STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555572	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grossmont Hospital D/P Snf	5555 Grossmont Center Drive LA Mesa, CA 91941

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22383 Based on interview and record review the facility failed to ensure 1 of 8 residents (74) was reassessed after pain medications were administered. As a result, the resident's pain may not have been relieved. Findings: Resident 74 was admitted to the facility on [DATE], with diagnosis that included gout and cancer. During initial survey screening on 5/22/24 at 9:02 A.M., Resident 74 requested a pain pill. On 5/22/24 at 9:13 A.M., a concurrent interview and review of Resident 74 physician orders was conducted with LN 10. Resident 74 had an order for Tylenol 650 mg (milligram) every 4 hours prn (as needed) for mild 1-4 pain, hydrocodone/acetaminophen 7.5/325 mg every 4 hours prn for moderate pain 5-6, and hydromorphone 2 mg every 6 hours prn for severe pain 7-10. On 5/18/24, Resident 74 received pain medications on the following times: At 1:58 A.M., pain medication was given for 6 out of 10 pain level. There was no documented evidence pain was reassessed. At 10:31 A.M., pain medication was given but there was no pain level documented. At 11 A.M., pain was reassessed 5 out 10 pain level, this was only after 30 minutes after medication administration, not the required 45 minutes per facility policy. At 5:10 P.M., pain medication was given. There was no documented evidence that pain assessment was completed before and after medication administration. At 7:49 P.M., Resident 74 complained 5 out of 10 pain level. Resident 74 was not medicated until 8:54 P.M., which was an hour after his initial complaint and his pain had increased to 6 out of 10. LN 10 stated the Resident 74 should have been reassessed an hour after the medication was given. LN 10 further stated the pain reassessment should have been documented in the pain assessment tab. This was not done for Resident 74. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON was conducted on 5/22/24 at 3:48 P.M. The DON stated pain level should have been reassessed after pain medication was given. The DON further stated it should have been reassessed an hour after pain medications given by mouth. The DON also stated the new EMR (electronic medical record) may not have triggered the reassessment, so it was missed. According to the facilities policy patient screening, assessment, and management of pain, last revised 5/2/24, .F. Perform reassessment of pain and sedation level to evaluate the safety and effectiveness of pain management and interventions. 1. NOTE: That's mean time is based on, dose. General guidelines are listed below. Review IV (intravenous) guidelines for specific medications PO/IM/SC/rectal (by mouth/intermuscular/subcutaneous): within 45-60 min 2. CAUTION: reassessments performed too early or too late may result in sub optimal pain management or delay in recognizing over- sedation and respiratory depression .G. Pain reassessment includes: 1. Pain intensity rating and function using scale consistent with patients age, condition, and ability to understand 2. Compare post-invention pain intensity rating to acceptable pain intensity to determine intervention effectiveness and slash or need for additional interventions.

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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. 39111 Based on observation, interview, and record review, the facility failed to ensure food was stored and served in accordance with professional standards for food safety when: 1. Spoiled food was stored amongst non-spoiled food inside the walk-in refrigerators; Food was stored without being covered in the refrigeration units; Food was not consistently labeled and dated; The cool-down process (a time sensitive procedure to chill cooked food to a safe temperature range) was not initiated for two trays of cooked chicken. 2. Three dietary aids (DA 1, DA 2, and DA 3) with long facial hair were not wearing beard guards in the kitchen and during food service; One DA (DA 1) used contaminated gloves to touch ready-to-eat food. These failures had the potential for residents consume contaminated and/or hazardous food which put them at risk for foodborne illnesses. Findings: 1. On 5/21/24 at 8:20 A.M., an observation of the facility's kitchen was conducted with regulatory affairs (RA) 1. A reach-in refrigeration unit contained three small-sized salads that were uncovered and were not labeled and dated. The lettuce and cucumbers in the salads were wrinkled and did not appear fresh. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a walk-in produce refrigerator, there was a bag with a manufacturer's label indicating basil and a date of 5/28/24. The contents of the bag of basil appeared moldy and slimy. At 8:25 A.M., the patient services manager for nutrition services (PSM) joined the observation in the walk-in refrigerator and observed the bag of basil. The PSM stated the basil was spoiled and should not have been stored among non-spoiled food. The PSM also stated the basil should have been dated when it was opened. Two unlabeled and undated bags containing produce that was tan in color, soft, and covered with patchy fuzzy areas resembling mold, was identified by the PSM as being bamboo. The PSM stated the bamboo was for eating and should have been labeled so everyone knew what it was. The PSM stated both bags of bamboo should have been removed from the walk-in refrigerator since they were rotten. Three open bags of: arugula, chopped celery, and chopped onions, were not labeled or dated. The PSM stated the open bags of produce should have been labeled and dated when staff first opened them. Two bell peppers in a box of approximately ten peppers were wrinkled and covered with fuzzy black spots. The PSM stated the spoiled bell peppers should have been removed. The PSM stated staff were to perform a daily walk through of the refrigeration units to check the quality of the food and to remove any spoiled items. The PSM stated this walk through was documented on a log. Two large trays of cooked chicken (approximately 30 pieces of breasts/thighs) were uncovered in the walk-in refrigerator. The PSM stated the chicken should have been covered while inside the walk-in. The PSM stated staff walk around inside the walk-in refrigerator and the chicken should not be out in the open uncovered. The PSM stated it could become contaminated. On 5/21/24 at 8:30 A.M., a joint observation and interview was conducted with cook (CK) 1. CK 1 observed the two trays of cooked chicken that were in the walk-in refrigerator. CK 1 stated he finished cooking the chicken around 7 A.M. and it was to be used for salads that would be served later in the day. CK 1 was asked if he had started a cool-down log for the chicken. CK 1 stated he usually started a log once the chicken was done cooking and recorded the initial temperature. CK 1 stated final cooking temperature of the chicken was something like 185 [degrees]. CK 1 stated he would check the temperature of the chicken once it was finished cooling down. CK 1 then stated that he did not start a cool-down log and that he should have done so. On 5/21/24 at 8:40 A.M., an interview was conducted with the sous-chef (SC). The SC stated the cool-down process was mandatory. The SC stated the initial temperature had to be recorded, then another temperature taken and recorded at 2-hour intervals. The SC then stated it was her expectation for the temperature to be checked and recorded every hour. The SC stated at the end of the six hours, the final temperature should be below 40 degrees Fahrenheit. The SC stated CK 1 should have stated a cool-down log for the chicken. On 5/21/24 at 8:50 A.M., another walk-in refrigerator unit was observed with the PSM. There was a package of provolone cheese left open to air. The PSM stated it should have been fully covered and dated and labeled when it was opened. 2. On 5/22/24 at 10:30 A.M., an observation of food and nutrition services was conducted in the facility kitchen. Also present was the director of regulatory affairs (DRA) and the general manager (GM). The kitchen staff were preparing for tray line (process of cooked food being prepared for delivery to residents). Dietary aide (DA) 1 was opening containers of cooked food, scooping out, pouring out, and placing the food onto the steam table. DA 1 had facial hair that was approximately half an inch long on his chin. The facial hair was not covered with a beard guard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:40 A.M., an interview was conducted with DA 1. DA 1 stated that he should have worn a beard guard when in the kitchen and preparing food. At 10:42 A.M., an interview was conducted with the GM. The GM stated DA 1 should have been wearing a beard guard. At 10:45 A.M., DA 3 was observed at a nearby steam table preparing food and beverage items for lunch service. DA 3 had a beard. DA 3 wore a beard guard below his bottom lip leaving his mustache, which was approximately half an inch long, exposed. At 10:47 A.M., a joint observation was conducted with the GM of DA 2. DA 2 was walking through the kitchen/food service area without a beard guard on. DA 2 had a mustache that was approximately one inch long and completely obscured his upper lip. The GM instructed DA 2 to go and put on a beard guard. The GM stated it was his expectation that, Beard guards, like hairnets, were to be applied before setting foot in the kitchen. At 10:51 A.M., a joint observation of DA 3's exposed mustache was conducted with the GM. The GM stated it was his expectation for beard guards to be worn correctly and to fully cover all the facial hair including the mustache. At 10:58 A.M., a joint observation was conducted with the GM at the steam table. DA 1 was observed plating resident food. DA 1, using his gloved hands, touched plates, plate covers, held onto the steam table, moved a nearby cart, retrieved items from the other side of the kitchen, and held meal ticket slips. At 11:05 A.M., DA 1 opened a large bag of bread rolls that another staff handed to him. DA 1 reached into the bag with his gloved hand, removed a roll and placed it onto a resident's plate. DA 1 plated two other resident plates with bread rolls in the same manner. At 11:07 A.M., the GM stated it was his expectation for staff to touch ready to eat food as little as possible. The GM further stated the bread rolls should have been placed into a tub and tongs should have been utilized to prevent contamination of the food from DA 1's gloves. On 5/23/24 at 7:42 A.M., a joint interview and record review was conducted with the GM. The GM stated food items that were spoiled or had quality issues should have been discarded immediately regardless of any best by date on the packaging. The GM stated the leader on duty was supposed to conduct an opening and closing walk through of the refrigerated units and food storage areas to check for quality issues. The GM stated this walk through was not documented. The GM stated the prompt removal of spoiled food was to ensure it did not make its way to a resident. The GM further stated what had been identified as bamboo by the PSM was not bamboo but lemon grass. The GM stated food if it's opened, it has to be labeled and dated. The GM stated all opened food should have been fully covered, except when actively cooling. The GM stated it was his expectation for the cool-down process to have been implemented and documented when cooked food was chilled. The GM stated the final cooked temperature had to be recorded with the corresponding time. The GM stated this had to be done for staff to know when to do the next temperature check which also had to be recorded. The GM stated it was a matter of food safety. The staff training logs were reviewed for cooling food, personal hygiene, labeling and dating, and preventing cross contamination. The GM stated CK 1, DA 1, DA 2, and DA 3, had received training and should have implemented their training when performing food and nutrition services. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Infection Prevention for Food & Nutrition Services revised 8/31/21, indicated, .A. Personnel .5. Beards and moustaches that are not closely cropped or neatly trimmed are covered . G. Food Storage/Disposal 1. All foods are labeled, covered and dated when stored. They are rotated to assure freshness. Outdated foods are discarded A review of the facility's policy titled Food Safety Management System revised 4/1/22, indicated, .Cooling TCS [time/temperature control for safety] Foods . Cooling- Verify temperature after 2 hours is 70 degrees Fahrenheit or less .Verify temperature of chilled product is 40 degrees or less after 4 hours . Forms and record keeping: Required: HACCP [hazard analysis and critical control points] Cooling and Chilling Log

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on interview and record review, the facility failed to implement an Antibiotic Stewardship Program to monitor antibiotic use. This failure had the potential to increase the risk of adverse events from unnecessary or inappropriate antibiotic use. Findings: A review of Resident 121's untitled facesheet indicated the resident was admitted on [DATE]. On 5/21/24 at 2:41 P.M., an interview was conducted with the infection prevention nurse (IPN) 1. During the interview, IPN 1 was informed of what the survey team would need to review and discuss with her regarding the facility's infection control practices, including antibiotic stewardship, monitoring, and the status of all residents' antibiotic use. On 5/24/24 at 10:42 A.M., a joint interview and record review was conducted with IPN 1. IPN 1 was asked how she tracked and monitored antibiotic use in the facility. IPN 1 logged into her email account and retrieved an untitled document with random words and names on it. IPN 1 stated the untitled document was her tracking list and that there were no residents on antibiotics. IPN 1 was asked when she updated her tracking list and she stated, sometime this month. IPN 1 again stated there were no residents this month who received antibiotics. The facility's Matrix for Providers (Centers for Medicare & Medicaid Services document required to be completed by facilities and given to the survey team) provided to the survey team on 5/21/24, was shown to IPN 1. The Matrix for Providers indicated Resident 121 had received antibiotics and had a urinary tract infection (UTI). At 10:50 A.M., IPN 2 joined the interview and record review with IPN 1. IPN 1 stated Resident 121 had not had a UTI but did have a history of ESBL (type of bacteria that can be found in urine and has shown resistance to antibiotics). IPN 1 reviewed the clinical record and then stated Resident 121 had a UTI and received antibiotics when in the acute care hospital but not here in the skilled nursing facility (SNF). IPN 1 stated Resident 121 was not on antibiotics while admitted to SNF. IPN 2 showed IPN 1 something on the electronic health record and IPN 1 then stated Resident 121 had been on antibiotics when admitted . IPN 1 stated she did not know why the resident had been on antibiotics. IPN 1 was asked if this resident information should have been tracked and monitored by the IPN and she stated, Yes. IPN 1 stated it was important to track and monitor residents' antibiotic use to ensure appropriate treatment was provided. IPN 1 stated she did not have any information on the facility's residents' antibiotic use at which point the interview was ended and IPN 1 was asked to locate and review her resident information so the interview could continue. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/24/24 at 12 P.M., a joint interview and record review was continued with IPN 1 and IPN 2. IPN 1 reviewed documentation of Resident 121's prescribed cefuroxime (antibiotic) 500 mg that had been administered twice a day for the resident's UTI from 5/13/24 through 5/18/24. IPN 1 stated the resident did receive antibiotics while admitted and was not currently on any other antibiotics. IPN 1 stated, This should have been identified by me and tracked. IPN 1 further stated she had not been monitoring or tracking antibiotic use in the facility since the new computer charting system was implemented. IPN 1 stated there was no monitoring/tracking in April or May 2024. IPN 1 stated she was unable to conduct antibiotic stewardship monitoring because of the new computer system. IPN 1 further stated she did not attend the daily stand-up (meetings where infection control issues and antibiotic use would be discussed). On 5/24/24 at 1:08 P.M., a joint interview was conducted with the director of nursing (DON) and director of regulatory affairs (DRA). The DON and DRA both stated reports could be generated in the new computer system for infection control surveillance and antibiotic monitoring. The DON and DRA both stated IPN 1 had access to this. A review of the facility's policy titled Antimicrobial Stewardship Program (ASP), 43167 revised 4/11/23, addressed antibiotic stewardship at the acute care level and did not provide guidance for the SNF.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on interview and record review, the facility failed to ensure two of five residents (5, 124) were appropriately offered the pneumococcal vaccine and had the education regarding benefits and potential side effects of pneumococcal vaccine explained to them and documented in the medical record. In addition, the facility's infection prevention nurse (IPN) 1 did not have a process to readily identify the residents' vaccination status. As a result of this deficient practice, the facility missed opportunities to ensure pneumococcal vaccines had been offered to all residents which put residents at potential risk of contracting pneumonia. Findings: A review of Resident 5's untitled Facesheet indicated the resident was admitted to the facility on [DATE]. A review of Resident 124's untitled Facesheet indicated the resident was admitted to the facility on [DATE]. On 5/21/24 at 2:41 P.M. an interview was conducted with IPN 1. During the interview, IPN 1 was informed of what the survey team would need to review and discuss with her regarding the facility's infection control practices, including the status of all residents for pneumococcal and COVID-19 vaccines. On 5/24/24 at 8:15 A.M. a joint interview and record review was conducted with IPN 1. IPN 1 stated that each residents' vaccination status was reviewed upon admission by the admitting nurse. IPN 1 reviewed Resident 124's pneumococcal vaccination status and stated the resident had been offered the vaccine on 5/22/24 and the resident had refused. Further review of Resident 124's clinical record indicated the resident tested positive for COVID-19 on 5/16/24 and was currently on isolation. IPN 1 stated the pneumococcal vaccine should not have been offered to a resident actively infected with COVID-19 and that it was not appropriate. IPN 1 stated she had been unaware that this had been done and that it was a learning opportunity. At 9:12 A.M., the director of nursing (DON) joined the interview and record review to assist IPN 1 with locating residents' vaccination information. The DON stated it was not appropriate to offer the pneumococcal vaccine to Resident 124 while the resident was COVID-19 positive and on isolation. The record review and interview was continued with IPN 1. IPN 1 reviewed Resident 5's clinical record and stated the resident had been offered the pneumococcal vaccine on 1/26/22 and the resident had refused. IPN 1 stated there was no documentation education about the vaccine had been provided to the resident. IPN 1 stated education should have been provided for the resident to make an informed refusal. IPN 1 further reviewed Resident 5's clinical record and stated the resident had not been re-offered the pneumococcal vaccine. IPN 1 stated the pneumococcal vaccine should be re-offered annually, if indicated, and that Resident 5 should have been re-offered the vaccine in 2023 and 2024. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IPN 1 stated she could not access all the vaccination information in the new medical record system. IPN 1 stated she was not compiling/tracking the information and reviewing it to ensure all residents were offered pneumonia vaccination and that education had been provided. IPN 1 was asked who was monitoring this. IPN 1 stated, It should probably be me. IPN 1 stated without keeping track of resident vaccination status, vaccinations could get missed. The joint interview and record review with IPN 1 took two hours and 27 minutes to determine the vaccination status of five residents. A review of the facility's policy titled Vaccination Program for Residents of Long Term Care/ Sub Acute Facilities, 39136 revised 8/29/23, indicated, .C. Pneumococcal and COVID-19 vaccine is offered year round . E. For persons with acute illness with suspected or laboratory -confirmed COVID-19, health care providers should consider delaying .vaccination until the residents are no longer acutely ill and criteria has been met for discontinuing COVID isolation

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on interview and record review, the facility failed to ensure two of five residents (122, 11) were offered/re-offered the COVID-19 vaccination and had documentation that education regarding the vaccine had been provided. In addition, the facility's infection prevention nurse (IPN) 1 did not have a process to readily identify the residents' vaccination status. As a result of this deficient practice, the facility did not provide all residents the opportunity to accept or change their decision to accept a COVID-19 vaccine which put residents at potential risk of contracting COVID-19. Findings: A review of Resident 11's untitled facesheet indicated the resident was admitted to the facility on [DATE]. A review of Resident 122's untitled facesheet indicated the resident was admitted to the facility on [DATE]. On 5/21/24 at 2:41 P.M., an interview was conducted with IPN 1. IPN 1 stated the facility was currently experiencing a COVID-19 outbreak, with the first positive case on 5/15/24. During the interview, IPN 1 was informed of what the survey team would need to review and discuss with her regarding the facility's infection control practices, including the status of all residents for pneumococcal and COVID-19 vaccines. On 5/24/24 at 8:15 A.M., a joint interview and record review was conducted with IPN 1. IPN 1 stated that each residents' vaccination status was reviewed upon admission by the admitting nurse. IPN 1 stated she did not have residents' COVID-19 vaccination status available and that she would have to review each residents' clinical record. At 9:12 A.M., the director of nursing (DON) joined the interview and record review to assist IPN 1 with locating residents' vaccination information. The interview and record review continued with IPN 1. IPN 1 reviewed Resident 122's clinical record and stated the resident received a COVID-19 vaccine on 1/13/22. IPN 1 stated there was no documentation Resident 122 had been offered the latest version of the COVID-19 vaccine. IPN 1 stated the resident should have been offered the COVID-19 vaccine. IPN 1 reviewed Resident 11's clinical record and stated the resident was offered the vaccine on 1/26/24 and had refused. IPN 1 stated there was no documentation education about the vaccine had been provided to the resident. IPN 1 stated education should have been provided for the resident to make an informed refusal. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IPN 1 stated she could not access all the vaccination information in the new medical record system. IPN 1 stated she was not compiling/tracking the information and reviewing it to ensure all residents were offered COVID-19 vaccination and that education had been provided. IPN 1 was asked who was monitoring this. IPN 1 stated, It should probably be me. IPN 1 stated without keeping track of resident vaccination status, vaccinations could get missed. The joint interview and record review with IPN 1 took two hours and 27 minutes to determine the vaccination status of five residents. On 5/24/24 at 12 P.M., a joint interview was conducted with IPN 1 and IPN 2. IPN 1 and IPN 2 both stated when the facility started their COVID-19 outbreak (5/15/24), that all residents' COVID-19 vaccination status should have been reviewed. IPN 1 and IPN 2 both stated the COVID-19 vaccine should have then been re-offered to eligible residents. A review of the facility's policy titled Vaccination Program for Residents of Long Term Care/ Sub Acute Facilities, 39136 revised 8/29/23, indicated, .A. All residents will be screened for .COVID-19 vaccine . and offered the vaccine(s) if eligible .C. Pneumococcal and COVID-19 vaccine is offered year round . 2. Provide resident (or designee) with education regarding the benefits and potential side effects associated with the vaccine .Document education provided in the resident's medical record