STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555492	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Glen Post Acute	9246 Avenida Miravilla Cherry Valley, CA 92223

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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** 2. A review of Resident 15's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included aphasia (a language disorder that affects a person's ability to communicate) following non-traumatic intracerebral hemorrhage (bleeding inside the brain that does not result from trauma or injury). On May 22, 2025, at 9:41a.m., in a concurrent interview and record review with the Social Services Director (SSD), the SSD stated a review of Resident 15's Advance Directive Acknowledgement Report indicated, Resident 15 had executed an Advance Directive on admission, however; the SSD stated a copy of the AD was not found in Resident 15's record. The SSD further stated the AD should be in the resident's record available for nurses and physician to access to have information how the resident wants to be cared for when he is held unconscious. The SSD stated if the AD was not available there is a potential that interventions provided would go against his wish. A review of the facility policy and procedure titled, Advance Directives, dated 2016, indicated, .Social service director or designee will inquires of the resident .about the existence of any written advance directive .If a resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives .Staff will document in the medical record the offer to assist and the resident decision to accept of decline assistance . Based on interview and record review, the facility failed to ensure the following for two of six residents (Residents 5 and 15) reviewed for Advance Directive (AD - written statement of a person's wishes regarding medical treatment): 1. For Resident 5, the resident or the resident's representative had been provided information and education regarding the formulation of an AD; and 2. For Resident 15, a copy of the AD was available in the resident's record. These failures had the potential to lead to the residents' wishes regarding medical treatment being unknown and ultimately not honored. Findings: 1. A review of Resident 5's admission Record, indicated Resident 5 was admitted to the facility on [DATE]. (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

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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	A review of Resident 5's History and Physical dated April 29, 2025, indicated Resident 5 has fluctuating capacity to understand and make decisions. On May 20, 2025 at 1:46 p.m., during an interview with Resident 5, he stated he did not know if he has an AD or what is the AD. On May 22, 2025, at 9:49 a.m., during a concurrent interview and review of Resident 5's medical record with the Social Service Director (SSD), she stated if a resident did not have an AD, she would offer resources and education to the resident or the resident representative. The SSD stated it was important for residents to be educated and have the opportunity to formulate an AD in the event the resident were unable to make decisions in the future. The SSD stated Resident 5 had no AD, was not provided education, and was not reviewed for AD. The SSD further stated she should have followed up and provided AD education to Resident 5 or the resident's representative.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two residents reviewed (Resident 159), was receiving oxygen treatment in accordance with the care plan developed by the facility. This failure had the potential for the staff to be unaware whether the resident is consistently receiving the appropriate supplemental oxygen which could negatively impact the resident's overall health. Findings: On May 19, 2025, at 10:06 a.m., Resident 159 was observed turning off the oxygen concentrator after an alarm had sounded. Resident 159 stated, oh that happens a few times a day, and if I turn it off and back on it will stop. On May 19, 2025, between 9:45 a.m. to 11:45 a.m., Resident 159 was observed to have turned the oxygen concentrator on and off on two occasions, and again between 1:45 p.m. to 3:45 p.m., for a total of four occasions. At no time during the observations were staff observed to enter the room to address Resident 159 about the oxygen concentrator or the need for use of the oxygen. On May 20, 2025, at 10:30 a.m., an observation and interview was conducted with Resident 159. Resident 159 was alert and sitting up in bed. The oxygen concentrator was observed to be turned off and the nasal cannula (a plastic tubing that delivers oxygen) was not placed in the appropriate area, along the face and nasal passage. Resident 159 stated, oh I turned it off because it made a noise, but you can turn it back on if you want. A review of Resident 159's record, indicated she was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure with hypoxia (shortness of breath, associated with a weakening of the lungs capacity to produce oxygen), and heart failure (a weakend ability of the heart to pump blood throughout the body) Resident 159's history and physical dated May 12, 2025, indicated she did have the capacity to understand and make decisions. A review of the physicians order dated May 11, 2025, indicated, .Oxygen at ___2liters / min (a unit of measure) or__90_% via [specify delivery system] Nasal Cannula, Humidification: [specify] Yes Frequency: [Continuously] - every shift for CHF AND as needed . A review of Resident 159's Care Plan indicated, .Care plan: Oxygen: Resident requires the use of oxygen r/t (related too) congestive heart failure. Start date. May 11, 2025 .Goal .will be compliant with oxygen therapy . Intervention .monitor oxygen saturation via pulse oximetry every (specify) .administer oxygen at___L via (specify) . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 20, 2025, at 10:35 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated it was the nurses responsibility to conduct morning rounds for the residents on oxygen to check the oxygen flow rates, dates of the tubing and assess the residents for shortness of breath. LVN 1 stated she did not check on Resident 159 today and she was not aware if Resident 159 was receiving oxygen or at what rate. LVN 1 stated Resident 159 had a behavior of turning the machine on and off and was able to 'reset it' on her own without the assistance of staff. LVN 1 further stated Resident 159 had the ability to tell when she needed the oxygen. On May 22, 2025, at 1:41 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated there should be a care plan developed for Resident 159's behaviors of turning off the oxygen concentrator and the nurses should be checking the oxygen rate, tubing, and should be assessing the residents each shift. The DON further stated there was a risk for the resident not to receive the necessary oxygen needed which could cause unwanted signs and symptoms such as shortness of breath. A review of the facility policy and procedure titled, Care Plans, Comprehensive Person-Centered dated 2016, indicated, .the comprehensive, person-centered care plan will .incorporate identified problem areas . incorporate risk factors associate with identified problems .aid in preventing or reducing decline in the resident's functional status and/or functional levels .identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process .

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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** Based on observation, interview, and record review, the facility failed to ensure nutritional care and services were provided, for one of two residents reviewed for nutrition (Resident 41). This failure had the potential for the resident to continue having weight loss due to the delay in provision of appropriate intervention. Findings: On May 20, 2025, at 2:57 p.m. an interview was conducted with Resident 41. Resident 41 stated she only enjoyed a small portion of the meals provided and that she had lost weight because of it. Resident 41 could not recall her current weight. A review of Resident 41's record was conducted. Resident 41 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (the inability to regulate sugar in the body), and muscle wasting and atrophy (decreased strength of the muscles causing weakness). Resident 41's history and physical dated April 7, 2025, indicated she did have the capacity to understand and make decisions. A review of the dietary notes dated April 21, 2025, indicated, .residents weight loss of -4 lbs (pounds - a unit of measure) within 1 week. Recommendations to change diet to fortified. Referred to (physicians name) and agreed with orders to change diet to fortified. Orders noted and carried out . A review of the change of condition notice dated April 25, 2025, indicated, .Resident with a -4 lb weight loss in 1 week. Resident had a -4 lb weigh loss on 4/18/25. Seen by RD (Registered Dietitian) Resident's average intake is <75%, HS snack offered daily. Resident has a preference of small portions. RD previous recommendation to add fortified foods to current diet order. MD (physician) .Will monitor resident and encourage meals with any supplemental meals offered if refuses meals . A review of the weekly weights indicated on May 2, 2025, Resident 41 weighed 110 lbs. On May 9, 2025, and on May 16, 2025, the resident weighed 105 pounds which is a -5 lbs Loss. A review of the care plan initiated April 9, 2025, indicated, .Resident has Type 2 diabetes mellitus without complications. interventions .monitor for signs of hyper/hypoglycemia (i.e weight loss). A review of the care plan initiated April 16, 2025, indicated, .Resident has nutritional problem or potential nutritional problem r/t anxiety, T2DM interventions .Monitor record/report to MD PRN s/sx of malnutrition: Emaciation (cachexia), muscle wasting, significant weight loss >5% in 1 month .provide and serve diet as ordered (Registered Dietitian) RD to evaluate and make diet change recommendations PRN . A review of the progress notes, dietary notes, nutritional notes, did not indicate discussion on the weight loss of the resident from May 9 to May 16, 2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 22, 2025, at 10:31 a.m., an interview and record review was conducted with the RD. The RD stated the weight for Resident 41 was addressed on April 28, 2025. The RD stated she would do monthly notes for residents with BMI and age related weight loss and that she did not make a note for Resident 41. The RD stated she was not aware of the weight loss for Resident 41 in May and that the DS should bring to her attention any concerns for residents and communicate any changes. On May 22, 2025, at 2:51 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated she was not aware of the 5 lbs. weight loss for Resident 41. The DON stated a change of condition should have been made for Resident 41 from May 2 to the May 9, 2025 weight change and the RD and the DS should have been made aware. The DON further stated the nurse aide and nurse assigned to the resident should have documented and communicated a weight change with the RD, the DS, and the charge nurse. On May 22, 2025, at 2:57 p.m. an interview was conducted with the DS. The DS stated she would consider a weight loss of 5 lbs in one week to be reportable to the RD so an evaluation could be made. The DS stated changes in weight should be communicated to the RD, so the RD could conduct an evaluation and a weight variance meeting. The DS stated she was not made aware of the recent weight loss for Resident 41 and the nursing staff should have informed her when it was identified on May 9, 2025. A review of the facility policy and procedure titled, Weight Assessment and Intervention, dated 2008, indicated, .the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents .negative trends will be evaluated by the treatment team .care planning shall address . identified causes of weight loss .monitoring and reassessment . A review of the facility policy and procedure titled, Change in a Resident's Condition or Status, dated 2017, indicated, .nurse will notify the resident's attending physician on call when there has been .significant change in the resident's physical/emotional/mental condition .impacts more than one area of the residents health status .a comprehensive assessment of the resident's condition will be conducted . A review of the facility policy and procedure titled, Charting and Documentation, dated 2022, indicated, . changes in the residents condition .the assessment data and/or any unusual findings obtained .notification of family, physician, or other staff .

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three residents reviewed for respiratory care (Resident 159) , received respiratory treatment in accordance with the physician order. This failure has the potential to result in Resident 159 not to receive the necessary oxygen treatment which could negatively impact the resident's already compromised health. Findings: On May 19, 2025, at 10:06 a.m., a concurrent observation and interview was conducted with Resident 159. Resident 159 was alert and sitting up in bed. She was observed to be using oxygen through a nasal canula (NC - a device to deliver oxygen using a plastic tubing placed in the nostrils) at four liters per minute (LPM - unit of measurement). Oxygen tubing was observed to have a label, dated May 18, 2025. Resident 159 stated she had been using oxygen since she was admitted . Resident 159 was observed turning off the oxygen concentrator after an alarm had sounded. Resident 159 stated, oh that happens a few times a day, and if I turn it off and back on it will stop. Resident 159 stated she was unsure if four liters of oxygen was the correct amount she needed. On May 20, 2025, at 10:30 a.m., a follow up observation and interview was conducted with Resident 159. Resident 159 was alert and sitting up in bed. The oxygen concentrator was observed to be turned off and the NC was not on the nostrils. Resident 159 stated oh I turned it off because it made a noise, but you can turn it back on if you want. On May 20, 2025, at 10:35 a.m., a concurrent observation, interview and record review was conducted with LVN 1 at the bedside of Resident 159. LVN 1 stated it was the nurses responsibility to conduct morning rounds for the residents on oxygen to check the oxygen flow rates, dates of the tubing and assess for adverse signs and symptoms and that she checks to see if Resident 159 was using her oxygen or at what rate. A review of the physicians order with LVN 1 indicated Resident 159 was to receive oxygen at a rate of two LPM continuously and as needed. LVN 1 stated it can be either one. LVN 1 stated Resident 159 should be receiving oxygen at a rate of two LPM. LVN 1 observed the oxygen concentrator at the bedside of Resident 159 and noted the oxygen concentrator was turned off. LVN 1 stated Resident 159 had a behavior of turning the machine on and off and was able to 'reset it' on her own without the assistance of staff. LVN 1 further stated that Resident 159 had the ability to tell when she needed the oxygen. LVN 1 turned the oxygen concentrator on and observed the rate was set to four LPM. LVN 1 stated she should not be on four but she should be on two. LVN 1 further stated staff should have checked the rate of oxygen and followed the physicians orders. On May 22, 2025, at 1:41 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the physicians order for oxygen administration should have been clarified by the nurse to indicate the proper flow rate, and the frequency and that it should not have read both continuous and as needed. The DON stated nurses should be checking the oxygen flow rates each shift. The DON stated the nurses should be assessing for the oxygen use to make sure the correct setting for the oxygen is in place each shift. The DON further stated the nurses should have followed the orders and conducted assessments so that there are no risks of the residents to not receive the inadequate oxygen levels. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 159's record, indicated she was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure with hypoxia (shortness of breath, associated with a weakening of the lungs capacity to produce oxygen). Resident 159's history and physical dated May 12, 2025, indicated she did have the capacity to understand and make decisions. A review of the physicians order dated May 11, 2025, indicated, .Oxygen at ___2liters / min (a unit of measure) or__90_% via [specify delivery system] Nasal Cannula (NC) , Humidification: [specify] Yes Frequency: [Continuously] - every shift for CHF AND as needed . A review of the nursing weekly summary dated May 19, 2025, indicated, .Oxygen saturation .Method . Oxygen via Nasal .Respiratory .Continuous .liters per minute .2 .route .NC . A review of the nursing weekly summary dated May 21, 2025, indicated, .Oxygen use .any changes in oxygen use .NO . A revieww of Resident 159's Care plan: Oxygen: Resident requires the use of oxygen r/t congestive heart failure. Start date. May 11, 2025 .Goal .will be compliant with oxygen therapy .Intervention .monitor oxygen saturation via pulse oximetry every (specify) .administer oxygen at___L via (specify) . A review of the facility policy and procedure titled, Oxygen Administration, dated 2010 indicated, .verify that there is a physician's order for this procedure .review the physician's orders or facility protocol for oxygen administration .review the resident's care plan to assess for any special needs of the resident .the nasal cannula is a tube that is placed .into the residents nose, held in place by an elastic band placed around the resident's head .while the resident is receiving oxygen therapy, assess for the following .oxygen saturation . documentation .the rate of oxygen flow, rout, and rationale .frequency and duration of the treatment .if the resident refused the procedure, the reason(s) why and the intervention taken .report other information in accordance with facility policy and professional standards of practice .

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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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to ensure multiple unused non-controlled medications were disposed in accordance with the policy and procedure. The medication disposition was not witnessed by two staff. This failure had the potential for medication diversion (the removal of a prescription drug from its intended path from the manufacturer to the patient). Findings: On May 21, 2025, at 12:21 p.m., during a concurrent interview and record review, the Director of Nursing (DON) stated the medication will be destroyed in a designated white receptacle and this will be witnessed by two staff. The DON further stated there was a potential for staff to use it for themselves and diversion to occur if theses procedure was not followed. The DON stated for the disposition on May 20, 2025, the disposition of the following non- controlled medications (medications not considered to have a significant potential for abuse or dependence), was not witnessed by two staff. a. 3 - carvedilol 25 mg tab (tablet); b. 31- potassium cl (chloride) ER (extended- release) 20 meq (milliequivalent, a unit of measurement); c. 11- metformin 500 mg tabs; d. 13- pantoprazole dr 40 mg (milligram, a unit of measurement) tab; e. 30- amiodarone 200 mg tab; f. 155- divalproex dr (delayed- release) 125 mg cap; g. 31- sertraline 25 mg tab; h. 19- tamsulosin 0,4 mg cap; A review of the facility policy and procedure titled, Discarding and Destroying Medications, dated April 2019, indicated .Medications will be destroyed in accordance federal, state, and local regulations of non-hazardous pharmaceuticals .controlled substance .for unused non hazardous .take the medication .mix the medication with either liquid or solid undesirable substance .place the waste mixture in a sealable bag . dispose .in the presence of two witness .

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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. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. Crumbs and debris were found on the floor under the storage shelves in the storeroom; 2. Four clear food storage container had white debris on the top lid; 3. Four multiple canned goods white residue on it; 4. A walk- in refrigerator had dried dark red residue, crumbs and grime were on the floor; 5. The freezer in the disaster supply room had crumbs, and grime on its side and back; 6. Crumbs and debris found under the shelves in the disaster supply room; 7. One fan that was used in the kitchen had white debris on the blades and cover; and 8. Three Cutting boards were found without a smooth surface. These failures had the potential to cause food contamination and pest infestation leading to food borne illness (stomach illness acquired from ingesting contaminated food) in a vulnerable population of 57 residents who received food prepared in the kitchen. Findings: On May 19, 2025, between 8:20 a.m. and 8:40 a.m., a concurrent observation and interview was conducted with the Director of Dietary Services (DDS) in the kitchen. The following areas were discussed: A. Crumbs, white debris, and trash were found under the storage shelves in the store room. The DDS stated the storeroom should be kept clean to prevent pest infestations. B. Four clear storage container lids had white debris. The DDS stated the food storage containers should not be dusty to prevent cross-contamination, which could lead to food borne illness to the residents. C. Multiple can goods on the shelf had white residues on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DDS stated the white residue was a cake mix that spilled and should be wiped clean immediately to prevent cross-contamination, which could lead to food borne illness to the residents. D. Inside the walk-in refrigerator, dried dark red residue, crumbs and grime where on the floor. The DDS stated the floor should be kept clean to prevent cross-contamination, which could lead to food borne illness to the residents. E. The freezer had crumbs, debris, and grime on its sides and back. The DDS stated it should be kept clean to prevent pest infestation which could lead to food borne illness to the residents. F. Crumbs, debris were found under the shelves on the floor in the disaster supply room. The DDS stated it should be kept clean to prevent pest infestation which could lead to food borne illness to the residents. G. One black fan was observed to have white debris on the blades and cover. The DDS stated the fan had dust buildup and should be cleaned more frequently to avoid cross-contamination of food which could cause food borne illness. A review of the facility's policy and procedure titled, Sanitization, dated 2008, indicated, .1 .all kitchen, kitchen areas and dining areas shall be kept clean, free from litter and rubbish .2 all utensils, counters, shelves and equipment shall be kept clean .18 .The Food services staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task . On May 21, 2025, at 8:50 a.m., a concurrent observation and interview was conducted with the Director of Dietary Services (DDS) in the kitchen. Three cutting boards (brown, green and red color measuring at 24 inches [(a unit measurement of length)] in width and 18 inches in length) were observed with deep indentations and rough surfaces. The DDS stated, the cutting boards had indentations and should have had smooth surfaces to prevent microorganisms (germs) from growing in the grooves, which could lead to foodborne illness among residents. A review of the U.S FDA Food Code 2022, Section 4-501.12 Cutting Surfaces, indicated, .Cutting 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 foods that are prepared on such surfaces . (continued on next page)

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Oak Glen Post Acute	9246 Avenida Miravilla Cherry Valley, CA 92223

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On May 22, 2025, at 10:30 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the storage shelves in the storage rooms, walk-in refrigerator and freezer should not have any grime, white buildup, dirt and should be kept clean to prevent cross-contamination which could cause food borne illness. The RD further stated the cutting boards should not have deep scratches and the fans should not have dust buildup, to prevent cross-contamination, which could cause food borne illness. A review of the facility's policy and procedure titled, Sanitization, dated 2008, indicated, .1 .all kitchen, kitchen areas and dining areas shall be kept clean, free from litter and rubbish .2 all utensils, counters, shelves and equipment shall be kept clean .18 .The Food services staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On May 19, 2025 at 10:45 a.m., during observation, two empty antibiotic (ceftriaxone and vancomycin) bags labeled May 14, 2025, were left hanging on an IV (intravenous) pole. In a concurrent interview and observation with LVN 4, LVN 4 stated that the empty bags and IV lines should have been removed immediately after they were consumed and discarded properly. LVN 4 further stated there was a potential for cross contamination. On May 22, 2025, at 8:39 a.m., during an interview with the IP, the IP stated empty IV antibiotics should be removed from the IV pole and from the room and discarded in an appropriate way. The IP stated empty antibiotic bags could be a source of infection gathering more bacteria. 3. On May 19, 2025, at 1:04 p.m., in front of Resident 107's room, two transporter, non-staff, entered a room with EBP signage without wearing proper PPE when attempting to transfer a resident. A concurrent interview was conducted with the IP, the IP stated the the transporter should have worn the proper PPE when transferring a resident. A review of Resident 107's admission Record indicated Resident 107 was admitted to the facility May 4, 2025, with diagnoses which included ESRD (end stage renal disease-inability of the kidney to make urine and remove waste from the blood). A review of Resident 107's care Plan titled Enhanced Barrier Precautions (EBP), dated May 5, 2025, indicated .EBP during high contact resident care due to preesence of indwelling catheter .Place EBP notification/signage to alert staff/visitors of precautions .Utilize PPE (gloves, gown , etc) .during high contact resident care activities (when transferring) . A review of the facility policy and procedure titled, Isolation-Categories of Transmission-Based Precautions, dated 2022, indicated, .transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected .appropriate notification is placed on the room entrance door and on the front of the cart so that personnel and visitors are aware of the need for and the type of precaution . the signage informs the staff of the type of precautions, instruction for use of PPE, and /or instructions to see a nurse before entering the room .Enhanced Barrier Precautions .visitors should wear gowns and gloves if participating in high-contact care activities .assistance with bathing , toileting .transferring .especially if interacting with multiple residents . Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. There was no signage for Enhanced Barrier Precaution (EBP) posted near Resident 40's room. In addition, there was no available personal protective equipment (PPE) supplies for the staff near the resident's room on EBP. 2. Two empty medication bags were not discarded in accordance with the standard of practice; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Two non-staff transporters did not follow the proper isolation precautions for Resident 107. These failures had the potential to result in cross contamination which could cause illnesses to a vulnerable population. Findings: 1. On May 19, 2025, at 11:11 a.m., a concurrent interview and record review, was conducted with Licensed Vocational Nurse (LVN) 4 stated Resident 40 was on EBP, and there was no signage of what PPE to wear, and there was no PPE cart by the doorway. LVN 4 stated if there is no signage, staff and non staff would not know what PPE to wear prior to entering the room. A review of Resident 40's admission Record indicated Resident 40 was admitted to the facility on [DATE], with diagnoses which included paraplegia (inability to voluntarily move the lower parts of the body). A review of Resident 40's Care Plan titled, Enhanced Barrier Precautions (EBP), dated April 30, 2025, indicated .EBP during high contact resident care due to presence of indwelling catheter .Place EBP notification/signage near resident room .items for following EBP are in place (gloves, gown , etc) . On May 21, 2025, at 9:15 a.m., a concurrent observation and interview was conducted with LVN 3. LVN 3 stated the staff should wear the appropriate PPE (gown, gloves, and face mask) before entering the room to conduct wound care, because the residents receiving wound care were at risk for infection. On May 21, 2025, at 9:48 a.m., a follow up interview was conducted with LVN 3. LVN 3 was asked how the staff were made aware of a resident on EBP precautions. LVN 3 stated a sign indicating EBP should be placed near the door frame that indicates the bed number of the resident on EBP and the type of PPE to wear. LVN 3 observed there was no signage posted on the door frame for the resident on EBP and stated you would not know because there is no signage posted. LVN 3 further stated if a sign was not posted within view the resident could be at risk for infection if no PPE was worn. On May 21, 2025, at 10:06 a.m., with the infection preventionist (IP). The IP observed there was no sign for EBP within view for a resident on EBP precautions. The IP stated all isolation precautions including EBP should have a sign posted within view so that all staff and non-staff could be aware of the necessary PPE to wear prior to entry into the room. The IP further stated if there were no sign posted indicating the proper PPE then a resident could be at risk for infection. On May 21, 2025, at 10:33 a.m., during a concurrent interview and observation of Resident 40's doorframe with the IP, the IP stated the EBP signage should have been posted, along with the required PPE on the doorframe for the staff and non staff to see before they enter the room.