the Infection Analysis section, showed Resident 20 met the Mcgeer's Criteria (criteria for definitive infection) for gastroenteritis (an inflammation of the stomach), not urinary tract infection as per the Infection Surveillance Report. b. Review of the Infection Surveillance Report for the week 9/20/24 to 9/26/24, showed Resident 9 was on azithromycin 250 mg (an antibiotic medication) for cough for five days. Medical record review for Resident 9 was initiated on 10/23/24. Resident 9 was readmitted to the facility on [DATE]. Review of Resident 9's Infection Screening Evaluation dated 9/19/24, under the Infection Analysis section, showed the section for the criteria was not marked to show whether Resident 9's infection met the criteria for true infection or not. c. Review of the Infection Surveillance Report for the week of 10/4/24 to 10/10/24, showed Resident 945 was on doxycycline 100 mg (an antibiotic medication) for an unknown infection for 10 days. Medical record review for Resident 945 was initiated on 10/23/24. Resident 945 was admitted to the facility on [DATE]. Review of Resident 945's Infection Screening Evaluation dated 10/1/24, under the Infection Analysis section, showed Resident 945 met the Loeb's Criteria (a set of minimum signs and symptoms that indicate a resident is likely to have an infection and may need antibiotics) for suspected skin and soft tissue infection and the McGeer's Criteria for soft tissue or wound infection. d. Review of the Infection Surveillance Report for the week of 10/4/24 to 10/10/24, showed Resident 25 was on Augmentin 100-125 mg (an antibiotic medication) for pneumonia for seven days. Medical record review for Resident 25 was initiated on 10/23/24. Resident 25 was admitted to the facility on [DATE]. However, review of Resident 25's Infection Screening Evaluation dated 10/5/24, under the Infection Analysis section, showed Resident 25 met the McGeer's Criteria for gastroenteritis, not pneumonia as per the Infection Surveillance Report. On 10/23/24 at 1356 hours, an interview and concurrent facility document review was conducted with the DSD/IP and RN 1/IP. Both verified the above findings. The DSD/IP confirmed the Infection Control Surveillance should be accurate because it showed the information readily available to report to their weekly Infection Control meeting. Both confirmed some of the McGeer's Criteria forms were inaccurate and not completed. Cross reference to F881, examples #1, #2 and #3. 2. On 10/21/24 at 1154 hours, an inspection of the laundry area and concurrent interview with the Director of Housekeeping was conducted. The following was observed: - Radio and charger observed on top of the folding area touching the clean linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Folded staff sweater and hat observed on top of the folding area, blue mesh bags (used for clean clothes) were observed on top of the sweater and hat. - Clean clothes observed touching the staff sweater, hat, and the radio. The Director of Housekeeping verified the above findings. 51539 2. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 11/16/23, showed the following: - All personnel shall follow the hand washing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; and - Wash hands by scrubbing for twenty seconds using soap and water for the following situations: a. Before direct contact with a resident. b. Before preparing or handling medications. c. After removing gloves. Medical record review for Resident 27 was initiated on 10/21/24. Resident 27 was admitted to the facility on [DATE], and readmitted on [DATE]. On 10/23/24 at 0840 hours, a medication pass observation for Resident 27 was conducted with LVN 1. LVN 1 was observed administering eye drops to Resident 27. Following the administration of the eyedrops to Resident 27, LVN 1 doffed her gloves and put into the trash can and did not perform hand hygiene before proceeding to put on a new pair of gloves. On 10/23/24 at 0842 hours, LVN 1 was observed washing her hands in the bathroom. LVN 1 then handed the television remote and call light to Resident 27's roommate. LVN 1 donned the new gloves without performing hand hygiene after touching the TV remote and call light of Resident 27's roommate, to administer the medications to Resident 27. On 10/23/24 at 1421 hours, an interview was conducted with LVN 1. When LVN 1 was asked about hand hygiene after instilling eyedrops to Resident 27 and doffing gloves, LVN 1 verified hand hygiene should have been completed before donning the new gloves. Furthermore, when LVN 1 was asked if she should have conducted hand hygiene after touching the remote control and call light of Resident 27's roommate, LVN 1 verified hand hygiene should have been conducted before resuming care for Resident 27. 35346 3. Medical record review for Resident 686 was initiated on 10/24/24. Resident 686 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 686's H&P examination dated 10/14/24, showed Resident 686 could make her needs known. On 10/24/24 at 0950 hours, an observation and concurrent interview for Resident 686 was conducted with CNA 1. CNA 1 was observed emptying the urine from Resident 686's urinary catheter drainage bag into Resident 686's urinal. CNA 1 was then observed putting the tip of Resident 686 urinary catheter tubing back into the end-port without cleaning the tip. CNA 1 was then observed rinsing out Resident 686's urinal with water. Furthermore, CNA 1 was observed storing Resident 686's urinal on a wall wire shelf next to the toilet used by Resident 686's roommate. When asked about cleaning the tip of Resident 686's urinary catheter tubing after draining the urine, CNA 1 stated sometimes she wiped off the tip before returning it to the valve. CNA 1 verified she did not wipe the tip. When asked about keeping Resident 686's urinal clean, CNA 1 verified she rinsed out the urinal with water. CNA 1 verified she stored Resident 686's urinal on a wire shelf next to the toilet used by Resident 686's roommate. On 10/24/24 at 1128 hours, an interview was conducted with the DSD. When asked about what to do after draining urine from a resident's urinary catheter bag, the DSD stated the staff should clean the urine catheter tubing tip after draining urine, and the urinal should be washed with soap and water. Review of Resident 686's October 2024 Order Summary Report showed Resident 686 had a physician's order dated 10/14/24, for urinary catheter for urinary retention. According to www.myhealth.ucsd.edu, after draining urine from a urinary catheter bag, the tip of the drainage valve is to be cleaned with an alcohol wipe.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, facility document, and facility P&P review, the facility failed to implement the antibiotic stewardship program. * The facility failed to ensure the appropriate use of antibiotics for one final sampled resident (Resident 25) and two nonsampled residents (Residents 9 and 20). This failure had the potential for inappropriate use and increased risk of drug resistant organisms. Findings: According to the CDC, the antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review of the facility's P&P titled Antibiotic Stewardship Program - Review and Surveillance revised on 11/16/23, showed the IP or designee will review the antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. 1. Review of the Infection Surveillance Report for the week of 8/30/24 to 9/5/24, showed Resident 20 was on ciprofloxacin 500 mg (an antibiotic medication) for urinary tract infection for five days. Medical record review for Resident 20 was initiated on 10/23/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Infection Screening Evaluation dated 8/25/24, under the Infection Analysis section, Resident 20 met the Mcgeer's Criteria for gastroenteritis (an inflammation of the stomach). However, review of Resident 20's medical record did not show documented evidence the physician was informed the resident did not meet the Mcgeer's Criteria for urinary tract infection. 2. Review of the Infection Surveillance Report for the week 9/20/24 to 9/26/24, showed Resident 9 was on Azithromycin 250 mg (an antibiotic medication) for cough for five days. Medical record review for Resident 9 was initiated on 10/23/24. Resident 9 was readmitted to the facility on [DATE]. Review of Resident 9's Infection Screening Evaluation dated 9/19/24, under the Infection Analysis section, showed the section for the criteria was not marked to show whether Resident 9's infection met the criteria for true infection or not. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Infection Surveillance Report for the week 9/20/24 to 9/26/24, showed Resident 9 was on azithromycin 250 mg (an antibiotic medication) for cough for five days. 3. Review of the Infection Surveillance Report for the week 10/4/24 to 10/10/24, showed Resident 25 was on Augmentin 100-125 mg (an antibiotic medication) for pneumonia for seven days. Medical record review for Resident 25 was initiated on 10/23/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Infection Screening Evaluation dated 10/5/24, under the Infection Analysis section, showed Resident 25 met the McGeer's Criteria for gastroenteritis. Furthermore, medical record review for Resident 20 did not show documented evidence the physician was informed that the resident did not meet the Mcgeer's Criteria for pneumonia. On 10/23/24 at 1356 hours, an interview and concurrent facility document review was conducted with the DSD/IP and RN 1/IP. Both verified the above findings. The DSD/IP stated the facility should have notified the physician if the residents did not meet the criteria or obtain clarification for the use of antibiotics. On 10/24/24 at 1615 hours, the Administrator and DON acknowledged the above findings. Cross reference to F880, examples #1.a, b, and d.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, and the facility P&P review, the facility failed to ensure two of 14 final sampled residents (Residents 4 and 25) were offered the influenza vaccine (vaccine given to protect the resident from influenza disease) and pneumococcal vaccine (a vaccine given to protect the resident from pneumococcal disease) when the residents were eligible to receive in accordance with the current CDC's guidelines and recommendations. This posed the risk of Residents 4 and 25 acquiring influenza and pneumonia. Findings: Review of the facility's P&P titled Immunization revised 11/16/23, showed immunization policy is to offer influenza and pneumococcal to residents and staff, in accordance with CDC and CDPH regulations and recommendations to reduce mortality and morbidity. Under the Procedure section, the residents and staff will be informed regarding the risks and benefits and potential side effects associated with the vaccine. 1. Medical record review for Resident 4 was initiated on 10/23/24. Resident 4 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's H&P examination dated 9/30/24, showed Resident 4 had no capacity to make medical decisions. Review of Resident 4's Pneumococcal Vaccine consent form showed the consent and decline to receive the pneumococcal vaccine sections were both blank. Review of Resident 4's Pneumococcal Vaccine consent showed the PCV 13 vaccination was received on 7/12/18, per the CAIR report. On 10/23/24 at 1356 hours, an interview and concurrent medical review was conducted with the DSD/IP and RN 1/IP. The DSD/IP and RN 1/IP both verified the above findings. The DSD/IP stated Resident 4 was offered PPV 23 on 12/2/23; however, Resident 4 refused the pneumococcal vaccine. The DSD/IP and RN 1/IP were unable to provide documentation for Resident 4's refusal. Furthermore, both DSD/IP and RN 1/IP were unable to provide documentation for the risk and benefits and potential side effects associated with the vaccine were discussed with Resident 4 or the resident's representative. 2. Medical record review for Resident 25 was initiated on 10/23/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 10/22/24, showed Resident 25 had no capacity to make medical decisions. Review of Resident 25's Influenza Vaccine consent signed by the resident on 10/19/23, showed an X mark for the declination to receive the influenza vaccine during the flu season from September 1 through April 1 due to the reason that Resident 25 did not take flu vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's Pneumococcal Vaccine consent signed by the resident on 10/19/23, showed an X mark for the declination to receive the pneumococcal vaccine due to the reason that Resident 25 did not take the pneumonia vaccine. Review of Resident 25's Progress Note dated 8/27/24, showed the flu vaccine was offered but Resident 25 needed more time to think about it. On 10/23/24 at 1356 hours, an interview and concurrent medical review was conducted with the DSD/IP and RN 1/IP. Both verified the above findings. The DSD/IP stated Resident 25 refused both the pneumococcal and influenza vaccines. Furthermore, both the DSD/IP and RN 1/IP were unable to provide documentation the risk and benefits and potential side effects associated with the vaccines were discussed with Resident 25 or the resident's representative. On 10/24/24 at 1615 hours, the Administrator and DON acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 51539 Based on interview, facility document review, and facility' P&P review, the facility failed to maintain the safe operating conditions. * The facility failed to maintain the essential temperature logs for the safe operating conditions of the Omnicell Anatomic Drug Dispensing system. This failure had the potential for the equipment to not function in the way intended, which could negatively affect the residents' medications. Findings: Review of the facility's P&P titled Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles revised 8/01/24, showed the facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturer guidance. -Facility should monitor the temperature of medication storage areas at least once a day. Review of the facility's P&P titled Automated Drug Delivery System (ADDS) CA-Omnicare revised 2020 showed the following: -The facility shall maintain the ADDS Daily Temperature and Cycle Count Log. -The two authorized facility staff will each sign the ADDS Daily Temperature and On 10/23/24 at 1046 hours, an interview and concurrent document review titled ADD Daily Temperature and Cycle Count Log dated 5/2024, 8/2024, and 9/2024 was conducted with the DON and RN 1. The DON was asked how often the temperature for the ADDS system should be recorded, she stated every day. Review of the Log showed the following: - Dates 05/18-05/21, the ADDs Temp gauge for 7 PM-7 AM was blank. - Dates 08/22-08/23, the ADDs Temp gauge for 7 PM-7 AM was not working. - Dates 08/24-08/27, the ADDs Temp gauge for 7 PM-7 AM was blank. - Date 08/28, the ADDs Temp gauge for 7 PM-7 AM was not working. - Dates 08/29-08/30, the ADDs Temp gauge for 7 PM-7 AM was blank. - Dates 09/02-09/03, the ADDs Temp gauge for 7 PM-7 AM was blank. - Dates 09/04-09/05, the ADDs Temp gauge for 7 PM-7 AM was not working. - Dates 09/06-09/10, the ADDs Temp gauge for 7 PM-7 AM was blank. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dates 09/11-09/12, the ADDs Temp gauge was not working. - Dates 09/13-09/27, the ADDs Temp gauge was blank. On 10/23/24 at 1058 hours, an interview and concurrent facility document review was conducted the DON. Review of the Pharmacy ADDS Checklist dated 7/30/24-8/21/24, showed the following: - Report all concerns to the DON and the pharmacy upon discovery (e.g., temperature out of range, ADDS binder issues, inventory discrepancies). - Document who was notified, and the action taken to resolve temperature excursion or other concerns. When the DON was asked about the missing temperatures documentation on the ADD Daily Temperature and Cycle Count Log for the months of August and September, the DON and RN 1 stated a work order was placed to replace the temperature thermometer, but the night shift nurses were still leaving the temperature log uncompleted. When asked what could potentially happen if temperature monitoring was not accurately recorded, the DON and RN 1 stated it could potentially affect the residents' medications.