STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555533	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Healthcare Center - Hayward	19700 Hesperian Boulevard Hayward, CA 94541

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36087 Based on observation, interview, and record review, the facility failed to ensure one of 17 sampled residents (Resident 25) received good grooming and personal hygiene care when resident did not receive complete fingernail care. This failure resulted in Resident 25 to feel helpless and placed him at risk for developing infections and hurting himself with long, pointed fingernails. Findings: A review of Resident 25's Face Sheet, printed 8/7/24, indicated resident was originally admitted to the facility on [DATE] with diagnoses of quadriplegia (loss of strength on all four limbs) and cerebrovascular disease (a condition that affects flow of blood in the brain and spine). A review of Resident 25's Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 6/8/24, indicated Resident 25 was understood and was able to understand others. The MDS indicated Resident 25's Brief Interview of Mental Status (BIMS, an assessment for cognition status) score was eight out of 15 which indicated moderately impaired cognition. Further review of the MDS showed resident was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two [2] or more helpers is required for the resident to complete the activity) for personal hygiene and grooming. During a review of Resident 25's Care Plan for Activities of Daily Living (ADL, activities related to personal care), dated 6/24/16, indicated Resident 25 would be provided with needed assistance to maintain comfort and dignity. During a concurrent observation and interview on 8/5/24, at 7:12 a.m., with Resident 25, resident was awake lying in bed, watching the television. Resident's bilateral hands were contracted without any brace or splint applied, with long and pointed (shaped like a rounded inverted letter V) fingernails to left hand (1/8 inch beyond the tip of his fingers). Resident 25 stated he did not remember why his right-hand fingernails were clipped and the left-hand fingernails were not. Resident 25 stated he preferred all his fingernails clipped evenly. During a concurrent observation and interview on 8/5/24, at 7:35 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated fingernails of non-diabetic residents are trimmed by the CNAs. CNA 1 stated resident fingernails should be trimmed short to prevent scratches that can lead to infection. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24, at 2:28 p.m., with the Director of Staff Development (DSD), DSD stated staff were expected to assist dependent residents to perform ADL care and provide nail care. The DSD stated it was very important for the dignity of the residents. DSD also stated fingernail care when not provided, could result in skin injury from scratching and possible infection. A review of the facility's undated Lesson Plan titled, Fingernails/Toenails, Care of, indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .Nail care includes daily cleaning and regular trimming. Proper nailcare can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .

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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** 50013 Based on observations, interviews, and record reviews, the facility failed to ensure consistent intervention and recommendation was carried out for tube feeds according to patient needs for (Resident 44) while tube feeds was the sole source of nutrition. This failure resulted in an unintended, unplanned weight gain of 21.27% in one year creating potential risks including: 1. Increased Risk of Cardiovascular Disease: Excess weight can lead to increased strain on the heart, potentially causing or worsening conditions such as hypertension, heart disease, and stroke. 2. Development or Worsening of Diabetes: Weight gain, particularly in the abdominal area, can lead to insulin resistance and increase the risk of developing type 2 diabetes or exacerbate existing diabetes. 3. Worsening of Respiratory Issues: Extra weight can compress the chest and diaphragm, making it harder for bed-bound patients to breathe and increasing the risk of respiratory problems, including sleep apnea. 4. Pressure Ulcers (Bedsores): Increased body weight can put additional pressure on areas of the body that are in constant contact with the bed or wheelchair, raising the risk of developing pressure ulcers. 5. Mobility and Joint Issues: Although bed-bound patients may have limited mobility, weight gain can put additional stress on joints and muscles, potentially leading to or exacerbating joint pain and mobility issues. 6. Increased Risk of Infections: Excess weight can lead to compromised immune function, making it harder for the body to fight infections and increasing susceptibility to illnesses. 7. Psychological Impact: Weight gain can affect a patient's self-esteem and mental health, potentially leading to feelings of depression or anxiety. 8. Wound Healing : Weight gain can affect blood flow to tissues, which can slow down the healing process of wounds or surgical sites. During review of Resident 44's Resident Face Sheet dated 8/7/2024, the Resident Face Sheet indicated Resident 44 was admitted to the facility on [DATE] and readmitted after hospitalization [DATE]. Past medical history included Chronic Respiratory failure with ventilator (breathing machine) dependency and tracheostomy (surgical opening in the windpipe for breathing), hypertension (high blood pressure), hyperlipidemia (high fat levels the blood) , diabetes, gastrostomy tube (tube in stomach for feeding), difficulty swallowing. A review of Resident 44's Weight Report dated 8/6/24 indicated: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight change from admit % change from admit 7/1/24 191 33 21.27% 6/1/24 190.5 33 20.95% 5/3/24 192 34.5 21.90% 4/2/24 189 31.5 20.00% 3/2/24 186.5 29 18.41% 2/3/24 185.5 29.3 17.97% 1/2/24 183 25.5 16.19% 12/4/24 177.5 19.7 12.51% 11/4/24 175.6 18.1 11.497.56% 10/3/24 169.4 11.9 7.56% 9/3/24 168 10.5 6.67% 8/1/23 166 0.5 5.40% 7/1/23 157.2 -0.3 -0.19% 6/1/23 156.8 -0.7 -0.44% 5/1/23 158 0.5 0.32% 4/3/23 158.5 1.3 0.83% 3/16/23 157.5 During review of Resident 44's Registered Dietician Notes dated 8/25/2023, indicated Resident 44 received Glucerna 1.5 at 75 ml/hour x24 hours. Registered Dieticiaan (RD) recommended a rate change to 70 ml/hr x24 hours. During review of Resident 44's Registered Dietician Notes dated 9/19/2023, indicated Resident 44 received Glucerna 1.5 at 75 ml/hour x24 hours. Registered Dieticiaan (RD) recommended a rate change again to 70 ml/hr x 24 hours. During review of Resident 44's Resident Progress Notes dated 9/21/2023, indicated physician was notified of RD recommendation and approved. Rate was changed to 70 ml/hr x24 hours (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of Resident 44's Registered Dietician Notes dated 11/02/2023, indicated Resident 44 had 7. 76% weight increase over 3 months. Resident 44 was receiving Glucerna 1.5 at 70 ml/hour x24 hours. RD documented significant weight gain 7.6% over 3 months. During review of Resident 44's Registered Dietician Notes dated 3/05/2024, indicated Resident 44 received Glucerna 1.5 at 70 ml/hour x24 hours. Registered Dietician (RD) recommended changing rate to Glucerna 1. 2 70 ml/hr x22 hours. Also indicates Notable weight gain changes r/t edema. During review of Resident 44's Enteral Administration History dated 3/01/2024-3/31/2024, indicated Resident 44 was receiving Glucerna 1.5 at 70 ml/hour x24 hours. During review of Resident 44's Observation Detail list report date 03/07/2024, indicated significant 11.01% weight gain over previous six months. During review of Resident 44's Enteral Administration History dated 4/01/2024-4/30/2024, indicated Resident 44 was receiving Glucerna 1.5 at 70 ml/hour x24 hours. During review of Resident 44's Enteral Administration History dated 5/01/2024-5/31/2024, indicated Resident 44 was receiving Glucerna 1.5 at 70 ml/hour x24 hours. During review of Resident 44's Registered Dietician Notes dated 5/30/2024, indicated RD was notified facility out of stock of Glucerna 1.5. RD recommends Nephro 65 ml/hr for 20 hours. During review of Resident 44's Enteral Administration History dated 5/31/2024-6/04 /2024, indicated Resident 44 was received Nephro at 65 ml/hour x20 hours twice per day. During review of Resident 44's Registered Dietician Notes dated 7/01/2023, indicated Resident 44 was receiving Nephro 65 ml/hour x20 hours. Registered Dieticiaan (RD) recommended changing tube feeding to Glucerna 1.5 at 67 ml/hr x22 hours During review of Resident 44 Registered Dietician Notes dated 7/8/2024, indicated RD notified facility out of stock of Glucerna 1.5. RD recommends Glucerna 1.2 850 ml/hr for 22 hours. A review of facility policy and procedure (P&P) titled, Weight Measurements - indicated weights should be obtained weekly, monthly or according to physician order. Additionally the policy indicates progressive weight loss or gain is noted and reported to residents attending physician, family or responsible party and documented in medical record.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46658 Based on observation, interview and record review, the facility failed to ensure nursing staff had physician order, facility policy and training to use enteral tube (tube placed into a surgically create hole leading into the gastrointestinal tract) clog removal tool and followed facility expectations when performing enteral tube clog removal care for two of 16 sampled residents (Resident 274 and 45) who were receiving medications through an enteral tube. This failure had the potential for enteral tube perforation or gastrointestinal damage when nursing staff inserted plastic clog removal tool into Resident 274 and 45's enteral tube without physician order, facility policy or training on use of the clog removal tool. Findings: A record review of Resident 274's admission record indicated Resident 274 was admitted for gastrostomy care, tracheostomy care, muscle wasting and atrophy, and chronic respiratory failure. During a review of Resident 274's physician orders set titled, Physician Order Report: 8/1/24-8/31/24, undated, the orders set indicated Resident 274 had enteral tube orders to Check tube for placement/patency every shift. Special Instructions: Verifying for enteral tube placement: 1. Physical assessment, 2. Aspiration of gastric contents, 3. Auscultation (injection of air into the enteral tube). During a review of Resident 274's physician orders titled, General Order: Resident 274, undated, the orders indicated Resident 274 had a physician's order for may use a declogger when indicated if unable to declog, may change the g-tube dated 8/8/24, at 10:36 a.m., created by the Director of Nursing (DON). A review of Resident 45's admission record indicated Resident 45 was admitted for gastrostomy care, tracheostomy care, chronic respiratory failure and dysphagia (difficulty swallowing). During a review of Resident 45's physician orders set titled, Physician Order Report: 8/1/24-8/31/24, undated, the orders set indicated Resident 45 had enteral tube orders to Check tube for placement/patency every shift. Special Instructions: Verifying for enteral tube placement: 1. Physical assessment, 2. Aspiration of gastric contents, 3. Auscultation (injection of air into the enteral tube). Resident 45 did not have an order to use a clog removal for an occluded enteral tube. The order set indicated Resident 45 did not have a physician order to use the plastic clog removal tool. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/7/24, at 11:10 a.m., with Registered Nurse 3 (RN 3), RN 3 was at Resident 274's bedside performing a medication pass. Using a large syringe with the plunger pulled out, RN 3 attached the syringe in Resident 274's enteral tube and poured 40 mL of water into the syringe body. RN 3 stated the enteral tube was clogged because the water did not instill into the enteral tube. RN 3 then massaged the enteral tube itself but was unsuccessful in unclogging it. RN 3 stated they would obtain a device to unclog Resident 274's enteral tube and left the room. RN 3 returned with a plastic clog removal tool. The packaging on the device indicated it was 39.5 centimeters in length and was used to unclog occluded enteral tubes. RN 3 inserted the clog removal tool approximately 2/3 of its length into Resident 274's enteral tube to unclog it but was unsuccessful in removing the occlusion. RN 3 used the clog removal tool a second time and inserted the clog removal tool into Resident 274's enteral tube until the handle of the tool reached the opening of the enteral tube. RN 3 had successfully unclogged the tube and finished the medication pass. During a concurrent observation and interview on 8/7/24, at 11:32 a.m., with RN 3, RN 3 was at 45's bedside performing a medication pass. Using a large syringe with the plunger pulled out, RN 3 attached the syringe in Resident 45's enteral tube and poured 40 mL of water into the syringe body. RN 3 stated the enteral tube was clogged because the water did not instill into the enteral tube. RN 3 then massaged the enteral tube itself but was unsuccessful in unclogging it. RN 3 exited the room obtained another clog removing tool and entered Resident 45's room. RN 3 inserted the clog removing tool into Resident 45's enteral tube and was able to unclog the tube. During a concurrent record review and interview on 8/8/24, at 8:48 a.m., with the Director of Nursing (DON), the facility inservice records for enteral tube management was reviewed. The DON stated she had not performed any inservice or training on the use of the clog removal tool and was unaware it was being used in non-emergency situations. The DON was unable to describe the procedure in its use but stated it was used in emergencies only. The DON stated nursing staff were expected to unclog an enteral tube by massaging the tube or instilling warm water or an enzymatic solution to unclog the tube. The DON stated if an enteral tube remained clogged nursing staff were expected to contact the provider for enteral tube replacement or obtain an order to use the plastic clog removal if there is an emergency. During a concurrent interview and record review on 8/8/24, at 8:48 a.m., with the DON, two facility policy and procedures (P&P) both titled, Enteral Feedings - Safety Precautions RC3 0406.02, one dated 1/8/24 and other undated, were reviewed. The DON stated the P&P dated 1/8/24 was the P&P staff were expected to follow and did not have a procedure for the use of the clog removal tool. The DON stated the undated P&P had an additional section which included clog removal tool indications for use and instructions for use. The DON stated she was unable to access the undated version at the online resource typically used to obtain P&P and the undated P&P was given to her by the facility's corporate office. During a concurrent record review and interview on 8/8/24, at 9:05 a.m., with Director of Staff Development (DSD), RN 3's orientation record was reviewed. The orientation record did not include training on the use of the clog removal. The DSD stated she did not perform any training on the use of the plastic clog removal tool. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/8/24, at 9:30 a.m., with RN 3, the P&P titled, Enteral Feedings - Safety Precautions RC3 0406.02, undated, was reviewed. RN 3 stated the facility did not have training or inservice on the use of the plastic clog removal tool and had not reviewed the P&P. RN 3 stated the tool was intended to be used for emergency purposes. RN 3 stated if an enteral tube remained clogged after massage or instilling warm fluid, the provider needed to change the tube.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36087 Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one of 17 sampled residents (Resident 43, receiving hemodialysis [a process of filtering the blood of a person whose kidneys are not working normally] treatment) when: 1. Licensed Nurse (LN) was not fully knowledgeable about the management of care in the event of Resident 43's arterial-venous fistula (a direct connection between the artery and a vein for dialysis access) site complications, post dialysis treatment. This failure resulted in the potential that staff may not correctly perform the proper intervention and prompt physician notification for a resident's dysfunctional access site condition after return from dialysis treatment. 2. LNs failed to ensure Resident 43 received Renagel (a phosphate binder used to lower high blood phosphorus [an essential mineral found in the blood to help form strong bones, teeth, and muscles] levels in patients who are in dialysis due to severe kidney disease) as ordered three times a day with meals, and to inform the physician of missed doses during dialysis treatment days. This failure resulted in Resident 43's elevated phosphorus level and had the potential to cause harm to resident's heart. Findings: 1. A review of Resident 43's Face Sheet, printed 8/7/24, indicated resident was originally admitted to the facility on [DATE] with diagnoses of diabetes mellitus (high blood sugar) and end-stage renal disease (ESRD, permanent kidney failure that requires dialysis or kidney transplant). A review of Resident 43's Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 5/29/24, indicated Resident 43 was dependent on renal dialysis due to diagnosis of ESRD. A review of Resident 43's Physician Order Report, for 7/7/24 - 8/7/24, indicated: Start date 6/11/24 - new dialysis schedule starting 6/8/24 (Tuesday and Saturday) from 9:30 a.m. - 1 p.m. Start date 4/8/24 - AV shunt fistula to left upper arm check for bruit (auscultation of shunt for swooshing sound), and thrill (lightly palpate for vibration of shunt), signs and symptoms of bleeding, and infection every shift. A review of Resident 43's Care Plan, dated 9/19/22, indicated Diagnosis: ESRD (on renal dialysis) Risk for: electrolyte imbalance (too much or not enough of certain minerals in the body), infection, bleeding, and fatigue. Access site: left arm. Approach start date: 9/19/22, indicated check access site for any signs/symptoms (s/s) of bleeding, swelling, infection, and inform Assistant Physician (AP). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/6/24, at 9:45 a.m., with Registered Nurse Supervisor (RNS), Resident 43's electronic clinical records indicated resident went to Dialysis Center every Tuesday and Saturday, between 9:30 a.m. to 1 p.m. RNS stated upon Resident 43's return from dialysis, post-dialysis form was checked for new orders, resident vital signs checked, and AV fistula site/dressing assessed. RNS stated she was unsure of what interventions to do with the AV fistula in case of major bleeding to the site. RNS stated she would put a tourniquet (to temporarily constrict and control blood flow and should only be used when other methods, such as pressure dressings have failed) on the resident's arm. RNS stated she needed further training on dialysis. During an interview on 8/7/24, at 2:32 p.m., with the Director of Staff Development (DSD), DSD stated post-dialysis, residents' AV fistula should be assessed and monitored for bruit and thrill, bleeding, and infection to the site. DSD further stated, with heavy bleeding put pressure on the fistula site and call 911. DSD stated all licensed staff needed to be in-serviced on hemodialysis. 2. A review of Resident 43's Physician Order Report, for 7/7/24 - 8/7/24, indicated: Start date 7/22/24 - Renagel tablet 800 milligrams (mg) - take two (2) tabs (1600 mg total) by mouth three times a day with meals for phosphate binder. With meals: 8:00 a.m., 12:00 p.m., and 5:30 p.m. A review of Resident 43's Medication Administration History (MAH), for 7/1/24 - 7/31/24, indicated LN initials on Renagel tablet doses were parenthesized (not administered or not charted, see Reasons/Comments) on the following dates during 12 p.m. administration time: 7/23/24, 7/27/24, and 7/30/24, with Reasons/Comments that indicated, Not administered: Resident unavailable. Comment: out for dialysis. Further review of Resident 43's MAH, for 8/1/24 - 8/7/24, indicated LN initials on Renagel tablet doses were parenthesized on the following dates during 12 p.m. administration time: 8/3/24 and 8/6/24, with Reasons/Comments that indicated, Not administered: Resident unavailable. Comment: out for dialysis. A review of Resident 43's Dialysis Center's Lab Draw Report, Result Release Date 5/30/24, indicated a phosphate level of 5.3 mg/deciliter(dL) high (H), (normal range 2.4-5.1). Result Release Date 6/08/24, indicated phosphate level of 5.2 mg/dL H, and Result Release Date 7/4/24, indicated phosphate level of 5 mg/dL. A review of Resident 43's Care Plan, dated 9/19/22, indicated Diagnosis: ESRD (on renal dialysis) Risk for: electrolyte imbalance (too much or not enough of certain minerals in the body), infection, bleeding, and fatigue. During a concurrent interview and record review on 8/7/24, at 10:14 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 43's electronic clinical record indicated an order for Renagel 1600 mg three times a day with meals. LVN 1 confirmed that on Tuesdays and Saturdays, Resident 43 left for dialysis after breakfast, takes a snack bag with her, and returned to facility around 2 p.m. during the morning shift. LVN 1 stated resident does not take the 12 p.m. dose of Renagel during dialysis days as shown on the MAH. LVN 1 stated Renagel, when not taken as ordered, can increase resident's level of phosphorus, and can cause hypocalcemia (low calcium level in the blood). LVN 1 confirmed she does not send Renagel with Resident 43 whenever resident went to dialysis. LVN 1 was unable to provide documentation that Medical Doctor 1 (MD 1) or Dialysis Center were informed of multiple missed 12 p.m. Renagel doses during dialysis days. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent telephone call and record review on 8/7/24, at 12:51 p.m., with MD 1, Resident 43's medication and lab results were discussed. MD 1 stated he was aware of resident's missed 12 p.m. doses of Renagel on multiple dialysis days but could not recall who informed him or when facility had last informed him. Resident 43's high levels of phosphorus were discussed and MD 1 stated resident's phosphorus level run on higher end of normal (normal range 2.4 - 5.1). For June 2024 - resident's phosphorus level was 5.2 mg/dL, July 2024 - 5 mg/dL, and on May 2024, a phosphate level of 5.3, which was outside the normal range. MD 1 stated since Resident 43 was constantly on high side of phosphorus levels, resident will have to take her 12 p.m. dose of Renagel with meals when at the dialysis center. A review of the facility's policy and procedure (P&P) titled, Hemodialysis, printed 8/7/24, dated 10/12/23, indicated, To provide residents with safe, accurate, and appropriate care, assessments and interventions to improve resident outcomes. Hemodialysis devices may only be accessed by medical personnel who have received training and demonstrated clinical competency regarding use of these devices .Hemodialysis access devices are surgically placed and removed .Vascular access may be accomplished in one of three ways: a. Arterio-venous fistula (AVF) .Post Hemodialysis Care .3. Mild bleeding from site (post dialysis) can be expected. Apply pressure to insertion site and contact dialysis center for instructions. 4. If there is major bleeding from site (post-dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is an emergency. Do not leave resident alone until emergency services arrives .8. Monitor laboratories work up. Notify Physician as ordered or when laboratory values are abnormal .Pre and post Dialysis Documentation .Medication given, Medications sent with resident to the dialysis center, meal provision during dialysis . Resident 43 was unavailable for interview during the time of survey.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46658 Based on observation, interview and record review, the facility failed to ensure 14 controlled medications (substances that have an accepted medical use, medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) from the Director of Nursing (DON) controlled medications cabinet were documented and destroyed according to state law and facility policy. This failure had resulted in 14 controlled medications not being destroyed and had the potential for drug diversion. Findings: During an interview on 8/8/24, at 10:45 a.m., with the DON, the DON stated Pharmacist Consultant 1 (PC 1) was the primary pharmacist who performed monthly destruction of controlled medications with the DON. The DON described the procedure for the disposal of controlled medications: 1. Nurse brings the discontinued controlled medications to the DON. 2. Every month, the DON and PC 1 reconciled and destroyed the controlled medications. 3. PC 1 destroyed controlled medications by placing the substance in plastic bucket and pouring water in until the controlled medications were dissolved. 4. The plastic bucket would be covered and locked in a biohazard container room for monthly pickup by a biohazardous waste disposal company. During a concurrent observation, interview and record review on 8/8/24, at 11:11 a.m., with the DON, the controlled medications cabinet in the DON's office was inspected. Upon inspection of the controlled medications cabinet the following medications were found: 1. One bottle of Norco (a pain relieving medication) 5-325 mg (milligram, unit of measurement) tablets with 45 tablets and two boxes of fentanyl patches containing 5 patches each box for a discharged resident. The associated count sheet did not indicate date of receipt of the medication, 2. One bottle of Hydromorphone (a pain relieving medication) 4 mg tablets with 60 tablets in the bottle for a discharged resident. The label on the bottle indicated an expiration date of 9/23/2023. There was no documentation associated with the bottle, 3. One bottle of lorazepam (a medication to reduce anxiety) 2mg per mL (milliliter, unit of measurement) liquid solution with 19 mL in the bottle with no resident label. The label indicated an expiration date of March 2024. There was no documentation associated with the bottle, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. One bottle of Norco 5-325 and one bottle of Norco 10-325 for a discharged resident. The label on the Norco 5-325 indicated an expiration date of 8/2023. There was no documentation associated with the bottle, 5. One bottle of morphine (a pain relieving medication) 20mg/5mL liquid solution with 275mL in the bottle for a discharged resident. A note, dated 8/19/21, was affixed to the bottle and read No count sheet. Hospice Supply, 6. One box containing a bottle of morphine 100mg/5mL liquid solution for a discharged resident. A label on the box indicated an expiration date of 2/2023. There was no documentation associated with the bottle, 7. One empty bottle of morphine liquid solution for a discharged resident. There was no documentation associated with the bottle, 8. One bottle of morphine liquid solution and one bottle of lorazepam liquid solution for a discharged resident. The label on the morphine bottle indicated an expiration date of 8/2022. The label on the bottle of lorazepam indicated an expiration date of 9/2022. There was no documentation associated with the two medications, 9. A plastic bag with one empty bottle of lorazepam with a worn out illegible label for a discharged resident. A document found in the bag titled Controlled Drug Record, undated, indicated the medication was received by a nurse on 1/2/21, 10. One bottle of morphine 20 mg/mL liquid solution for a discharged resident. There was no documentation associated with the bottle. 11. One sheet of packaged alprazolam (a medication to reduce anxiety) 0.25 mg tablets containing 53 tablets for a discharged resident. The DON stated an associated record titled Controlled Drug Record, undated, indicated no tablets were administered and the sheet originally contained 56 tablets. The record indicated an expiration date of 2/2022. 12. One sheet of packaged Norco 5-325 mg tablets for a discharged resident. The label on the sheet indicated a package date of 9/26/2019, there was no expiration date on the label. There was no documentation associated with the medication. The DON stated she did not destroy the controlled medications because she did not know the procedure for destroying controlled medications without documentation of its receipt and date of discontinuation. During a concurrent observation and interview, on 8/8/24, at 2:17 p.m., with Pharmacist Consultant 2 (PC 2), the 14 controlled medications were observed on the DON's office desk. PC 2 was completing documentation to destroy the controlled medications. PC 2 stated the facility was expected to destroy controlled medications 90 days after receiving them. PC 2 stated the facility's use of water to dissolve controlled medications was not an acceptable destruction method. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility policy and procedure (P&P) titled, Medication Destruction, undated, the P&P indicated the facility destroy controlled medications in accordance with state and federal guidelines .the pharmacist and Director of Nursing/registered nurse designee document that drugs were destroyed .record the destruction of controlled substances in the drug destruction log book, as required by state and federal law. During a review of facility P&P titled, Disposal of medications, syringes, and needles Disposal of Medications, dated 1/23, the P&P indicated the director of nursing and consultant pharmacist will monitor for compliance with federal and state law and regulations regarding the disposal of medications .mixing medications with an undesirable substance, such as used coffee grounds or kitty litter .will further ensure the drugs are not diverted .dispose of discontinued medications within 90 days of the date the medication was discontinued .outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed according to the above policy. The policy did not indicate water was an appropriate substance for destruction of controlled medications.

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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. 50013 Based on interview and record review, the facility failed to ensure the Kitchen Manager (KM) had completed the required six hours of inservice training on the specific California dietary service requirements contained in California Code of Regulations (CCR) Title 22 prior to assuming full time duties as a dietetic services supervisor at the health facility, This failure resulted in the KM not possessing competencies and skills for California to carry out food and nutrition functions, potentially putting residents at risk for foodborne illness. Findings: During an interview on 8/5//24, at 11:00 AM, with KM, KM stated she worked full time and was certified as a dietary manager. KM stated she does not have 6 hours of inservice training on the specific California dietary service requirements. During an interview on 8/5//24, at 11:00 AM, with Registered Dietician (RD), RD stated she had not administered or developed the required six hour inservice training for the KM.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 50013 Based on observation, interview, and record review. the facility failed to ensure cooks had education and skill to puree food properly for 11 of 11 residents receiving a pureed diet when they over processed and over mechanicalized food, which was watery, bland and without flavor. This failure resulted in residents being at risk for decreased satiety and nutrition intake which could result in weight loss. Findings: During an observation on 8/5/24, at 11:30 a.m., [NAME] 1 (C-1) used a handheld slotted strainer to place vegetables (mixed vegetables-cauliflower and broccoli) from cooking vessel into the blender. C-1 proceeded to puree the vegetables, periodically checking the consistency. Upon completion C-1 poured the remaining liquid into the blender which resulted in 6 cups of product. The end result was a pourable product, which resembled a slightly thick cream soup. C-1 was required to add 3-ounces of thickener, yielding vegetables which resembled a thin, pourable pudding texture. This resulted in the addition of excess cooking water being inadvertently added to blender, diluting the nutritional value of the pureed item. The C-1 did not taste vegetable puree upon completion according to procedure. During an observation on 8/6/24, at 11:20 a.m., in the kitchen, C-1 transferred carrots from the cooking vessel into the blender without draining them, resulting in cooking water being added to the blender. The added cooking water diluted the carrot puree. C-1 did not taste the vegetable puree after completion. During a concurrent observation and interview on 8/6/24, at 12:30 p.m., with Kitchen Manager (KM) and Registered Dietician (RD) in the conference room, a test tray was provided. Two Surveyors and KM stated the pureed carrots lacked flavor, were watery, and needed seasoning. RD chose not to perform taste test. During a review of a facility quantified recipe titled, Seasoned Carrots FRZ PU, dated April 4, 2024, the recipe indicated carrots and food thickener as the only ingredients. The recipe did not include water listed as an ingredient. During a review of Inservice/Training Attendance Record for Pureed Food,dated 1/6/2022, the training record and roster indicated education on how to puree food and adherence to recipe was delivered to dietary staff. During review of Lesson Plan Pureed Food, undated, the lesson plan described the expected procedure for pureed food. Steps included review of recipe, following recipe, and tasting food to make sure the texture, consistency and flavor is appropriate for palatability.

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F 0803 Level of Harm - Minimal harm or potential for actual 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. 50013 Based on observation and record review, the facility failed to follow menu portions when serving orzo, baked apples and Boston cream pie. This failure resulted in residents receiving portion sizes in excess or below their required needs per physician order or dietician recommendation, potentially putting residents at risk for inability to maintain normal body weight and receiving acceptable nutritional values. Findings: During a concurrent observation and record review on 8/5/24, at 12:15 p.m., in the kitchen, Dietary Aide (DA-1) served 1/2 cup of orzo to 24/24 Controlled Carbohydrate (CCHO - a diet to keep carbohydrate consumption at a steady level) diet residents. The Spring/Summer 2024 Diet Spreadsheet, indicated CCHO diet residents should receive 1/3 cup of orzo. During a concurrent observation and record review on 8/5/24, at 12:30 p.m., in the kitchen, DA-1 used a #12 scoop (2.5-3 oz) to serve baked apples for both regular and CCHO diets. The Spring/Summer 2024 Diet Spreadsheet indicated a #10 scoop (3-4 oz) is required for serving baked apples for both regular and CCHO diets. During a concurrent observation and record review on 8/6/24, at 12:30 p.m., in the kitchen, DA-1 served residents a 1x2 inch square of Boston cream pie. The Spring/Summer 2024 Diet Spreadsheet indicated residents should receive a 2x3 inch square of Boston cream pie.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50013 Based on observation, interview, and record review, the facility failed to ensure the juice machine was cleaned according to manufacturer's instructions when the machine was not flushed weekly and the bar gun was soaked in hot water. This failure resulted in improper sanitation and the risk for transmission of foodborne illness to 56 residents receiving juice. Findings: During a concurrent observation and interview on 8/5/24, at 10:00 a.m., in the kitchen, Kitchen Aide 1 (KA-1) soaked the juice bar gun from the juice machine in a large pitcher of hot water (water with steam emanating from vessel). KA-1 stated the required cleaning included submerging and soaking the bar gun (nozzle) daily to prevent blockages or clogs caused by sugar build-up. KA-1 stated the juice bag junction (connection to juice bag) is disconnected and rinsed when each juice bag is empty. KA-1 stated they do not use a log to document the cleaning or a cleaning schedule. During a review of [NAME] Bag in the Box Equipment Cleaning Procedure, the procedure indicated the bar gun should be soaked daily in luke warm water (water that is neither hot nor cold) only. The procedure also stated weekly flushing of all hoses, pumps and bar gun lines was required.

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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** 46658 Based on observation, interview and record review, the facility failed to ensure infection control policy and procedure was followed for 10 of 23 sampled (Residents 21, 16, 32, 60, 3, 27, 51, 273, 272 and 59) residents when: 1. staff did not use sterile gloves when performing sterile tracheostomy (artificial airway at the throat which is kept open with a tube inserted into the opening) suctioning (procedure to remove secretions from the respiratory tract by vacuum) on Resident 21, 2. staff did not perform hand hygiene when switching between three residents (Resident 16, 32, and 60) who needed tracheostomy care, 3. facility did not have equipment to change suction canisters (a plastic container connected to a vacuum which stores liquid from suctioning) for Resident 3, 32 and 60 and did not have equipment to change the ventilator circuit (plastic tubing which connects a tracheostomy to a ventilator [a machine used to help a resident breath mechanically]) for Resident 51, 4. staff allowed open system tube feeding lines (a system to deliver tube feed fluid which includes a bag that can be opened to add more tube feed fluid) to be used for more than 24 hours for Residents 32, 273, 272 and 44, 5. licensed nurse did not cleanse wound with normal saline before applying wound treatment. These failures placed the residents at risk of wound, respiratory and gastrointestinal infection and had the potential for residents to be hospitalized . Findings: 1. A review of Resident 's admission record indicated Resident 21 was admitted for acute respiratory failure, attention for tracheostomy, seizures, dysphagia and type 1 diabetes. During a record review of Resident 21's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 7/4/2024, indicated Resident 21 received tracheostomy care including suctioning, oxygen therapy. During a record review of Resident 21's care plan titled, Respiratory Presence of tracheostomy, dated 6/3/24, the care plan indicated Resident 32 receive tracheostomy care which included suctioning as needed. During a concurrent observation and interview on 8/6/24, at 11:15 a.m., Resident 21 was in their room in bed waiting for a nurse to perform tracheostomy suctioning. Resident 21 stated they were sounding junky and needed to be suctioned. Resident 21 stated they were not in respiratory distress. As Resident 21 spoke they sounded like phlegm was partially occluding the tracheostomy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 8/6/24, at 11:29 a.m., Registered Nurse Supervisor 2 (RNS 2) was at Resident 21's bedside preparing to perform tracheostomy suctioning with a disposable suction catheter (a sterile one time use catheter used to suction tracheostomy openings). Wearing non-sterile gloves, RNS 2 opened the disposable suction catheter packaging. With the same gloves, RNS 2 grasped the suction catheter, removed it and attached it to the suction machine. The sterile gloves remained in the package. Continuing to use the same gloves, RNS 2 uncoiled the suction catheter, inserted the suction catheter into Resident 21's tracheostomy and began suctioning. Respiratory therapist (RT) entered the room and observed the suctioning process. After suctioning Resident 21's tracheostomy, RNS 2 discarded the suction catheter. RNS 2 then discarded the packaging with the sterile gloves still in the packaging. During an interview on 8/6/24, at 2:33 p.m., with RNS 2, RNS 2 stated nursing staff were expected to wear sterile gloves when performing tracheostomy cleaning using disposable suction catheters. RNS 2 stated disposable suction catheter came packaged with sterile gloves. RNS 2 stated sterile gloves would keep the suction catheter sterile when inserted into the tracheostomy. RNS 2 stated the suction catheter needed to remain sterile to avoid respiratory infection. During an interview on 8/7/24, at 12:38 p.m., with Respiratory Therapist (RT), RT recalled observing RNS 2 perform tracheostomy suctioning on Resident 21 without use of sterile gloves. RT stated nursing staff were expected to use sterile gloves and sterile technique when using disposable suction catheters. RT stated after she started overseeing the respiratory practice of the nursing staff, she had observed nursing staff were not consistently using sterile gloves when performing tracheostomy suctioning. During an interview on 8/7/24, at 2:51 p.m., with infection preventionist (IP), the IP stated nursing staff were expected to adhere to sterile technique including using sterile gloves when performing tracheostomy suctioning using disposable suction catheters to prevent respiratory illness. During an interview on 8/9/24, at 9:23 a.m., with the Director of Nursing (DON), the DON stated all staff were expected to adhere to hand hygiene policy during which included performing hand hygiene when moving to care for another resident in the same room. The DON stated nursing staff were expected to use sterile gloves to prevent residents from contracting respiratory illness. During a record review of facility policy and procedure titled, Procedure-sterile suctioning, undated, indicated when using a disposable suction catheter, nursing staff put sterile glove on your dominant hand. 7. Grasp sterile suction catheter with gloved hand and suction tubing attached to the suction source with your ungloved hand .do no touch the sterile catheter with your ungloved hand. 2. A review of Resident 32's admission record indicated Resident 32 was admitted for anoxic brain damage (brain damage due to lack of oxygen), attention for tracheostomy, attention to gastrostomy, dysphagia and chronic respiratory failure. The record also indicated Resident 32 was on transmission-based precautions (also called Isolation Precautions, are actions implemented in addition to standard precautions that are based upon the means of transmission for the infectious agent in order to prevent or control infections), for methicillin resistant staphylococcus aureus (MRSA, an antibiotic resistant bacteria), carbapenem resistant enterobacterales (CRE, an antibiotic resistant bacteria) and carbapenem resistant Acinetobacter baumannii (CR-AB, an antibiotic resistant bacteria) in the sputum. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 32's MDS, dated [DATE], indicated Resident 32 received tracheostomy care including suctioning, oxygen therapy and was completely dependent on nursing staff for all aspects of medical and personal hygiene care. During a record review of Resident 32's physician order set titled, Physician Order Report: 8/1/24-8/31/24, undated, the order set indicated Resident 32 had physician orders for isolation contact precaution (a type of transmission-based precaution requiring nursing staff to wear gown and gloves to prevent spread of infection) due to MRSA, ordered on 6/25/2020, and suction tracheal secretions every two hours PRN (as needed), ordered on 8/15/2022. During a record review of Resident 32's care plan titled, Respiratory Presence of tracheostomy, dated 6/3/24, the care plan indicated Resident 32 receive tracheostomy care as ordered and per protocol. A review of Resident 60's admission record indicated Resident 60 was admitted for anoxic brain damage, respiratory failure, care for tracheostomy and care for gastrostomy. During a record review of Resident 60's MDS, dated [DATE], indicated Resident 60 received tracheostomy care including suctioning, oxygen therapy and was completely dependent on nursing staff for all aspects of medical and personal hygiene care. During a record review of Resident 60's physician order set titled, Physician Order Report: 8/1/24-8/31/24, undated, the order set indicated Resident 60 had physician orders for suction tracheal secretions q2h, ordered on 7/23/24. The order set indicated Resident 60 had a medication order for ipratropium-albuterol (a mediation to help breathing) nebulization (a method to administer medication by inhalation of a gaseous form of medication) every 6 hours including an administration time at 9:00 a.m A review of Resident 16's admission record indicated Resident 16 was admitted for respiratory failure, care for tracheostomy and care for gastrostomy. During a record review of Resident 16's MDS, dated [DATE], indicated Resident 16 received tracheostomy care including suctioning, oxygen therapy and was completely dependent on nursing staff for all aspects of medical and personal hygiene care. During a concurrent observation and interview on 8/5/24, at 9:46 a.m., with Respiratory Therapist (RT), RT was in Resident 32, 16 and 60's room performing respiratory care on Resident 16. RT was wearing a gown and gloves. While performing tracheostomy care on Resident 16, Resident 32 could be heard coughing and had coarse breath sounds. RT paused Resident 16's care and Resident 32 needed to be suctioned. RT removed their gloves and disposed of them in a trash receptacle. Without performing hand hygiene, RT donned a new pair of gloves and went over to Resident 32 to perform tracheostomy suction. After suctioning Resident 32, RT removed their gloves and without performing hand hygiene, donned a new pair of gloves. RT stated they would perform tracheostomy suctioning prior to administering Resident 60's ipratropium-albuterol nebulizer medication. RT walked to Resident 60's bedside and began to setup oxygen tubing to administer the nebulizer treatment. Using the same pair of gloves and without performing any hand hygiene, RT suctioned Resident 60's tracheostomy. RT administered the ipratropium-albuterol to Resident 60. After administering the nebulizer treatment, RT removed their gown and gloves and exited the room. (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 on 8/7/24, at 2:51 p.m., with the IP, the IP stated all staff were expected to perform hand hygiene when changing care between residents whether they were on transmission-based precautions or not. IP stated residents with tracheostomies were at higher risk of respiratory infection and adherence to hand hygiene was important to prevent infection. During an interview on 8/9/24, at 9:23 a.m., with the Director of Nursing (DON), the DON stated all staff were expected to follow infection prevention policy including hand hygiene policy when changing care between residents. During a review of facility P&P titled, Policy: Hand Hygiene, dated 2/2017, the P&P indicated all personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors .use an alcohol-based hand rub .for the following situations .before and after direct contact with residents; .before preparing or handling medications .before and after handling an invasive device .after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; . after removing gloves .the use of gloves does not replace hand washing/hand hygiene. 3. During an observation on 8/5/24, at 9:39 a.m., Resident 60's suction canister attached to Resident 60's dedicated suction equipment was inspected. The lid of the canister had a date 7/21/24 written on it and the canister was approximately half full with cloudy white liquid. During an observation on 8/5/24, at 10:04 a.m., Resident 32's suction canister attached to Resident 32's dedicated suction equipment was inspected. The lid of the canister was undated, and the canister was half full with a cloudy white liquid. A review of Resident 's admission record indicated Resident 3 was admitted for respiratory failure, attention for tracheostomy, seizures, dysphagia and type 1 diabetes. During a record review of Resident 3's MDS, dated [DATE], indicated Resident 3 received tracheostomy care including suctioning, oxygen therapy. The MDS indicated Resident 3 had was able to use their upper extremities for cares of living such as eating and drinking but was completely dependent on staff to transfer out of bed and to get dressed. During a concurrent observation and interview on 8/5/24, at 7:49 a.m., with Resident 3, Resident 3's suction canister was inspected. Resident 3 stated he was able to perform suctioning of his mouth by himself. Resident 3 stated the staff were responsible for changing the suction canister. The lid of the canister had a date 7/6 written on it and the canister was approximately 75% full with cloudy white liquid. A review of Resident 's admission record indicated Resident 51 was admitted for respiratory failure and attention for tracheostomy. During a record review of Resident 51's MDS, dated [DATE], indicated Resident 51 received tracheostomy care including tracheostomy care, suctioning and oxygen therapy. The MDS indicated Resident 51 had was non-verbal and was completely dependent on staff for all aspects of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555533	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Healthcare Center - Hayward	19700 Hesperian Boulevard Hayward, CA 94541

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/5/24, at 9:26 a.m., Resident 51 was in their room in bed with a ventilator circuit attached to their tracheostomy. At the end closest to the resident, the ventilator circuit had a mix of dry and wet red-brown residue on inside of the tube. During a concurrent observation and interview on 8/7/24, at 12:45 p.m., with RT, the storage closet for respiratory supplies was observed. RT stated the facility did not have enough supplies to change respiratory care equipment as required by the facility policy. Inspection of the storage closet indicated there were no ventilator circuits or suction canisters. RT stated there were suction canisters were expected to be changed weekly. RT stated Resident 51's ventilator circuit was soiled and needed to be changed but there were no ventilator circuits to change it. RT stated she did not know how long Resident 51's current ventilator circuit was in use because it was not dated. RT stated there were many rooms which needed suction canister changes, but the respiratory supply closet did not have any suction canisters. During an interview on 8/7/24, at 2:51 p.m., with IP, the IP stated equipment related to tracheostomy care needed to be changed regularly to prevent bacterial growth in the equipment which could potentially lead to respiratory infection. IP stated staff needed to label the equipment with a date to ensure equipment was replaced appropriately. During an interview on 8/9/24, at 9:23 a.m., with the DON, the DON stated the respiratory care contractor was responsible for stocking and ordering respiratory care equipment. The DON stated there had been past issues with a previous respiratory therapist ordering enough respiratory care equipment. During a review of facility P&P titled, Changing Disposable Equipment, Respiratory, Infection Control, undated, the P&P indicated disposable equipment must be labeled with a date and respiratory equipment such as suction canisters were changed every week on Sunday nights and ventilator circuits were changed on the first Sunday of each month. During a review of facility P&P titled, Policy: Hand Hygiene, dated 2/2017, the P&P indicated all personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors .use an alcohol-based hand rub .for the following situations .before and after direct contact with residents; .before preparing or handling medications .before and after handling an invasive device .after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; . after removing gloves .the use of gloves does not replace hand washing/hand hygiene. 4. During a record review of Resident 32's enteral feeding administration record titled, Enteral Administration History: 8/1/24-8/8/24, dated 8/8/24, the record indicated on 8/4/25, at 1:31 p.m., Resident 32 received Jevity (a type of tube feed) 1.5. The record indicated Resident 32 received Jevity 1.2 on 8/2/24, 8/3/24 and 8/4/24. During an observation on 8/5/24, at 7:15 a.m., Resident 32's tube feeding lines and pump was inspected. Resident 32's tube feeding circuit was administered through an open system and contained two bags which was filled with water and approximately 75 mL of tube feeding liquid. Resident 32 was receiving tube feed fluid through the gastric tube at a rate of 50 ml/hour. A label affixed to the bag with tube feed liquid indicated the tube feeding circuit was initiated on 8/3/24 with no start time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 273's admission record indicated Resident 273 was admitted for anoxic brain damage, lack of coordination, care for gastrostomy, care for tracheostomy and dysphagia. During a record review of Resident 273's MDS, dated [DATE], indicated Resident 273 received nutrition through a feeding tube. The MDS indicated Resident 272 was not able to make their needs known and was completely dependent on nursing staff for all aspects of medical and personal care. During a record review of Resident 273's enteral feeding administration record titled, Enteral Administration History: 8/1/24-8/8/24, dated 8/8/24, the record indicated Resident 273 was administered Jevity 1.5 at 65 mL/hr from 8/1/24 to 8/6/24. During an observation on 8/5/24, at 7:15 a.m., Resident 273's tube feeding lines which led into Resident 273's gastric tube was inspected. Resident 273's tube feeding line was administered through an open system and contained two bags which was filled with water and approximately 100 mL of tube feeding liquid. Resident 273 was receiving tube feed fluid through the gastric tube at a rate of 65 ml/hour. A label affixed to the bag with tube feed liquid indicated the tube feeding line was initiated on 8/3/24 at 11:00 a.m. A review of Resident 272's admission record indicated Resident 272 was admitted for disorder of muscle, care for tracheostomy, failure to thrive, dysphagia and care for gastrostomy. During a record review of Resident 272's MDS, dated [DATE], indicated Resident 272 received nutrition through a feeding tube. The MDS indicated Resident 272 was able to make their needs known but was completely dependent on nursing staff for all aspects of medical care. During a record review of Resident 272's tube feeding record titled, I&O Monitoring Administration Record: 8/1/24-8/9/24, dated 8/9/24, the record indicated Resident 272 received tube feeding from 8/1/24 to 8/9/24 on all three shifts. During an observation on 8/5/24, at 7:46 a.m., Resident 272's open system tube feeding line and tube feeding pump was inspected. The pump indicated Resident 272 was receiving tube feed at a rate of 50 mL/hr. The label affixed to the bag containing tube feed was dated 8/3/24 with no time. During a concurrent interview and record on 8/7/24, at 2:51 p.m., with IP, images of tube feeding lines observed on 8/5/24 were reviewed. IP stated the images showed residents were using an open system tube feed line, and the tube feed lines needed to be changed every 24 hours. IP stated open system feeding lines were at risk for bacterial growth in the system and could cause gastrointestinal issues and was an infection risk. During an interview on 8/9/24, at 9:23 a.m., with the DON, the DON stated nursing staff were expected to change tube feeding lines every 24 hours for residents who received tube feeding through open system systems. During a review of facility P&P titled, Enteral Feedings - Safety Precautions, dated 1/8/24, the P&P indicated nursing staff change administration sets for open-systems enteral feedings at least every 24 hours. 36087 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A review of Resident 59's Face Sheet, printed 8/7/24, indicated Resident 59 was admitted to the facility with multiple diagnoses which included diabetes mellitus (high blood sugar in the body) with diabetic neuropathy (diabetic nerve damage which often affect the legs and feet). A review of Resident 59's Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 6/13/24, indicated Resident 59 had clear speech, was understood, and was able to understand others. Further review of the MDS showed Resident 59 was at risk of developing pressure ulcers/injuries related to his diagnoses. A review of Resident 59's Physician Order, start date 8/7/24, indicated right lateral foot venous stasis ulcer (wound caused by problems with blood flow): Clean area with normal saline (NS, mixture of water and salt with a salt concentration of 0.9%), pat dry, paint area with betadine (a topical antiseptic used for skin disinfection) then leave air to dry daily x 14 days then re-evaluate. A review of Resident 59's Care Plan, dated 5/14/24, indicated Right Lateral Foot Border Venous Stasis, Treatment (Tx) as ordered: cleanse with NS . During Resident 59's concurrent wound treatment observation and interview on 8/7/24, at 9:32 a.m., with the Treatment Nurse (TN), resident's wound to right lateral foot venous stasis ulcer treatment was performed. TN painted resident's right lateral foot with the betadine-soaked gauze directly to the resident's foot without cleansing the area with NS, as indicated in the treatment order. TN stated she should have cleansed the wound before applying the betadine solution to avoid infection. During an interview on 8/7/24, at 2:24 p.m., with the Director of Staff Development (DSD), DSD stated Wound Treatment Procedure should be followed according to the physician's order. If there was an order for NS, then the wound should be cleansed with NS before the application of the ordered solution or ointment. A review of the facility's policy and procedure (P&P) titled, Wound Care and Treatment, undated, indicated, . Wash tissue around the wound that is usually covered by the dressing, tape, or gauze with antiseptic or soap and water .Apply treatments as indicated .