STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555524	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Care Ctr at the Forum at Rancho San Antonio	23600 via Esplendor Cupertino, CA 95014

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46552 Based on observation, interview and record review, the facility failed to ensure to treat with dignity and privacy for 1 of 2 sampled Resident (Resident 332) when: 1. Resident 332's foley catheter (F/C: a semi-flexible plastic tube, one end inserted into bladder [a body organ that stores urine] and the other end attached to a bag that collects urine) drain bag (collects urine that drains through the F/C) was left uncovered. These failure had the potential for adverse effects on the psychosocial well-being and health of Resident 332. Findings: 1. Review of Resident 332's face sheet ((FS: a document that gives a resident's information at a quick glance) indicated Resident 332 was admitted to facility on 7/9/224. Review of Resident 332's admission diagnoses included fracture of superior rim of left pubis (broken bone in pelvis (basin shaped complex of bones that connects the trunk and legs of the body)]. Review of Resident 332's physician order dated 7/9/2024 indicated, Foley Catheter Fr.16 (F/C size) due to diagnosis ---change per MD (medical doctor) schedule and PRN (as needed) obstruction. During an observation on 7/15/2024 at 9:27 a.m., noted Resident 332's F/C drain bag uncovered and secured in a wash basin (durable plastic container used for body wash for residents) on the floor next to Resident's 332's bed. During an interview with license vocational nurse C (LVN C) on 7/15/2024 at 9:37 a.m., LVN C confirmed Resident 332's F/C's drain bag was not covered. LVN C Stated F/C drain bag should be covered with a privacy bag. LVN C also stated nursing staff should have covered F/C drain bag with a privacy bag to provide privacy and dignity for Resident 332. During an interview with facility's infection preventionist (IP) on 7/19/2024 at 8:37 a.m., IP stated nursing staff should have covered Resident 332's F/C drain bag with privacy bag to maintain privacy and dignity for Resident 332. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with facility's director of nursing (DON) on 7/19/2024 at 10:08 a.m., DON stated nursing staff should have used privacy bag to cover F/C drain bag for resident's privacy and dignity. During a review of facility's policy and procedure (P&P) titled, Dignity, revised February 2021, the P&P indicated, Residents are treated with dignity and respect at all times. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered;

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 32398 Based on interview and record review, the facility failed to ensure 5 of 11 resident (Residents 3, 13, 24, 334, and 336) had: 1. documentation of reviewing advance directive status, when there was no documentation of a staff member discussing the status with four of the residents or residents' representative, or 2. the POLST (Physician Orders for Life Sustaining Treatment) for three residents, were not filled in accurately, when Section D had no check marks for the advance directive status. Findings: 1. Review of Resident 13's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 13 was admitted to facility on 3/4/2019. Review of Resident 13's POLST form dated 11/1/2022 indicated, section D for advance directive (AD)'s all three options were left blank, not completed. Review of Resident 13's clinical record indicated there was no document for advance directive. Further review of Resident 13's clinical record indicated there was no documented evidence for facility discussed for AD or offered help to execute AD or requested copy of executed of AD for Resident 13. Review of Resident 24 's FS indicated Resident 24 was admitted to facility on 10/1/2023. Review of Resident 24's POLST form dated 4/25/2024 indicated, section D for AD documented as Advance Directive not available. Review of Resident 24's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for Resident 24. Review of Resident 334's FS indicated Resident 334 was admitted to facility on 6/26/2024. Review of Resident 334's POLST form date prepared on 6/26/2024 indicated, section D for AD documented as No Advance Directive. Review of Resident 334's clinical record indicated there was no documented evidence of facility discussed for AD or offered or assisted to execute AD for Resident 334. Review of Resident 336's face sheet indicated Resident 336 was admitted to facility on 3/27/2018. Review of Resident 336's POLST form date prepared on 5/22/2024 indicated, section D for AD's all three options were left blank, not completed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with facility's social worker (SW) on 7/18/2024 at 12:55 p.m., SW confirmed there was no documentation to provide evidence for facility requested copy of executed AD or discussed for AD or offered or assisted to execute AD for Residents 13, 24, and 334. SW stated social service staff should have obtained copy of executed AD or discussed for AD or offered and assisted to execute AD for Residents 13, 24, and 334. During an interview with facility's director of nursing (DON) on 7/19/2024 at 10:593 a.m., DON confirmed above Residents 13, 24, 334 and 336 for AD and POLST form findings. DON stated social service staff should have discussed or offered or assisted to execute AD or requested for a copy of executed AD and documented in the resident's medical record for Residents 13, 24, and 334. DON also stated nursing staff should have completed all sections of POLST form for Residents 13 and 336. 2. Resident 3 was admitted with diagnoses which included Alzheimer's Disease (involves parts of the brain that control thought, memory, and language), moderate persistent asthma, need for assistance with personal care, and nutritional deficiency. During a review of the POLST in Resident 3's medical record, Section D, titled Information and Signatures, indicated their were no checked boxes for Advance Directive date_____ available and reviewed, Advance Directive not available, nor No Advance Directive. One of these boxes should have been checked to inform of the status of Resident 3's Advance Directive. During an interview with an admissions staff member (AD) on 7/18/24 at 10:19 a.m., AD stated Resident 3's Advance Directive is not in the system. None of the check boxes in section D of Resident 3's POLST are checked. Review of facility's P&P titled, Advance Directive, revised, undated, the P&P indicated, Determining Existence of Advance Directive 1 Prior to or upon admission of a resident, the social service director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 4. Written information includes a description of the facilities policies to implement advance directives and applicable state law. If the Resident Does not have an Advance Directive: 1 b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance. 2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff. If the Resident Has an Advance Directive: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any staff. Review of State of California law for POLST form indicated Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers and provides immunity to those who comply in good faith. Any incomplete section of POLST implies full treatment for that section. Refer to WWW. caPOLST.org. 46552

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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. 32398 Based on interview and record review, the facility failed to give notice of ending of Medicare Part A stay or therapies under Part B within a timely manner to one of three randomly selected residents (Resident 26). This failure had the potential for Resident 26 not being able to appeal for continued payment by Medicare. Findings: During a review of Resident 26's SNF (Skilled Nursing Facility) Beneficiary Notification Review (SNF BNR), dated 5/23/2024, the SNF BNR indicated Resident 26's Medicare part A Skilled Services last day of coverage was 5/23/2024. The date Resident 26's SNF BNR was signed was 5/23/2024. During an interview on 7/18/24 at 10:57 a.m. with the administrator (ADM), ADM stated Resident 26's last day covered was 5/23/24, and the SNF BNR notice was given on 5/23/24. ADM stated Resident 26 should have had 48 hours between giving notice and their last day of coverage. It was not done in this situation. During a review of the facility's policy and procedure titled Health Information Record Manual: Chapter VII 7020 Medicare Notice of Medicare Non-Coverage/Advance Beneficiary Notice, revised 11/21/2018, indicated 1) The facility will give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing no later than two days before the termination of services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) was accurate for one of 14 sampled residents (Resident 19). For Resident 19, the assessment of his alarm device was inaccurate and the MDS did not reflect the presence of a wanderguard (a device that activates an alarm when a resident attempts to leave a safe area.) Failure to accurately assess Resident 19's use of a wanderguard had the potential to compromise the facility's ability to develop and implement resident-centered care plans and interventions. Findings: Review of Resident 19's clinical record indicated he had diagnoses including dementia (decline in mental capacity affecting daily function), history of falling, and the need for assistance with personal care. Review of Resident 19's MDS, dated [DATE], indicated he had a brief interview for mental status (BIMS, an assessment to test a person's cognition level) score of 3 [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact]. Review of Resident 19's clinical notes, dated 8/3/23, indicated an attempted elopement (leaving unsupervised and undetected) occurred by Resident 19. The clinical notes indicated an ordered was obtained from Resident 19's physician to apply a wanderguard, and Resident 19's family was notified and gave consent for the wanderguard to be applied to Resident 19's left wrist. Review of Resident 19's MDS, dated [DATE], indicated Section P0200 assessed alarms. Section P0200 identified an alarm as any physical or electronic device that monitors resident movement and alerts staff when movement is detected. Section P0200 identified Coding: 0. not used, 1. Used less than daily, and 2. Used daily. The MDS assessment performed on 3/8/24 indicated Resident 19's Wander/elopement alarm was coded as 0, indicating wanderguard not used. During an interview and concurrent record review with the director of nursing (DON) on 7/17/24 at 10:43 a.m. , she confirmed Resident 19 was wearing a wanderguard and a physician's order and consent had been obtained on 8/3/23. The DON reviewed the MDS, dated [DATE] and confirmed Section P0200 indicated that wander/elopement alarm was not used. The DON stated the MDS is inaccurate and should reflect the use of Resident 19's wanderguard. She further stated the staff member who authored the 3/8/23 MDS was no longer employed by the facility and was not available for an interview. According to the 2023 Resident Assessment Instrument Version 3.0 Manual (RAI Manual, MDS coding instructions), Alarms are defined as Any physical or electronic device that monitors resident movement and alerts the staff when movement occurs. Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. The RAI Manual further indicates coding instructions to Record the frequency that the resident was restrained by any of the listed devices or an alarm was used at any time during the day or night.

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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** 38087 Based on observation, interview and record review the facility failed to implement their elopement risk care plan (a written document which communicates and directs the care and services, including goals and interventions required to meet a resident's individualized need) for one of 14 sampled residents (Resident 19). This failure had the potential for Resident 19's attempts at elopement to go undetected and jeopardize Resident 19's safety. Findings: Review of Resident 19's clinical record indicated he had diagnoses including dementia (decline in mental capacity affecting daily function), history of falling, and the need for assistance with personal care. Review of Resident 19's MDS, dated [DATE], indicated he had a brief interview for mental status (BIMS) score of 3 (a score of 0 to 7 indicates severe cognitive impairment). Review of Resident 19's clinical notes, dated 8/3/23, indicated an attempted elopement (leaving unsupervised and undetected) occurred by Resident 19. The clinical notes indicated an ordered was obtained from Resident 19's physician to apply a wanderguard (a device that activates an alarm when a resident attempts to leave a safe area.), which was applied to Resident 19's left wrist. During an interview with the director of nursing (DON) on 7/17/24 at 10:43 a.m., she confirmed Resident 19 has a wanderguard applied to his left wrist and she stated he has frequent behaviors of wandering and looking for his wife. During a concurrent record review, the DON confirmed Resident 19 had the wanderguard applied on 8/3/23 after an episode of attempted elopement. When asked if staff is monitoring Resident 19's wandering and exit seeking behaviors, the DON stated licensed nurses would document wandering episodes every shift on Resident 19's treatment record (TAR). During a concurrent record review with the DON, she reviewed Resident 19's TAR and confirmed there was no evidence that licensed nurses were monitoring Resident 19's wandering behaviors or exit seeking episodes. Review of Resident 19's care plan, dated 1/13/24, indicated Resident 19 was an elopement risk and had impaired safety awareness. The interventions to address the elopement risk problem included: to identify pattern of wandering; monitor location throughout the shift; and to document wandering behavior. During an interview and concurrent record review with the director of nursing (DON) on 7/17/24 at 10:43 a.m., Resident 19's care plan was reviewed. The DON confirmed the interventions to monitor Resident 19's wandering behaviors were not implemented. The DON stated the wandering behaviors and exit seeking episodes need to be monitored. Review of the facility's undated policy titled Wandering and Elopements, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm. The policy further indicated If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain resident's safety.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on observation, interview, and record review the facility failed to follow their policy and procedure (P&P) for medication order for one of five sampled resident (Resident 340) when; 1. Resident 340 received medication pantoprazole sodium delayed release (used to reduce amount of acid in stomach to release the active ingredient (s) later after taking it) after breakfast. This failure had the potential to affect the health and well-being of Resident 340. Findings: Review of Resident 340 face sheet (a document that gives a resident's information at a quick glance) indicated Resident 340 was admitted to the facility on [DATE]. Review of Resident 340's physician orders dated 7/6/2024 indicated, pantoprazole Sodium Oral Tablet Delayed Release 40 mg (pantoprazole Sodium) Give 1 tablet by mouth in the morning for every morning before breakfast. Review of Resident 340's minimum data set (MDS: clinical assessment tool) assessment dated [DATE] indicated Resident 340 brief interview for mental status (BIMS) score of 14/15 (0-7: severely impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition). During a medication administration observation on 7/17/2024 at 8:09 a.m., with license vocational nurse A (LVN A), observed LVN A administered medication pantoprazole sodium delayed release 40 mg to Resident 340 along with other ordered medications for Resident 340. During an interview with Resident 340 on 7/17/2024 at 11:10 a.m., Resident 340 confirmed LVN A gave all medications after Resident 340 ate breakfast, not before breakfast. During an interview with facility's director of nursing (DON) on 7/19/2024 at 9:58 a.m., DON stated license nurse should have followed MD (medical doctor)'s order to give medication before breakfast not after Resident 340 ate breakfast on 7/17/2024. Review of facility's P&P titled, Medication and Treatment orders, revision dated July 2016, the P&P indicated, Nursing staff will review the overall situation for the resident to ensure that any related issues are addressed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on observation, interview and record review, the facility failed to follow physician's orders to administer oxygen (O2: colorless, odorless, and tasteless gas supports life) for 1 of 2 sampled resident (Resident 24). This failure had the potential to compromise Resident 24's health, and well-being. Findings: Review of Resident 24's face sheet (a document that gives a resident's information at a quick glance) indicated Resident 24 was admitted to the facility on [DATE]. Review of Resident's admission diagnoses including transient ischemic attack (a condition caused by brief blockage of blood flow to the brain), thrombocytosis [blood has a higher-than-normal platelet (particles in blood that help the blood to become gel to manage bleeding) count], and atherosclerotic heart disease (a sticky substance called plaque builds up inside arteries [blood vessels carry blood from heart to body organs]). Review of Resident 24's physician orders for dated 6/23/2024 indicated, Oxygen: Administer 5 LPM (liters per minute: oxygen measured in liters per minute) via Nasal Cannula (NC: a medical device to provide supplemental oxygen to residents) continuously. May increase up to 8 LPM of O2 saturation (blood oxygen level) below 90 or increased SOB (shortnesss of breath, difficulty breathing). During an observation on 7/15/2024 at 10:53 a.m., noted Resident 24's room air concentrator (RAC: a medical device that take in air from the room and filter out nitrogen to provides higher amounts of oxygen) was set at 4LPM oxygen to deliver via NC for Resident 24. During an interview with license vocational nurse A (LVN A) on 7/15/2024 at 11:03 a.m., LVN A confirmed Resident 24's RAC oxygen rate indicator was set at 4 LPM. During a second observation on 7/17/2024 at 9:15 a.m., noted Resident 24's RAC oxygen rate indicator was set at 4LPM oxygen to deliver via NC for Resident 24. During another concurrent observation, review of Resident 24's physician orders for oxygen and interview with registered nurse B (RN B) on 7/17/2024 at 1:30 p.m., RN B confirmed Resident 24's RAC oxygen rate indicator was set at 4 LPM. RN B also confirmed Resident 24 had an order for oxygen 5 LPM. RN B adjusted RAC's oxygen rate to 5 LPM and stated staff should have verified and followed physician order for oxygen rate for Resident 24. RN B also stated staff should have set oxygen rate at 5 LPM, not at 4 LPM for Resident 24 as ordered. During an interview with director of nursing (DON) on 7/19/2024 at 9:50 a.m., DON stated staff should have followed MD (medical doctor) 's order to set oxygen rate at 5 LPM for Resident 24. Review of facility's policy and procedure (P&P) titled, Oxygen Administration, revised undated, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 32398 Based on interview and record review, the facility failed to determine if bed rails were appropriate for two of 39 resident (Residents 17 and 81) prior to installing them. This failure had the potential of the residents being harmed from improper bed rail use. Findings: During a review of the medical record for Resident 17, a bed rail assessment was not located. Nor was the alternatives used, a physician order, or a care plan for their use, prior to installation. During a review of the medical record for Resident 81, neither a bed rail assessment, the alternatives used, a physician order, or a care plan for their use, prior to installation, were not located. During an interview on 7/19/24 at 2:28 p.m. with the director of nursing (DON), the DON stated Residents 17 and 81 do not have a physician order, assessment, alternatives attempted documented, nor a care plan. During a review of the facility's policy and procedure titled Bed Safety and Bed Rails, revised 08/2022, indicated under the sub-heading Use of Bed Rails .3. The use of bed rails or side rails .is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. 4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted 5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: .d. consultation with the attending physician.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 32398 Based on observation and interview, the facility failed to post the nurse staffing hours in a prominent place. This failure did not follow the federal regulation of posting them in a prominent place readily accessible to residents and visitors. Findings: During an observation of the nurses station during the time of the survey, the posting for the licensed and unlicensed nursing staff total number and actual hours worked was not located. During an interview on 7/19/24 at 9:29 a.m. with the administrator (ADM), the ADM stated the nursing numbers are posted in the hallway that is blocked off right now because of constriction and painting. After the surveyor brought it to the ADM's attention, the ADM stated let me get those moved.

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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** 46552 Based on interview, and record review, the facility failed to ensure 1 of 2 sampled resident (Resident 339) was free from unnecessary psychotropic medication (drug that affects brain activities associated with mental processes and behaviors) when; 1. No target behavior monitoring for use of medication quetiapine (antipsychotic medication used to treat certain mental/mood disorders); 2. No non-pharmacological (any type of healthcare interventions without use of medications) approaches to minimize the need to use for medication quetiapine; 3. Pharmacy consultant (expertise in managing medications and providing clinical guidance on safe and appropriate medication use for residents)'s recommendations for quetiapine had not been followed up and; 4. MD (medical doctor)'s response for pharmacy recommendations had not been followed up. These failures resulted in inadequate monitoring and unnecessary medication for Resident 339, which potentially placed the resident at risk for experiencing harmful adverse effects from the antipsychotic medication. Findings: Review of Resident 339's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 339 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that affects memory, thinking, and behavior). Review of Resident 339's physician's orders indicated, Quetiapine Fumarate Oral Tablet 25 MG (milligram, unit of measure) (Quetiapine Fumarate) Give 1 tablet by mouth in the afternoon for Alzheimer's with behavioral disorder as m/b (manifested by), dated 6/28/2024. 1. Review of clinical documentation for Resident 339 indicated there was no documented evidence for target behavior monitoring for use of Quetiapine for Resident 339. 2. Review of clinical documentation for Resident 339 indicated there was no documented evidence of facility used non-pharmacological approaches to minimize the need for use of Quetiapine for Resident 339. 3. Review of pharmacy consultant's recommendations for medication Quetiapine for Resident 339 dated 7/1/2024 indicated, Please identify target behaviors. If resident's behaviors have stabilized, please notify MD for gradual dose reduction (GDR: attempts of lowest effective dose and discontinuation of medication) of Quetiapine Fumarate to 12.5 mg qd (one time every day) x 3 days, then DC (discontinue). (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 pharmacy consultant's report indicated for Physician's Response indicated Resident 339's MD approved above pharmacy consultant's recommendations for Quetiapine on 7/10/2024. 4. Review of Resident 339's clinical documentation indicated there was no documented evidence for pharmacy consultant's and MD's response for Quetiapine been followed up for Resident 339. During an interview with facility's director of nursing (DON) on 7/19/2024 at 10:11 a.m., DON acknowledged there were no monitoring for target behaviors, providing non-pharmacological approaches, pharmacy consultant's recommendations and MD's response for Quetiapine had not been followed up for Resident 339. DON stated nursing staff should have monitored target behaviors and provided non-pharmacological approaches when Resident 339 received antipsychotic medication quetiapine. DON further stated nursing staff should have been followed up as soon as possible when received MD's response for pharmacy consultant's recommendations for Quetiapine for Resident 339. Review of facility's policy and procedure P&P titled, Psychotropic Medication Use, revised July 2022, the P&P indicated, Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics d. adequate monitoring for efficacy (effectiveness) 8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. 10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and follow for discontinuation of medications when possible.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46552 Based on observation, interview, and record review, the facility failed to ensure proper storage of medications in medication room when the following were found: 1. An expired over the counter (OTC: medications can buy without written by medical doctor) medications; 2. An expired suppositories (supp: solid, small, and cone shaped medications that melts upon insertion into the body). These failures had the potential for residents to receive medications with reduced efficacy (effectiveness). Findings: 1. During an observation of facility's medication room (where facility stores medications) along with director of nursing (DON) on 7/18/2024 at 7:59 a.m., observed one container of psyllium powder (fiber supplement to help with digestive health and bowel regularity) expired on 6/2024. One bottle of geri-lanta (used to treat for stomach upset) expired on 5/2024, and one bottle of milk of magnesia (used to treat for stomach upset or indigestion [stomach discomfort after eating food]) expired on 6/2024. These expired medications were stored in OTC medication supply cabinet in medication room. During interview with DON on 7/18/2024 at 8:10 a.m., DON confirmed above findings. DON stated license nursing staff should have verified expiration dates for OTC medications in the medication room every week. DON also stated license nursing staff should have removed expired OTC medications and disposed every week. 2. During an observation medication room along with DON on 7/18/2024 at 8:30 a.m., noted below medications stored in OTC medication supply cabinet: a. Box of 12 prochlorperazine (brand name for compro: used to treat nausea and vomiting) 25 mg (milligram: a unit of measure) supp expired on 3/2023. b. Count of three supp of acetaminophen (used to treat minor aches, pains, and fever) 650 mg expired on 7/13/2023, and another four supp expired on 3/6/2024. c. Count of 4 bisacodyl (used to treat constipation [a problem with passing stool] 10 mg supp expired on 7/13/2024, and one another supp expired on 7/5/2024. d. Count of 3 hydrocortisone (used to treat variety of skin conditions to reduce pain and swelling) 25 mg supp expired on 7/2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Box of benacalorie (brand name nutritional supplement to enhance more calories and protein sources) expired on 6/21/204. During an interview with DON on 7/18/2024 at 8:43 a.m., DON confirmed above observations. DON stated license nursing staff should have verified expiration date for all OTC medications and nutritional supplements in the medication room once a week. DON also stated license staff should have removed expired medications, nutritional supplements and disposed every week. During review of facility's policy and procedure (P&P) titled, Disposal/Destruction of Expired Of Discontinued Medications, revised February 2023, the P&P indicated, Facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction.

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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. 38087 Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food safety when: 1. Bowls used for food preparation and food service were stacked and stored wet; 2. There were undated and outdated food items in the facility's kitchen freezer; These failures had the potential to cause food contamination and food-borne illness to 38 of 39 residents who received their food from the kitchen. Findings: 1. During an observation on 7/15/24 at 8:55 a.m., there were 3 large metal bowls and one small metal bowl observed to be stacked on a metal wire rack. The bowls were stacked upside down on top of one another and were wet inside and outside of the bowl's surfaces. During a concurrent interview with the certified dietary manager (CDM), he confirmed the bowls were stacked wet and he stated they should be air dried before being stacked and stored. Review of the facility's policy titled Dishwashing Machine Use revised March 2010, indicated The following guidelines will be followed when dishwashing: . f. After running items through entire cycle, allow to air dry. According to the 2017 Food and Drug Administration (FDA) Food Code, Section 4-901.11 Equipment and Utensils, Air-Drying Required, After cleaning and sanitizing, equipment and utensils: shall be air-dried . According to the FDA Food Code 2017 Annex 4-901.11 items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. 2. During an initial kitchen tour on 7/15/24 at 9:10 a.m., accompanied by the certified dietary manager (CDM), in the walk-in freezer the following were observed: a. One unopened 5-pound bag of yokisaba noodles with a manufacturer's use by date of 6/8/24 printed on the bag and 5 unopened packages of prosciutto with a manufacturer's use by date of 1/22/24 printed on the packages. During a concurrent interview with the CDM, he confirmed the noodles and prosciutto were beyond the use by date and he stated they should be discarded. b. Two unopened 17.5 ounce packages of gnocci with spinach. The two packages were undated and had no manufacturer's use by date on the packages. During a concurrent interview with the CDM, he stated the packages had probably been removed from their original carton. He further stated the two packages of gnocci with spinach should be discarded since no use by dates were available on the packages. Review of the facility's policy titled Food Receiving and Storage, revised July 2014, indicated All foods stored in the refrigerator or freezer will be covered, labelled, and dated (use by date).

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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. 46552 Based on observation, interview and record review, the facility failed to ensure infection control practices were implemented when: 1. Foley catheter ((F/C: a semi-flexible plastic tube, one end inserted into bladder (a body organ that stores urine] and the other end attached to a bag that collects urine)'s tubing (hard plastic tube attached between F/C and F/C's drain bag [urine collection bag] to drain urine from body) laying on floor for Resident 332; 2. Nasal Cannula (NC: a medical device to provide supplemental oxygen [O2: colorless, odorless, and tasteless gas supports life] to residents) tubes on floor and unchanged for Resident 334; 3. Licensed nurse failed to do hand hygiene after removing gloves; and 4. Phlebotomist (PHMT: person responsible to take samples of blood from residents for testing) was in the hallway with gloves on. These failures could result in the spread of infections and cross-contamination that could affect all the residents residing in the facility. Findings: 1. Review of Resident 332's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 332 was admitted to facility on 7/9/2024. Review of Resident 332's admission diagnoses including fracture of superior rim of left pubis (broken bone in pelvis [basin shaped complex of bones that connects the trunk and legs of the body]). Review of Resident 332's physician order dated 7/9/2024 indicated, Foley Catheter Fr.16 (F/C size) due to diagnosis --- change per MD (medical doctor) schedule and PRN (as needed) obstruction. During observation on 7/15/2024 at 9:27 a.m., noted Resident 332's F/C's tube on floor, left side next to Resident 332's bed. During a concurrent observation and interview with license vocational nurse C (LVN C) on 7/15/2024 at 9:37 am., Resident 332's F/C tube on floor, LVN C acknowledged Resident 332's F/C's tube touched the floor. LVN C stated F/C's tube should be placed above the floor for infection control. 2. Review of Resident 334's FS indicated Resident 334 admitted to facility on 6/26/2024. Review of Resident 334's admission diagnoses including sleep apnea (a potential serious sleep disorder in which breathing repeatedly stops and starts), atrial fibrillation (an irregular, often rapid heart rate causes poor blood flow), and heart valve replacement (replaced damaged heart valve with a new synthetic material valve or animal tissue). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 334's physician orders dated 6/27/2024 indicated, Continuous O2 at night @ 2LPM (liters per minute: oxygen measured in liters per minute) via NC. Notify MD (medical doctor) if O2 sat (O2 level in blood) <90% every evening and night shift. Review of Resident 334's physician order dated 6/27/2024 indicated, Change and date O2 tubing every night shift every Wed. During an observation on 7/15/2024 at 10:29 a.m., noted NC tube attached to emergency oxygen tank (E tank: portable oxygen tank used to administer oxygen) was dated 7/4/2024, and NC tube was on the floor next to Resident 334's bed when O2 was not in use. Resident 334's room air concentrator (RAC: a medical device that take in air from the room and filter out nitrogen to provides higher amounts of oxygen) placed next to Resident 334's bed attached with another NC tube was also on floor when O2 was not in use. During a concurrent observation and interview with LVN C on 7/15/2024 at 10:32 a.m., LVN C conformed Resident 334's NC tubes were on the floor, and E-tank NC tube changed on 7/4/2024. LVN C stated NC tubing should have placed in a bag when O2 was not in use and NC tube should have been changed every week on Wednesday. LVN C also stated nursing staff should have been changed NC tube on past Wednesday, and both NC tubes placed in a bag when O2 was not in use for infection control practices. During an observation on 7/18/24 at 9:51 a.m., Resident 15's oxygen tubing was observed lying on the floor of his room, from the oxygen concentrator to Resident 15 who was lying in bed, which was approximately five to six feet distance. During an interview on 7/15/24 at 10:50 a.m., with the Infection Preventionist (IP), IP stated the oxygen tubing should not be on the floor. During an interview on 7/17/24 at 3:22 with the director of nursing (DON), the DON stated it is not ok to have long oxygen tubing on floor. The facility did not have a P&P which covers not letting the NC and oxygen tubing rest on the floor. 3. During medication administration observation on 7/16/2024 at 8:45 a.m., with LVN C, observed LVN C donned (put on) both gloves, cleaned sphygmomanometer (medical device to monitor blood pressure [BP: pressure of blood against walls of blood vessels]) and stethoscope (a medical device to listen internal sounds of human body) with a sanitizing wipe. LVN C doffed (removed) both gloves, discarded in garbage bin along with sanitizing wipe. LVN C taken medication cart keys from her uniform and opened medication cart and placed both devices inside the cart, no hand hygiene (HH) after removing gloves from both hands. During an interview with LVN C on 7/16/2024 at 9:20 a.m., LVN C confirmed no HH was performed after gloves were removed. LVN C stated she should have washed hands after removing the gloves. 4. During a concurrent observation and interview with PHMT on 7/17/2024 at 8:27 a.m., PHMT walked in hallway with left hand glove on. PHMT acknowledged she walked in the hallway with a glove on her left hand. PHMT stated staff should not walk in hallway with gloves on. PHMT also stated staff should have removed gloves and washed hands before coming out to the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with facility's infection preventionist (IP) on 7/19/2024 at 8:37 a.m., IP stated nursing staff should have changed O2 NC tube every week and placed tube in a bag when O2 was not in use for infection control. IP also stated F/C tube should be above the floor for standard infection control practice. During an interview with IP on 7/19/2024 at 9:29 a.m., IP stated PHMT should not wear gloves in hallway. IP also stated PHMT should have removed glove and washed hands before coming out to the hallway. IP further stated staff should have washed hands after removing gloves each time. During facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) Prevention of Infection, revised dated November 2011, the P&P indicated, Change the oxygen cannulae and tubing every seven (7) days, or as needed. During review of facility's P&P titled, Handwashing/Hand Hygiene, revised dated October 2023, the P&P indicated, Hand hygiene is indicated: g. immediately after glove removal. During review of facility's P&P titled, Personal Protective Equipment-Gloves, revised July 2009, the P&P indicated, 2. Gloves shall be used only once and discard into the appropriate receptacle located in the room in which the procedure is being performed. 8. Wash hands after removing gloves. Review of facility's P&P tilted, Catheter Care, Urinary, undated, the P&P indicated, Be sure the catheter tubing and drainage bag are kept off the floor. 32398