STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555623	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemet Valley Healthcare Center	371 North Weston Pl Hemet, CA 92543

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988 Based on interview and record review, the facility failed to ensure: 1. Information regarding formulation of Advanced Directive (AD- a written document that indicates a resident's medical wishes) was provided to the Residents' Representatives (RR), for two of 14 residents reviewed for AD (Residents 18 and 7); and 2. Resident 11's AD was not readily available in the resident's medical record. These failures had the potential for the resident/resident representative's current wishes for medical care not to be honored. Findings: 1. On July 29, 2024, Resident 18's record was reviewed. Resident 18 was admitted to the facility on [DATE]. Resident 18's Resident Representative (RR- makes decisions for the resident due to the resident not having mental capacity to make medical decisions) was his family member (FM). Resident 18's History and Physical, dated July 10, 2024, indicated a history of alcohol and cocaine use, post assault, stroke, status post craniotomy (opening in the skull to access the brain for surgery), chronic respiratory failure requiring tracheostomy (opening into the wind pipe from outside the neck to allow air and oxygen to reach the lungs). Resident 18 required high complexity medical decision making. Resident 18's Minimum Data Set (MDS- an assessment tool), dated July 16, 2024, indicated Resident 18 had severe cognitive impairment. Resident 18's Physician's Order for Life Sustaining Treatment (POLST), signed by the RR on July 22, 2024, did not indicate the presence of an AD. There was no documented evidence information on formulating an advance directive was provided to or received by Resident 18's RR. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On July 31, 2024, at 11:43 a.m. the Infection Preventionist (IP) was interviewed. The IP stated upon a resident's admission to the facility, the POLST was to be given to the resident and/or RR and the form was to be filled up to indicate their medical wishes, then the resident and/or RR and the physician would sign the form. The IP stated if the resident had an AD, a copy would be requested and be filed in the resident's chart. She further stated if there was none, the Social Services Liaison (SSL) would work with the resident and/or RR, as well as the Ombudsman, to formulate one. On July 31, 2024, at 11:50 a.m., the SSL was interviewed. The SSL stated she would talk to the RR for residents who were not alert and oriented, provide them the pamphlet regarding AD, they could fill them out, then the Ombudsman would come to the facility to witness it. She stated if the resident was not oriented, the Ombudsman would not sign off on the AD, then she would talk to the RR about considering applying for conservatorship for the resident. On July 31, 2024, at 3:07 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON) and the SSL. The DON and SSL confirmed there was no documentation information regarding AD formulation was offered to Resident 18's RR. The SSL further stated, there was no discussion with the RR until today, regarding ADs, since she was unable to get a hold of the RR beforehand. On July 31, 2024, at 4:07 p.m., the DON was further interviewed and stated, information regarding AD formulation should have been provided to the RR when Resident 18 was admitted . 2. On July 29, 2023, at 3:42 p.m. Resident 7's record was reviewed. Resident 7 was admitted to the facility on [DATE]. Resident 7's RR was her family member (FM). The History and Physical, dated January 20, 2024, indicated a chief complaint of chronic respiratory failure, as well as a history of cardiac arrest and anoxic brain injury (brain is deprived of oxygen leading to brain cell death after four minutes), currently unresponsive and unconscious. The POLST,' signed by Resident 7's RR on August 11, 2023, did not indicate the presence of an AD for Resident 7. The Progress Notes, indicated Resident 7's RR declined to complete an AD on July 19, 2019. There was no documented evidence recent attempts were made by the facility to provide information on formulating an advance directive to Resident 7's RR. On July 31, 2024 at 3:07 p.m., a concurrent interview and record review was conducted with the DON and SSL. When asked how often the facility provided follow ups with RR's regarding AD formulation, the DON and SSL were unable to state any frequency per facility protocol. The DON and SSL confirmed there were no recent attempts made to discuss or provide information to Resident 7's RR regarding AD formulation. 3. On July 30, 2024, at 10:48 a.m., Resident 11's record was reviewed. Resident 11 was admitted to the facility on [DATE], and was self-responsible. The POLST, signed by Resident 11 on May 31, 2022, did not indicate the presence of an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The History and Physical, dated June 9, 2024, indicated Resident 11 was alert and oriented. There was no documented evidence information on formulating an advance directive was provided to or received by Resident 11. There was no evidence there was an AD filed in Resident 11's record. On July 31, 2024 at 3:07 p.m., a concurrent interview and record review was conducted with the DON and SSL. The SSL stated Resident 11 was initially admitted from the acute side on May 30, 2024, and had an AD in her chart so she left it alone, nor did she write any notes regarding the AD since it was already there. The SSL attempted to locate the AD in the paper record in the unit, as well as electronic record but was unable to do so. The DON attempted to locate Resident 11's electronic records outside of the unit but within the hospital system. The DON was able to locate the POLST while Resident 11 was in the Direct Observation Unit (DOU) indicating yes to and AD, but was unable to locate an actual scanned copy of the AD. The DON stated Resident 11's AD should have been available in the current record. A review of the facility's policy and procedure titled, ADVANCE DIRECTIVE, dated March 2024, indicated, .It is the policy of (name of facility) and the Patient Access Department that every adult receiving medical care is interviewed and the appropriate responses be noted and/or the requested information be provided at the time of registration excluding routine laboratory, radiology services, concerning the patient's individual rights under state law to make decisions regarding his or her medical care. The patient's legally completed Advanced Health Care Directive (AHCD/AD) Information is to be documented in the patient's visit as well as scanned in the patient's Medical Record for future reference as needed for patient care decisions to be administered as necessary .On or before every registration, even for patients who are frequently readmitted . Patient Access staff will inquire about the status of any existing Advanced Health Care Directive .Upon completion of he questions and entry into the computer system the patient will be provided any requested Advance Directive information in order to review or discuss with the appropriate person, such as the social Workers or Nursing Staff during time of Admission and patient care .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988 Based on interview and record review, for one of 18 residents, the facility failed to ensure interventions were placed to address Resident 4's frequent shower refusals . This failure had a potential to result in a delay in the care and treatment of Resident 4's skin conditions and to develop new skin conditions. Findings: On July 29, 2024, at 2:33 p.m., Resident 4's record was reviewed. Resident 4 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure (not enough oxygen in the blood) and diabetes mellitus (abnormal blood sugars). The Minimum Data Set (MDS - an assessment tool), dated May 5, 2024, indicated Resident 4 had a BIMS score of zero, indicating severely cognitive function. The Medication Administration Record (MAR), included physician's orders for Nystatin (an antifungal-medication to prevent fungal growth) powder to the following areas: - Inflamed skin under left axillary (armpit) area; - Inflamed skin under left breast; - Inflamed skin under right breast; - Inflamed skin on left axilla; and - Inflamed skin on right axilla. The MAR, included physician's orders for Nystatin-Triamcinolone cream (combination antifungal and antibacterial medication) to the following areas: - Redness on left groin; and - Redness on right groin. On July 31, 2024 at 9:30 a.m., a concurrent interview and review of Resident 4's record was conducted with the Infection Preventionist (IP). The IP stated she also performed Treatment Nurse responsibilities during the week from Monday to Friday in the facility. The IP was asked regarding any current skin issues Resident 4 had which required treatments. The IP stated Resident 4 frequently refused showers, so she usually presented with redness to her underarms, under her breasts or groin, for which she had orders for Nsytatin to be applied to the affected areas. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP stated bed bath would be offered to the resident if the resident would refuse showers. Resident 4's Progress Notes, were reviewed with the IP and the IP stated there was one bed bath offered and completed on May 6, 2024 and on June 17, 2024, Resident 4 had a shower. Resident 4's care plans were reviewed with the IP and indicated medication treatments for multiple areas in the resident's body were included. The care plans did not include any interventions to address Resident 4's frequent refusals for showers or bed bath. On July 31, 2024, at 5:01 p.m. the Director of Nursing (DON) was interviewed. The DON stated there should have been a plan of care or interventions developed to address Resident 4's skin issues in relation to her shower refusals. The DON stated, At one point in time, it should have been identified why the issues keep happening so it can be addressed accordingly. A review of the facility's policy and procedure titled, INTERDISCIPLINARY CARE PLANS, dated March 2024, indicated, .an individualized plan of care for the resident .should be initiated when a resident is admitted and may be adjusted in response to identified problems throughout the hospital stay .Each implemented Care Plan must be addressed by Nursing at least once every 7 days in weekly summary until the problem has been resolved .Documentation in the resident's medical record by licensed Health Care Team members will identify each Care Plan by number and will include an evaluation of the progress or lack of progress towards the goal .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49613 Based on interview and record review, the facility failed to develop policies and procedures for the monthly drug regimen review. This failure had the potential for delayed identification of harmful drug interactions, side effects, and inadequate monitoring that could negatively impact residents' physical, mental, and psychosocial well-being. Findings: On July 31, 2024 at 11:30 a.m., during a concurrent interview and record review with the Director of Pharmacy (DOP), the facility's policies and procedures (P&P) were reviewed. There was no documented evidence the facility had developed and implemented written policies and procedures for monthly drug regimen reviews by a pharmacist. On July 31, 2024 at 1:26 p.m., during an interview with the DOP, the DOP stated there was no current policy addressing monthly drug regimen review.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49613 Based on interview and record review, the facility failed to ensure two of five residents reviewed for unnecessary medication (Residents 17 and 18) were free from unnecessary psychotropic (drug that affects brain activities associated with mental processes and behavior) medications when: 1. For Resident 17, the facility did not have the prescriber-documented rationale for extended use of the as-needed (PRN) lorazepam (a psychotropic medication for anxiety) beyond 14 days; 2. For Resident 18, the facility did not monitor the effectiveness of the antipsychotic (quetiapine - medication to treat mental illness). These failures had the potential to result in unnecessary use of medications. Findings: 1. During a concurrent interview and record review on July 31, 2024 at 2:50 p.m., with staff pharmacist (RPH) 1 and Licensed Vocational Nurse (LVN) 1, Resident 17's electronic medical record was reviewed. The record indicated a physician's order, dated June 27, 2024, for lorazepam 0.5 milligrams (mg - unit of measurement), to be administered via feeding tube every six hours as needed for anxiety manifested by verbalization of feeling anxious, stop on July 4, 2024 (seven days). The record indicated an identical order for lorazepam dated July 4, 2024 to stop on July 18, 2024 (14 days). The record indicated an additional identical order for lorazepam dated July 20, 2024 to stop on July 27, 2024 (seven days). The record indicated a final identical order for lorazepam dated July 27, 2024 to stop on August 10, 2024 (14 days). RPH 1 and LVN 1 each stated they were unable to find any documentation for the extended use of the as-needed lorazepam. During an interview on July 31, 2024 at 4:29 p.m. with Director of Nursing (DON), DON stated the expectation is for the physician to evaluate the resident when extending orders for as-needed psychotropic medications. DON stated the expectation is the physician will document the need for the extension. DON stated there should be documentation of the rationale for extension for Resident 17. During a review of the facility's policy and procedure (P&P) titled, Chemical Restraints, dated, March 2024, the P&P indicated: Chemical restraints [antipsychotic/psychotropic medications] are used in the lowest possible dose and are discontinued when no longer required . 2. During a review of Resident 18's medical records on July 31, 2024, included the following: - .was admitted to the facility on [DATE], with diagnoses that included history of alcohol and cocaine abuse, multiple injuries from assault, CVA (cerebrovascular accident, stroke), craniotomy (temporary removal of part of skull to work on the brain), and chronic respiratory failure on tracheotomy tube (a tube inserted to windpipe to help with breathing) .; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was a physician order on July 13, 2024, for Seroquel (quetiapine, an antipsychotic medication to treat various mental and thought disorder including altered sense of reality) 25 mg to be given to the resident by feeding tube every 8 hours for psychosis manifested by pulling at tubes, trach(eostomy) and G-Tube (gastrostomy tube, a feeding tube); The facility's Care Plan titled, Antipsychotic Drug Use, initiated, July 13, 2024, was reviewed and it indicated: .Will have decreased episodes of pulling at tubes lines trach (tracheotomy) .Monitor episodes report increase or decrease in episodes to MD (physician) and adjust medications as needed . The electronic documentation for behavior monitoring in the resident's medical record for Seroquel indicated the documentation was not consistently done as indicated by two, or sometimes one, or sometimes no documentation of behavior monitoring each day. During an interview on July 31, 2024, at 11:30 a.m., the Clinical Nurse Educator (CNE) and the Infection Preventionist (IP) stated there were two nursing shifts per day and each day nursing staff would document behavior monitoring at the end of their shifts. They both agreed there were less than two behavior documentation in some of the days. During an interview on July 31, 2024, at 4:50 p.m., the DON stated the behavior documentation should be consistent to reflect the effective of the medication. The DON stated there had been some issues with nursing staff regarding documentation in the residents' medical records. The facility's policy and procedure titled, Interdisciplinary Care Plan, dated, March 2024, was reviewed, and it indicated, .To outline the correct use and completion of an individual multidisciplinary Care Plan that is directed toward achieving and maintaining a resident's optimal physical, psychosocial and functional status . Care Plans serve as the plan of care for the resident. They address the quality of care the resident will receive from the staff .Staff are to choose desired and measurable goals that are appropriate for the resident to attain .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49613 Based on observation, interview, and record review, the facility had a medication error rate of 9.68% when three medication errors occurred out of 31 opportunities during medication administration, for two out of four residents (Residents 2 and 5). This failure resulted in medications not given according to the prescriber's orders and/or manufacturer's specifications and had the potential for residents to not receive the full therapeutic effects of medications. Findings: 1a. During a medication pass observation on July 30, 2024 at 9:34 a.m., Licensed Vocational Nurse (LVN) 1 was observed preparing and administering nine medications to Resident 2. The medications included tobramycin (to treat eye infections) 0.3% eye drops. During an observation on July 30, 2024 at 10:03 a.m. in Resident 2's room, LVN 1 administered one drop of tobramycin into Resident 2's left eye and then one drop into the right eye. During a review of Resident 2's electronic medical record, the record indicated a physician's order dated June 3, 2024 for tobramycin sulfate 0.3% eye drops, to be administered as one drop every 12 hours for red right eye. During a concurrent interview and record review on July 30, 2024 at 11:19 a.m. with LVN 1, Resident 2's physician's orders were reviewed. LVN 1 stated she gave Resident 2 one drop of tobramycin in each eye. When asked to read the physician's orders dated June 3, 2024 for tobramycin eye drops, LVN 1 stated she accidently gave Resident 2 a drop into the left eye. During an interview on July 31, 2024 at 4:19 p.m. with Director of Nursing (DON) regarding Resident 2's tobramycin eye drops given to both eyes, DON stated her expectation is that Resident 2 only gets tobramycin in the right eye as the physician ordered. 1b. During the same medication pass observation on July 30, 2024 at 9:34 a.m., LVN 1 was observed preparing and administering nine medications to Resident 2. LVN 1 had an additional medication, fludrocortisone (to treat low blood pressure) set aside. LVN 1 stated the fludrocortisone would be held because Resident 2's blood pressure (BP) was 107/68 (BP result consists of two numbers: the top number or systolic blood pressure [SBP] and the bottom number or diastolic blood pressure [DBP]). During a review of Resident 2's electronic medical record, the record indicated a physician's order dated June 3, 2024 for fludrocortisone 0.1 milligrams (mg), to be administered via feeding tube (a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach or small intestine) twice a day, hold for SBP greater than 110. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on July 30, 2024 at 11:19 a.m. with LVN 1, Resident 2's physician's orders were reviewed. LVN 1 stated to hold the fludrocortisone for SBP less than 110. When asked to re-read the physician's orders dated June 3, 2024 for fludrocortisone, LVN 1 acknowledged that the orders indicated to hold for SBP greater than 110 and stated she would clarify the orders. During an interview on July 30, 2024 at 11:31 a.m. with LVN 1, LVN 1 stated she was supposed to give fludrocortisone to Resident 2 this morning because the blood pressure was lower than the hold parameters. During an interview on July 31, 2024 at 4:19 p.m. with the Director of Nursing (DON) regarding Resident 2's fludrocortisone, the DON stated her expectation is nursing staff give medications if the parameters are met as ordered by the physician. The DON stated Resident 2's fludrocortisone should have been given with SBP reading of 107. 2. During a medication pass observation on July 31, 2024 at 8:24 a.m., registered nurse (RN) 1 was observed preparing and administering ten medications to Resident 5. The medications included two packets of Phos-NaK (supplement with sodium, potassium, and phosphorous) powder. RN 1 poured the two packets into a cup and diluted with water. RN 1 stated she added about 30 milliliters (ml) of water to the powder before giving to Resident 5 via feeding tube. During a review of Resident 5's electronic medical record, the record indicated there was a physician's order dated November 13, 2023 for Phos-NaK, two packets to be administered via feeding tube every 12 hours. During a review of Resident 5's Phos-NaK package labeling, undated, each packet indicated, .Directions: Mix contents of 1 packet with 2.5 ounces (75 ml) of water or juice. Stir well . During a review of Lexicomp Online (a nationally recognized drug information resource), updated May 9, 2024, the Phos-NaK monograph (a document that describes a medication's uses, dosing, and administration) indicated, .Each packet must be diluted in 75 mL of water or juice prior to administration; stir well . During an interview on July 31, 2024 at 10:20 a.m. with RN 1, RN 1 stated she gave 40 ml of water with Resident 5's Phos-NaK. When shown the Phos-NaK labeling indicating to add 75 ml of water to each packet, RN 1 stated she would need to check the directions with someone. RN 1 stated she did not receive any training on how to dilute Phos-NaK for feeding tube administration. During an interview on July 31, 2024 at 4:19 p.m. with DON, regarding Resident 5's Phos-NaK, DON stated the expectation is for the nurse to follow the dilution directions or check with the pharmacy if directions are not specified in the orders. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated, March 2024, the P&P indicated, Medication is considered to be given in error if any of the following conditions are present .Wrong dose .Omission of a dose .

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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** 41459 Based on observation, interview, and record review, the facility failed to ensure food safety requirements for food storage and sanitary food preparation were followed in the kitchen when: 1. Multiple items in the walk-in refrigerator, freezer, and dry storage area were not labeled and/or left open to air; 2. Multiple kitchen equipment and areas in the kitchen were not clean; 3. Cooking pans were stacked wet with puddle of water at the bootom of each pot; and 4. Freezers 2 and 3 had ice buildup on the floors. This failure had the potential to place the residents at risk for foodborne illness or to receive an incorrect food or outdated food items. Findings: On [DATE], at 9:50 a.m. an initial tour of the kitchen was conducted with the weekend Dietary Aide (DA), Dietary Supervisor (DS) , and the Deputy Regional Director (DRD). The following were observed: - In walk in refrigerator 4 (four), 4 bags of red grapes and 8 heads of green leafy lettuce stored in plastic containers without a lid, open to air. Dietary Aide 1 (DA1) stated the food should never be stored open to air." - In walk in refrigerator 1, 1 (one) gallon of lime juice opened, not labeled with open date. The DS confirmed the juice did not have a label with open date; - In walk in refrigerator 1, 1 (one) gallon of lime juice with an expiration date of [DATE]. The DS confirmed that the lime juice was expired risking food borne illness. - In freezer 2, 1 (one) large vacuum sealed pork was not labeled or dated. The DS and DRD confirmed that the pork was not labeled or dated risking food borne illness; - In kitchen, on shelf above sink, 4 (four) large containers of spices being used, not labeled with open date. The DA, DS, and DRD all confirmed the spices should all be labeled; - In dry storage area on shelf, a 5-pound (lb - a unit of measurement) bag of Cinnamon Strudel Topping Mix not labeled, left open to air. The DS confirmed that the Strudel Topping Mix was not labeled and open to air risking food borne illness; - On shelf outside of dry storage area, 7 stainless steel pans stacked upright and wet. The DS confirmed it was not appropriate to stack wet cooking equipment that it risks cross contamination and risk of food borne illness. The DS stated this could collect particles of debris and store bacteria.; (continued on next page)

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Hemet Valley Healthcare Center	371 North Weston Pl Hemet, CA 92543

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One used black rubber glove left on a cooking prep table across from one of the warming ovens. The Prep [NAME] stated, the glove should not be laying there risking cross contamination. - On rack above table between ovens, 2 oven mitts observed hanging, tattered with batting exposed. The DS and DRD agreed the oven mitts risked material falling into food which is a risk of harm to residents; - The stainless steel shelf above one oven was observed to have peeling plastic and small loose white particles. The DRD agreed the peeling plastic and small loose particles could put residents at harm; and - Freezer 3 was observed to have thick patches of ice on the freezer floor. The DRD stated the ice build up is unacceptable and would be fixed. On [DATE], at 10:51 AM an interview was conducted with the DS who stated the kitchen staff should always label the food items showing the date received and the date opened on all the items to prevent food borne illness or harm to the residents. On [DATE], at 11:17 a.m., Freezer 3 was still observed with ice build up on the floor. The facility had contacted an engineer to resolve the problem. On [DATE], at 11:17 a.m., A review of the policy and procedure titled, Food Storage, revised [DATE], indicated, .Manufacturer's expiration,use by, or sell by dates must be adhered to .Dry food which is opened or removed from original packaging, should be stored properly covered, in food grade containers and clearly labeled .spices, extracts, and or seasonings may be labeled with opened date and are to be used within the natural shelf life .Frozen meats are to be discarded 3 months from received date . A review of the policy and procedure titled, Preventing Transmission of Disease,revised [DATE], indicated, . all food and nutrition service employees are educated as to the relationship between personal hygiene and food safety to include the association of hand hygiene/contact, personal habits and behaviors, and food employee health to foodborne illnesses . A review of the policy and procedure titled, FNS Cleaning and Sanitation Program revised ,d+[DATE], indicated . Food Service Director develops cleaning schedules for all department services wares, equipment, walls, ceilings, floors, storage racks, and vents .it is the responsibility of the Food and Nutrition Services General Manager to ensure this work is performed on a routine basis .

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 40988 Based on interview and record review, the facility failed to electronically submit staffing information based on payroll data to the Federal (Center for Medicare & Medicaid Services- CMS) database for the second Fiscal Quarter (FQ) of the year. This failure had the potential to result in inaccuracy of numbers of Direct Care Staff needed to provide care to residents. This failure also prevented the provision of complete and accurate direct care staffing information to the public. Findings: A review of the CMS PBJ (pay roll based journal) Staffing Data Report CASPER (Certification and Survey Provider Enhanced Report) FY (fiscal year) Quarter 2 (January 1- March 31) indicated, .Failed to submit Data for the Quarter . During an interview on with the Director of Nursing Services (DON) on July 30, 2024, at 2:30 p.m., the DON stated the Infection Preventionist (IP) was also was responsible for submitting the report to CMS. However, during the said reporting period, the facility was having several issues with staffing and she and the IP were still transitioning in their roles, hence the data was not submitted timely. The DON stated the data should have been submitted timely. A review of CMS' Electronic Staffing Data Submission Payroll-Based Journal: Long-Term Care Facility Policy Manual, Version 2.6., dated June 2022, indicated, .Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate . Staffing and census data will be collected for each fiscal quarter (FQ 1 is from October 1-December 31; FQ 2 is from January 1-March 31; FQ 3 is from April 1-June 30; FQ4 is from July 1-September 30) . Submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely .

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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** 41459 49613 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. One out of four licensed nurses used her finger to check the water temperature before use for diluting medications and flushing the feeding tube (a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach or small intestine) for Resident 2; 2. Two out of four nurses did not perform hand hygiene before administering eye drops to Residents 2 and 5; and 3. One suction canister was found not labeled or dated. These failures had the potential to spread infections between residents and staff. Findings: 1. During a medication pass observation on July 30, 2024 at 9:34 a.m., Licensed Vocational Nurse (LVN) 1 was observed putting on a pair of gloves and preparing nine medications, including feeding tube medications and eye drops, for Resident 2 outside the resident's room. Wearing the same gloves, LVN 1 entered the room and filled up the water pitcher at the sink. LVN 1 then put her gloved finger in the water inside the water pitcher and stated she wanted to make sure the water was warm enough for the resident. LVN 1 stated the water is used to dilute the medications and was observed pouring the water from the pitcher to dilute Resident 2's medications for administration. The same water was used to flush out Resident 2's feeding tube between each medication given. During an interview on July 30, 2024 at 11:26 a.m., with LVN 1, LVN 1 verified she used her finger to check the temperature of the pitcher water. LVN 1 stated she did this to make sure the water was not too hot for the resident or too cold for diluting the medications. During an interview on July 31, 2024 at 11:08 a.m. with the Infection Preventionist (IP), the IP stated it was not acceptable for a nurse to put their finger in the water pitcher. The IP stated this was an infection control issue and the nurse contaminated the water. During an interview on July 31, 2024 at 4:36 p.m., the Director of Nursing (DON), the DON stated the nurse should not have put her finger in the water pitcher. The DON stated this practice was an infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. During the same medication pass observation on July 30, 2024 at 9:34 a.m. for Resident 2, LVN 1 was observed putting on a pair of gloves and preparing nine medications, including feeding tube medications and eye drops, for Resident 2 outside the resident's room. Wearing the same gloves, LVN 1 entered the room and filled up the water pitcher at the sink. LVN 1 proceeded to administer feeding tube medications to Resident 2. LVN 1 then administered the eye drops as one drop into each of Resident 2's eyes, all without changing gloves or performing hand hygiene. During an interview on July 30, 2024 at 10:11 a.m. with LVN 1, LVN 1 stated she put on one pair of gloves before entering Resident 2's room and discarded the same pair of gloves after medication pass was complete. LVN 1 stated there were no gloves in Resident 2's room so she couldn't change her gloves and stated she was supposed to change gloves between residents. During an interview on July 30, 2024 at 11:31 a.m. with LVN 1, LVN 1 stated she was supposed to change her gloves after giving feeding tube medications and before giving eye drops to Resident 2. 2b. During a medication pass observation on July 31, 2024 at 8:24 a.m., registered nurse (RN) 1 was observed preparing and administering ten medications to Resident 5, including feeding tube medications and eye drops. RN 1 administered the last feeding tube medication wearing gloves. RN 1 then removed her gloves and immediately put on a new pair of gloves without performing hand hygiene. RN 1 then administered the eye drops as one drop into each of Resident 5's eyes. During an interview on July 31, 2024 at 10:20 a.m. with RN 1, RN 1 stated nurses are supposed to wash or sanitize hands before taking care of a patient and when hands are soiled. RN 1 stated she did not perform hand hygiene during Resident 5's medication pass because her hands were not soiled. RN 1 verified she did not need to wash her hands after changing gloves unless her hands were soiled. During an interview on July 31, 2024 at 11:08 a.m. with the IP, the IP stated the expectation is nurses perform hand hygiene by either washing or sanitizing their hands before administering eye drops. The IP stated after giving feeding tube medications, the nurse was supposed to remove gloves, wash or sanitize hands, put on new gloves, and then give eye drops. During an interview on July 31, 2024 at 4:36 p.m., with the DON, the DON stated the expectation was after giving feeding tube medications, the nurses removed their gloves, used hand sanitizer, put on new gloves, and then administer the eye drops. The DON stated there was a risk of transferring infections to eyes. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene Five Moments, dated, April 2024, the P&P indicated:, .5 Moments for HAND HYGIENE for Healthcare Providers Before clean/aseptic procedure .After body fluid exposure risk .Gloves should not be worn in the place of hand hygiene . 3.On July 28, 2024 at 11:12 a.m., Resident 15 was observed lying in bed, with trach (to allow air to fill the lungs patent and intact attached to oygen. There was a suction canister at the wall of the back of the bed which was not labeled or dated. On July 28, 2024, Resident 15's record was reviewed. Resident 15 was admitted to the facility on [DATE] with a diagnosis of respiratory failure (a condition where you don't get enough oxygen). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On July 28, 2024, at 12:40 p.m., an interview was conducted with the Respiratory Therapist (RT). The RT confirmed the suction cannister of Resident 15 did not have a label and was not dated. The RT stated the suction cannisters should have a label and date to know when to change them. The suction cannisters are to be changed every two weeks and as needed. A review of the policy and procedure titled, Resident Equipment Change revised on March 3, 2024, indicated, .supplies will be labeled .suction canisters are changed every other week or when 2/3 (two third) full or PRN (as needed) .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on observation, interview, and record review the facility failed to ensure a safe and sanitary environment was provided, when two (2) air vents above Resident 17 and 107's beds were found to be stained with dark colored dust particles. This failure had the potential to cause and/or worsen medical conditions of the residents who have respiratory conditions which could lead to respiratory distress. Findings: On July 30, 2024, at 10:30 a.m., a concurrent observation and interview was conducted with the Director of Nursing DON) and the Deputy Regional Director (DRD) confirmed that there was staining and dark colored dust particles coming for the air vents above bed of 409A and 410A and that these particles could cause harm to the residents. On July 30, 2024 Resident 17 record was reviewed. Resident 17 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure (not enough oxygen in the blood). On July 30, 2024 Resident 170 record was reviewed. Resident 170 was admitted to the facility on [DATE], with a diagnosis of respiratory failure. On July 30, 2024, at 10:55 a.m., an interview was conducted with the Director of Facility (DOF). The DOF stated, We are planning to place new covers on the vents." A review of the policy and procedure titled, Environment of Care, revised March 2021, indicated, .Hazards that are identified are expected to be resolved within a reasonable timeframe .Hazards that pose an imminent danger to life or property must be corrected immediately .