STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555587	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Totally Kids Rehabilitation Hospital - D/P Snf	1720 Mountain View Loma Linda, CA 92354

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS- a facility assessment tool that consists of the resident assessment instrument (RAI) and the care area assessment (CAA) was conducted and submitted to the Centers of Medicare and Medicaid Services (CMS) in accordance with federal submission timeframes, for nine of nine residents (Residents 1, 2, 6, 21, 23, 24, 31, 38, and 42) reviewed for resident assessment. These failures resulted in inadequate monitoring of progress or decline for Residents 1, 2, 6, 21, 23, 24, 31, 38, and 42), and a lack of resident specific information to be sent to CMS for payment and quality measure monitoring. Findings: During a concurrent interview and record review on January 9, 2025, at 9:13 AM, with the Director of Case Management (DCM), Resident 1, 2, 6, 21, 23, 24, 31, 38, and 42's Electronic Health Records (EHR), and CMS Submission Reports (a report with details of when MDS assessments were completed and submitted to CMS) were reviewed. The DCM stated resident MDS assessments were supposed to be done quarterly or approximately every 90 days. The DCM further stated multiple residents had their MDS assessments completed late in November 2024 because she (the DCM) was the only individual that was able to enter the assessments when usually there were more people to help with the task. Resident 1, 2, 6, 21, 23, 24, 31, 38, and 42's EHR, and CMS Submission Reports were reviewed and the following was identified: -For Resident 1, the CMS Submission Report, (undated), indicated the MDS assessment dated [DATE], was not completed until December 23, 2024 (70 days after the due date). The DCM stated Resident 1's MDS assessment was completed late. -For Resident 2, the CMS Submission Report, (undated) and the residents EHR, indicated the residents most recent MDS assessment was dated August 27, 2024, and there was no MDS assessment completed after this date (135 days since the most recent MDS assessment). The DCM stated Resident 2's MDS assessment should have been done sometime in November 2024, but it was never completed and must have been missed. -For Resident 6, the CMS Submission Report, (undated) indicated the MDS assessment dated [DATE], was not completed until January 8, 2025 (43 days after the due date). The DCM stated Resident 6's MDS assessment was completed late. (continued on next page)

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

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For Resident 21, the CMS Submission Report, (undated) and the residents EHR indicated the residents most recent MDS assessment was dated August 4, 2024, and there was no MDS assessment completed after this date (157 days since the most recent MDS assessment). The DCM stated Resident 21 was supposed to have an MDS assessment done in November 2024, but it was never completed and must have been missed. -For Resident 23, the CMS Submission Report, (undated), indicated the MDS assessment dated [DATE], was not completed until January 8, 2025 (56 days after the due date). The DCM stated Resident 23's MDS assessment was completed late. -For Resident 24, the CMS Submission Report, (undated), indicated the MDS assessment dated [DATE], was not completed until January 7, 2025 (69 days after the due date). The DCM stated Resident 24's MDS assessment was completed late. -For Resident 31, the CMS Submission Report, (undated), indicated the MDS assessment dated [DATE], was not completed until January 8, 2025 (51 days after the due date). The DCM stated Resident 31's MDS assessment was completed late. -For Resident 38, the CMS Submission Report, (undated), indicated the MDS assessment dated [DATE], was not completed until January 6, 2025 (56 days after the due date). The DCM stated Resident 38's MDS assessment was completed late. -For Resident 42, the CMS Submission Report, (undated), indicated the MDS assessment dated [DATE], was not completed until January 8, 2025 (47 days after the due date). The DCM stated Resident 42's MDS assessment was completed late. During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessments, revised March 7, 2024, the P&P indicated, A comprehensive assessment of a patient's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS must be completed for all patients in [name of facility] .Assessments are completed within specific guidelines and timeframes. MDS assessments are transmitted electronically to the national MDS database at CMS. - Comprehensive assessments must be completed within 14 calendar days after patient admission, on significant change in status and annually. - Quarterly review assessment (non-comprehensive) must be completed at least every 92 days following the previous assessment of any type .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure one of 22 sampled residents (Resident 42) had a comprehensive care plan (an individualized plan for the medical care of a resident) in place for his tracheostomy (an opening into the trachea [windpipe] from outside the neck to help air and oxygen reach the lungs) and ventilator dependent status (someone who requires a machine [ventilator] to breathe because they are unable to breathe independently.) This failure had the potential for Resident 42 to have unidentified care concerns related to the monitoring and care of his tracheostomy or ventilator dependent status. Findings: During a review of Resident 42's clinical record and the face sheet (contains demographic and medical information), the face sheet indicated Resident 42 was admitted on [DATE], with diagnoses which included dependence on respirator [ventilator] status (a medical condition where a patient is unable to breathe independently and requires continuous support from a mechanical ventilator (respirator) to maintain adequate oxygen levels), tracheostomy status, and bronchopulmonary dysplasia (a chronic lung disease that affects newborns, particularly those who are born prematurely or have low birth weight). During an observation on January 6, 2025, at 10:37 AM, Resident 42 had a tracheostomy and required the use of a ventilator. During a review of Resident 42's Minimum Data Set assessment (MDS assessment - an electronic assessment tool), dated August 22, 2024, the MDS assessment indicated Resident 42 received oxygen therapy, suctioning, tracheostomy care, and mechanical ventilation. During a review of Resident 42's clinical record, there was no active care plan for Resident 42's respiratory status. During a review of Resident 42's physician's orders, dated August 11, 2024, indicated, tracheostomy care, q 24 [every 24hr], change trach ties [a band that secures a tracheostomy tube around the neck] cleanse trach site every AM with sterile water and prn [as needed] re: [regarding] soiling. During a concurrent interview and record review on January 8, 2025, at 3:11 PM, with the Director of Respiratory Therapy (DRT), Resident 42's clinical record was reviewed and there was no evidence of an active respiratory care plan. The DRT stated Resident 42 was supposed to have a respiratory care plan but does not. The DRT further stated the care plan was usually initiated by case management. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on January 9, 2025, at 9:47 AM, with the Director of Case Management (DCM), the DCM stated the case management department was the department which initiated care plans for the residents. Resident 42's clinical record was reviewed, and the DCM stated she was unable to find an active respiratory care plan. The DCM further stated Resident 42 was supposed to have a respiratory care plan in place but it fell off on November 19, 2024, because someone mistakenly indicated the goal was met and the care plan was closed out and no longer active. During a review of the facility's policy and procedure titled, Plan of Care, dated January 11, 2024, the policy indicated, [name of facility] provide comprehensive medical, therapeutic, and clinical services to patients in a relevant individualized manner. Each patient and his/her parent/guardian participate in the development of their individual plan of care that includes problems identified, measurable goals, and applicable interventions. Care plans are used as a measure of goal progress, discharge planning, and communication among all interdisciplinary team (IDT) members including the patient, family, clinicians, therapists, dieticians, etc .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50964 Based on observation, interview, and record review, the facility failed to ensure controlled medications (medications that are controlled by the government because it may be abused or cause addiction) verification process was not accurately completed for two of seven medication carts (room [ROOM NUMBER] and room [ROOM NUMBER] medication cart) when the medication verification was not completed and signed with two (2) licensed nurses. This failure had the potential to cause the diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by staff in a highly vulnerable population of 50 patients. Findings: 1. During a concurrent observation and interview on January 7, 2025, at 2:59 PM, with a License Vocational Nurse (LVN 2), room [ROOM NUMBER]'s medication cart, the Controlled Substance Inventory Count (CSIC-a form used by the facility to verify counting of controlled drugs at the change of shift by oncoming and off going licensed nurses), for Valtoco (a medication used to treat episodes of uncontrolled bodily movements) 15 milligram (MG-unit of measurement) Nasal Spray, dated December 9, 2024, to December 31, 2024, was reviewed. The CSIC indicated the following: a. On December 20, 2024, missing signature from the night shift (6:00 PM to 6:00 AM), oncoming nurse. b. On December 21, 2024, missing signature from the day shift (6:00 AM to 6:00 PM), oncoming nurse. c. On December 21,2024, missing signature from the day shift, off going nurse. d. On December 31, 2024, missing signature from the day shift, oncoming nurse. LVN 2 confirmed the missing signatures on the CSIC form and stated oncoming and off going nurses must sign the form during every change of shift and indicate if there are any missing discrepancy counts. 2. During a concurrent observation and interview on January 7, 2025, at 3:04 PM, with LVN 2, room [ROOM NUMBER]'s medication cart, the CSIC for Valtoco 5 MG Nasal Spray, dated January 4, 2025, to January 7, 2025, was reviewed. The CSIC indicated, on January 7, 2025, missing signature from the day shift, oncoming nurse. LVN 2 confirmed the missing signature on the CSIC form and stated the missing signature for today at 6:00 AM should have been signed when she counted with the off going nurse in the morning but she had forgotten and left the room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on January 8, 2025, at 3:29 PM, with the Chief Nursing Officer/Vice President of Patient Care Services (CNO 1), the facility's policy and procedure (P&P) titled, Controlled Substance Management-Nursing, dated November 12, 2020, was reviewed. The P&P indicated . Accountability: At the change of each shift, both the licensed nurse leaving the shift and the nurse coming on duty must verify the count of controlled substances documented in both controlled Substances Count sheets 3019-2 (SA) and 2019-6 (H). The CNO 1 stated policy was not followed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47360 Based on interview and record review, the facility failed to ensure the pharmacists Monthly Medication Review (MRR- a review of patient medications by a pharmacist aimed at optimizing the health outcomes of residents) was reviewed in a timely manner for two of 50 residents dated October 1, 2024, through October 31, 2024, when the facility failed to implement a policy and procedure (P&P) that included timelines and steps to be followed once the MRR was received. This failure resulted in a delay of two months in physician review of the MRR recommendations provided by the pharmacist and had the potential for an urgent recommendation to go unnoticed, that could have resulted in residents' harm. Findings: During an interview on January 9, 2025, at 2:49 PM, with the Pharmacist (PharmD), the PharmD stated he performs a monthly MRR and at the beginning of each month, for the previous month, then sends a copy to the Chief Nursing Officer (CNO) of the facility. The PharmD stated, it is the facilities responsibility to review his recommendations at the beginning of each month with the resident's physician. The PharmD further stated, the facility should have their own policies to ensure the MRR recommendation are reviewed and acknowledged. During a concurrent interview and record review on January 9, 2025, at 3:43 PM, with the CNO 1, the Consultant Pharmacists Recommendations, dated October 1, 2024, through October 31, 2024, was reviewed. The Consultant Pharmacists Recommendations indicated, the recommendations for antipsychotics (medication to treat hallucination) and hynoptics (medication to help sleeping) medication were received on November 6, 2024, reviewed, and responded by the attending physicians on January 9, 2025, two months after being received. The CNO 1 stated, there was a two- month delay in physicians response to the recommendations by the PharmD and the goal for review is one week. During a concurrent interview and record review on January 9, 2025, at 3:45 PM, with the CNO 1, the Consultant Pharmacists Recommendations, dated April 1, 2024, through April 30, 2024, was reviewed. The Consultant Pharmacists Recommendations were not dated with a received date and were reviewed and responded by the physician on July 15, 2024. The CNO 1 stated, there was over a two-month delay in physician response to the recommendations made by the PharmD and the goal for response is one week. The CNO 1 stated, she had delegated one of the nurses to review the MRR with the physicians, and two months for a physician to review and response to the PharmD recommendations is not acceptable. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on January 9, 2025, at 3:50 PM with the CNO 1, the facility's policy and procedure P&P titled, Medication Regimen Chart Review, dated July 01, 2020, was reviewed. The P&P indicated, .The designated pharmacist will monitor medication therapy. Completion of each regimen review will be dated and documented. Potential or actual medication therapy issues are communicated to the physician. For those requiring the immediate attention of a physician; the responsible physician, or his/her designee is contacted by the pharmacist or nurse caring for the patient . The CNO 1 stated, the policy does not outline the facilities expectation related to the MRR and physician review or outline time frames for the process. The CNO 1 stated, it is the expectation to have the physician review and have all recommendations addressed within a week and returned. The CNO 1 further stated, if there was an urgent concern requiring immediate action to a resident's medications, the recommendation would be brought to her attention immediately by the PharmD or nursing staff so that changes could be made timely.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview and record review the facility failed to ensure the PRN (as needed) lorazepam (anti-anxiety drug) medication order did not exceed 14 days time limitation without the prescriber's documented rationale in the resident's medical record for one (Resident 99) of five residents reviewed for medications. This failure had the potential to result in adverse health outcomes, including but not limited to exposure to unnecessary medications, side effects, and/or habit-forming mental or physical dependence. Findings: During a review of Resident 99's clinical record and face sheet (contains medical and demographic information), the face sheet indicated Resident 99 was admitted on [DATE], with diagnoses which included tracheostomy status (an opening into the trachea [windpipe] from outside the neck to help air and oxygen reach the lungs), hypoxic ischemic encephalopathy (a brain injury that occurs when the brain doesn't receive enough oxygen or blood flow), and extreme immaturity of newborn, gestational (period of time between conception and birth) age 23 completed weeks. During a review of Resident 99's Electronic Health Record (EHR) and physician's orders, an order dated December 20, 2024, indicated, Lorazepam 0.8 mg [milligram - unit of measure], gastrostomy [via feeding tube inserted into the stomach], q8hr [every eight hours], PRN [as needed] agitation, first dose: 12/20/24 [December 20, 2024], 4 week(s), refill #0, indication: agitation . Further review indicated the order was discontinued on January 8, 2024 (order was active for 20 days). During a review of Resident 99's Medication Administration Record (MAR - a document used by staff to record the administration of medications to residents), dated December 2024, through January 2024, the MAR indicated the resident received the Lorazepam medication on the following dates and for the following documented reasons: 12/21/24 for Reason for medication .agitation.; 12/25/24 reason for medication . agitation; 12/26/24 for reason for medication .agitation; 12/27/24 reason for medication .agitation; 12/28/24 at 0639 reason for medication .agitation; 12/28/24 at 1554 reason for medication .agitation; 12/31/24 at 0825 reason for medication .agitation; 12/31/24 at 2051 reason for medication .agitation; 1/1/25 at 1708 reason for medication .agitation. During a review of Resident 99's EHR, there was no prescriber documentation regarding rationale of why the PRN psychotropic medication (Lorazepam 0.8 mg, gastrostomy, q8hr, PRN agitation, first dose: 12/20/24, 4 week(s), refill #0, indication: agitation) was written with a duration of longer than 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on January 9, 2025, at 2:48 PM, with the Pharmacist 1 (Pharm 1), the Pharm 1 stated he was unable to review medical records, at the time of interview, because his current location was experiencing a power outage. Pharm 1 stated he was the individual who performed the facility's monthly medication regimen reviews for the residents. When asked what the expectation was regarding the duration of psychotropic PRN medication orders, Pharm 1 stated per regulation, psychotropic medication orders were supposed to be re-written every 14 days and re-evaluated periodically after that. Pharm 1 was informed of the physician order for Resident 99, dated December 20, 2024, which indicated, Lorazepam 0.8 mg, gastrostomy, q8hr, PRN agitation, first dose: 12/20/24, 4 week(s), refill #0, indication: agitation. Pharm 1 stated he would consider the duration of the PRN medication order to be an irregularity since it was more than 14 days. During a concurrent interview and record review on January 9, 2025, at 3:12 PM, with the Chief Nursing Officer (CNO 1), Resident 99's clinical record and physician's orders were reviewed. The CNO 1 reviewed the physicians order dated December 20, 2024, which indicated Lorazepam 0.8 mg, gastrostomy, q8hr, PRN agitation, first dose: 12/20/24, 4 week(s), refill #0, indication: agitation. The CNO 1 then confirmed the order was active from December 20, 2024, through January 8, 2024 (20 days). Resident 99's clinical record was reviewed, and the DON was unable to find documented rationale from the prescriber indicating the need for the psychotropic medication beyond 14 days. During continued interview on January 9, 2025, at 3:12 PM, with the CNO 1, the CNO 1 Stated the facility did not have a policy and procedure regarding PRN psychotropic medication orders and that the facility relied upon the pharmacist to review the drug regimen review of the residents and ensure the orders were within regulations and met requirements.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51269 Based on observation, interview, and record review, the facility failed to ensure a medication was stored in accordance with the facility's policy and procedure (P&P) when one bottle of Humulin R (a short-acting medication used to lower blood sugar) 100 units per milliliter (ml-units of measurement) medication was found with an expiration date of [DATE] (33 days expired) in one of four medication emergency kits (E-Kit- a collection of medications and supplies that can be used to treat medical emergencies when pharmacy services are unavailable). This failure had the potential to cause unsafe medication administration and care during an emergency situation to residents from beyond the use date (expired) medication. Findings: During a concurrent observation and interview on [DATE], from 3:55 PM through 4:20 PM, with the Charge Nurse (CN 1) in a medication storage room where refrigerated medications were kept, one refrigerated medication E-Kit was found with an expiration date of [DATE]. The CN1 confirmed the E-Kit was expired and further stated this failure had the potential for expired medication to be administered or not be readily available during an emergency which could be detrimental to a resident's health and safety. During a follow-up concurrent observation and interview on [DATE], at 4:21 PM, with the CN1 and Nurse Manager (NM), the E-Kit with an expiration date of [DATE] was opened. One medication, Humulin 100 units per ml, was found with an expiration date of [DATE]. The NM confirmed and stated the medication was expired 33 days and further stated the E-Kit should not be stored in the medication fridgerator if it is expired. During concurrent interview and record review on [DATE], at 9:20 AM, with the Chief Nursing Officer (CNO 1), the facility's P&P titled, Medication Management, dated [DATE], was reviewed. The P&P indicated, .Any expired, damaged and/or contaminated medications shall be removed from drug storage areas as soon as possible and disposed appropriately . The CNO 1 stated the policy was not followed and should have been. During a phone interview on [DATE], at 3:35 PM, with the in-house Director of Pharmacy (DP), the in-house DP stated the nurses are involved in the process to make sure medications are not expired and if an expired medication is found, they are to remove the medication from stock and notify the pharmacy for replacement. The in-house DP further stated, the E-Kit should have been readily available without any expired medication due to the risk of potential harm to the residents in an emergency. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE], at 4:30 PM, with the CN 2, a document titled, Subacute Charge Nurse Report, dated [DATE], and [DATE], was reviewed. The Subacute Charge Nurse Report indicated the E-Kit was checked by the nurse on both dates. The CN2 stated the E-kits should not have been expired and further stated the nurse checking should have found the expired dates and called the pharmacy for replacement to prevent potential harm to the residents needing to receive the emergency medication.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Totally Kids Rehabilitation Hospital - D/P Snf	1720 Mountain View Loma Linda, CA 92354

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40171 Based on observation, interview, and record review, the facility failed to follow safe and sanitary food storage practices when: - Seven onions located in the facility's dry storage area, were available for use and labeled with an expired use by date. - Ice cream in the facility's walk-in freezer was found unlabeled. These failures had the potential to compromise the integrity of the food and cause foodborne illness to three of fifty vulnerable residents who received food from the kitchen. Findings: During a concurrent observation and interview on [DATE], at 7:44 AM, with [NAME] 1 (CK 1), in the facility's dry storage area of the kitchen, there was a bin located on a shelf which contained seven onions. The onion bin had a label which indicated, Onions whole .prep [DATE] .use through [DATE] (three days expired). CK 1 observed the onions and stated the onions should not be available for use and should have been thrown away. CK 1 then removed the onions from the dry storage area. During a concurrent observation and interview on [DATE], at 8:02 AM, with CK 1, in the facility's walk-in freezer, there was a large 1-gallon bucket of ice cream on a shelf. The gallon bucket of ice cream was not labeled by the facility with the date it was received or with the date it was to be used by. CK 1 observed the unlabeled bucket of ice cream and stated it was supposed to be labeled with a received date and a use by date, but it was not. CK 1 further stated she was unsure of exactly when it was bought or received but stated the ice cream was purchased for an employee Christmas party. The ice cream was not labeled for employee or staff use. During an interview on [DATE], at 3:25 PM, with the Registered Dietician 1 (RD 1), RD 1 stated when food was received by the facility, it was supposed to be labeled to indicate when it was received or prepared and a date when it was supposed to be used by. RD 1 further stated food for employee meetings or staff parties were kept in the same walk-in freezer where resident food was stored. RD 1 stated employee food was supposed to be labeled or identified in some way to indicate it was food for employees and not residents. RD 1 further stated it was not the ideal practice to have unlabeled food in the fridge or freezer. During a follow up interview on [DATE], at 3:35 PM, with RD 1, RD 1 stated onions were ok to be stored for 30 days in the dry storage area. RD 1 further stated onions should be labeled for the date they are received and the date they were to be used by and are only good for 30 days. During a review of the facility provided document (provided by RD 1), which was untitled, and undated, the document indicated, Onions .for freshness and quality, this item should be consumed within: 1 month if in the pantry from the date of purchase . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure P&P titled, Labeling and Dating of Food, revised [DATE], the P&P indicated, A labeling and dating machine will be utilized in the Nutritional Services Department to ensure food items are rotated and used by expiration dates.

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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** 47360 Based on observation, interview and record review, the facility failed to ensure infection control practices were developed and maintained for two of 20 sampled residents (Residents 7 and 10) when: 1. Enhanced Barrier Precautions (EBP - extra steps taken to prevent the spread of germs to vulnerable residents during close contact care by wearing gowns and gloves) were not implemented when providing wound care for one resident (Resident 10). 2. Sterile technique (the use of practices that restrict microorganisms in the environment and prevent contamination of the field) was not followed during urinary catheterization (procedure where a thin, flexible tube called a catheter is inserted into the urethra to drain urine from the bladder) for one resident (Resident 7). 3. Hand hygiene (hand washing) was not performed after resident care for one resident (Resident 7). These failures had the potential for an increased risk of a health-care associated infection (HAI - an infection that is unintentionally caused when receiving treatment at a medical facility) or exposure to a Multiple Drug Resistant Organism (MDRO - germs that resist treatment with more than one antibiotic) which can result in a preventable infection and worsening of medical condition. Findings: 1. During a review of Resident 10's History and Physical (H&P - a formal assessment document by the residents physician), dated June 10, 2024, the H&P indicated, Resident 10 was admitted to the facility on [DATE], with diagnoses including [NAME] syndrome (a genetic disorder that causes physical abnormalities in the face, arms, hands, and feet) and currently hospitalized for wounds secondary to tracheostomy (trach - a hole made during a surgical procedure to help air and oxygen reach the lungs) ties (used to secure the tracheostomy in place). During an observation on January 8, 2025, at 9:33 AM, at Resident 10's bedside, Registered Nurse 1 (RN 1) and Respiratory Therapist 1 (RT 1) provided wound care to erosive wounds (wounds caused to the resident's neck from tracheostomy dressing change) for Resident 10. RN 1 and RT 1 did not wear gowns during these high contact care activities. During a concurrent interview and record review, on January 8, 2025, at 3:00 PM, with the Infection Preventionist (IP 1), the facility's policy and procedure (P&P) titled, Isolation Precautions, dated February 24, 2023, was reviewed. The P&P did not include EBP procedure. The IP 1 stated, this is the only policy regarding any isolation precautions or use of personal protective equipment (PPE - equipment like gloves, gowns, masks and face shields that can minimize exposure and transmission of infection) and the P&P did not address EBP regulatory standards and did not specify when gowns need to be worn to protect residents at high risk of infection from MDRO during high-risk care. The IP 1 further stated, she was aware of the EBP regulation requirements, but the P&P had not been updated and EBP had not been implemented within the facility. The IP 1 further stated, not wearing a gown during high-contact care, such as wound care, could spread MDRO. (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 concurrent interview and record review, on January 9, 2025, at 2:00 PM, with the [NAME] President of Regulatory Compliance (VPR), the Centers for Medicare & Medicaid Services (CMS) Memorandum titled, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Ref: QSO-24-08-NH (QSO-24-08-NH), dated March 20, 2024, was reviewed. The QSO-24-08-NH memorandum indicated, .CMS is issuing new guidance for State Survey Agencies and long-term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status . The VPR stated, the facility has not yet adopted the EBP procedure and does not have a policy specific to EBP. 51269 2. During a record review of Resident 7's Admission Record (contains the admitted) and History and Physical (H&P-contains demographic information), the Admission Record indicated Resident 7 was admitted to the facility on [DATE]. The H&P indicated Resident 7 was admitted with diagnoses of anoxic encephalopathy (a serious condition that occurs when the brain is deprived of oxygen, causing brain cells to die), neurogenic bladder (a condition that occurs when the nerves that control the bladder are damaged, resulting in a loss of bladder control), and spasticity (a serious condition that occurs when the brain is deprived of oxygen, causing brain cells to die). During an observation on January 9, 2025, at 9:22 AM through 9:35 AM, with a Licensed Vocation Nurse (LVN 3), in Resident 7's room, LVN 3 was observed preparing the catheterization kit (a collection of supplies used to insert a catheter into a body cavity) and irrigation (the process of washing out an organ or wound with a continuous flow of water or medication.) supplies needed to straight catheterize (procedure where a thin, flexible tube called a catheter is inserted into the urethra to drain urine from the bladder) Resident 7. LVN 3 then proceeded, with non-sterile gloves, to touch everything inside of the sterile (free from bacteria or other living microorganism; totally clean) kit. LVN 3 placed the drape that goes under Resident 7, pulled out the iodine swabs, opened the swabs and placed them on top of the drape that was under Resident 7. LVN 3 placed the half-opened catheter to the right side of the bed. LVN 3 removed gloves and donned (the processes of putting on personal protective equipment (PPE)) sterile gloves and used the iodine swabs to cleanse the genitals. LVN 3 then proceeded to toss the iodine swabs on the sterile drape and noticed the catheter was still in the package. With the same gloves, LVN 3 opened the package and placed the catheter in the kit to lubricate it. During an interview on January 9, 2025, at 9:55 AM, with LVN 3, LVN 3 stated, the straight catheterization should have been performed with sterile technique. LVN 3 further stated, she should not grab inside the sterile kit with her non-sterile gloves since it increases the risk of spreading infection. During a concurrent interview and record review on January 9, 2025, at 12:25 PM, with the Nurse Manager (NM) and the Chief Nursing Officer (CNO 1), the facility's policy and procedure (P&P) titled, Urinary Catheterization, dated April 21, 2021, was reviewed. The P&P indicated, . use sterile technique to insert the catheter. The NM and the CNO 1 stated the policy was not followed and should have been due to the risk of a resident developing a urinary tract infection if proper sterile technique is not performed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a record review of Resident 7's Admission Record and H&P, the Admission Record indicated Resident 7 was admitted to the facility on [DATE]. The H&P indicated Resident 7 was admitted with diagnoses of anoxic encephalopathy, neurogenic bladder, and spasticity. During an observation on January 9, 2025, at 9:40 AM through 9:53 AM, with LVN 3 and a Certified Nursing Assistant 3 (CNA 3), in Resident 7's room, LVN 3 was observed to unable to insert a catheter to drain Resident 7 urine during straight catheterization. LVN 3 stated to CNA 3, I am going to leave it in there and get another kit. LVN 3 proceeded to remove her gloves, got the keys out, and went to open medication cart located in the room without performing hand hygiene. LVN 3 stepped out of the room without performing hand hygiene to grab another catheterization kit. During an interview on January 9, 2025, at 9:55 AM, with LVN 3, LVN 3 stated she did not remember if she washed her hands after the second attempt of straight catheterization. LVN 3 further stated she was supposed to wash hands after any contact with residents prevent spreading infections. During a concurrent interview and record review on January 9, 2025, at 12:25 PM, with the NM and the CNO 1, the facility's P&P titled Infection Control-General, dated February 24, 2023, was reviewed. The P&P stated . Standard Precautions [set of infection control practices that are used to prevent the spread of disease in healthcare settings] and appropriate hand hygiene should be used with all patient care activities . The NM and the CNO 1 stated the policy were not followed and should have been due to the risk of a resident developing a urinary tract infection if proper hand hygiene is not performed. The CNO 1 further stated, the facility also followed the Centers for Disease Control and Prevention (CDC) guideline that staff are expected to wash their hands before entering and leaving a resident's room.