STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Diego Post-Acute Center	1201 South Orange Ave. El Cajon, CA 92020

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interviews and facility documents review, the facility failed to ensure a safe discharge for one of four sampled residents, reviewed for closed record (Resident 80). This failure had the potential to compromise Resident 80's health, safety and well-being and, as a result, Resident 80 was admitted to an acute care hospital on 2/16/25. Findings: Resident 80 was readmitted to the facility on [DATE], with diagnoses which included encephalopathy (disease that affects the brain), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), infection of the skin and subcutaneous tissue and, that he needed assistance with personal care, per the facility's Admission Record. On 2/25/25, a review of Resident 80's clinical record was conducted. Resident 80's attending physician completed Resident 80's history and physical (H&P) dated 11/1/24. The H & P indicated Resident 80 did not have the capacity to understand and make decisions. Resident 80's minimum data set (MDS - a federally mandated resident assessment tool), completed 11/29/24, indicated Resident 80's brief interview for mental status (BIMS, ability to recall) score was 0/15 (a score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). Resident 80's MDS for functional abilities such as toileting, showering, lower body dressing and putting on/ taking off/ footwear indicated Resident 80 needed moderate staff assistance which meant the helper (staff) does less than half the effort. Resident 80's MDS under section bladder and bowel indicated Resident 80 was frequently incontinent on bladder and bowel. Resident 80's nursing progress notes and discharge summary completed by Licensed Nurse (LN) 11, dated 2/11/25, indicated Resident 80 was discharged to a hospice (end of life) house and will be followed up by a home health (HH, medical care delivered in the resident's home) service. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 11:13 A.M., a telephone interview was conducted with hospice house owner (HHO). The HHO stated he had independent living facility (ILF, Independent living is designed for seniors who can still live independently, without the 24-hour support from trained caregivers and nurses) not a hospice house. The HHO stated the social service director (SSD) contacted him, informed him about Resident 80's discharge and received Resident 80 to the ILF on 2/11/25. The HHO stated Resident 80's insurance benefits were exhausted and was not eligible for hospice care. The HHO stated the SSD did not inform Resident 80's insurance was exhausted. On 2/25/25 at 12:21 P.M., a telephone interview was conducted with the HH service director (HHSD). The HHSD stated Resident 80 was not referred for home health services. On 2/26/25 at 2:01 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated Resident 80 had a lot of hallucinations (a false perception of objects or events involving your senses: sight, sound, smell, touch and taste), and a lot of agitation towards staff. CNA 11 stated Resident 80 was bedbound, incontinent on both bowel and bladder and was dependent to staff in his activities of daily living (ADL, self- care activities such as grooming, toileting, etc.). On 2/26/25 at 2:09 P.M., a joint review of Resident 80's clinical record, and an interview with LN 11 was conducted. LN 11 stated Resident 80's capacity to make decisions was in question and could only make his needs known. LN 11 stated Resident 80 was dependent to staff in his ADLs. Per LN 11, the discharge plan for Resident 80 was made by the interdisciplinary team (IDT, group of health care professionals to plan, coordinate and deliver a patient's personalized health care). LN 11 stated Resident 80 was discharged to hospice house on 2/11/25 with a home health service. On 2/26/25 at 3:55 P.M., a joint review of Resident 80's clinical record, and an interview with SSD was conducted. The SSD stated should had she known the hospice house was an ILF, she had not sent Resident 80 to the place. On 2/27/25 at 1:02 P.M., a joint review of Resident 80's clinical record, and an interview with the acting Director of Nursing (aDON) and Assistant DON (ADON) was conducted. The ADON stated Resident 80 had a gradual decline in his cognition from he was able to make his own decision on 1/22/24 to not able to make his own decisions on 11/1/24. The ADON stated the IDT made the decision to discharge Resident 80 to a hospice house. The ADON stated there was no documentation the HHO came to evaluate and if the HHO was able to take care of Resident 80 prior to discharge to the receiving facility. The ADON stated Resident 80's discharge care plan indicated long term care to current facility. The ADON and the aDON stated there was not enough documentation Resident 80 would get enough care where he was supposed to be discharged . The aDON stated it was to ensure the resident was discharged safe. A review of the facility's policy titled, Discharging the Resident, revised 12/2016 was conducted. The policy did not indicate a safe discharge of a cognitively impaired and a dependent resident.

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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 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** 40610 Based on interview and record review, the facility failed to implement a care plan (detailed plan with information about a patient's treatment, goal, and interventions) related to nail care for two of four sampled residents (90 and 131). This failure had the potential to not meet the goals of treatment and needs of Resident 90 and Resident 131. Cross reference to F 677 Findings: 1.Resident 90 was readmitted to the facility on [DATE], with diagnoses which included parkinsonism (a brain disorder that causes unintended or uncontrollable movements) and that he needed assistance with personal care, per the facility's Admission Record. Resident 90's attending physician completed Resident 90's history and physical (H&P) dated 12/16/24. The H & P indicated Resident 90 had the capacity to understand and make decisions. On 2/24/25 at 9:44 A.M., an observation and an interview of Resident 90 was conducted in his room. Resident 90 was watching a television show. Resident 90 had a contracted right hand with long fingernails. Resident 90 stated he was fine. On 2/26/25 at 10:49 A.M., a follow up observation and an interview of Resident 90 was conducted in his room. Resident 90 was watching a television show. Resident 90 still had pointed long fingernails in his contracted right hand. Resident 90 stated his nails were cut couple of weeks ago. On 2/26/25 at 2:28 P.M., a joint review of Resident 90's clinical record and an interview with Licensed Nurse (LN) 11 was conducted. LN 11 stated Resident 90's care plan dated 8/17/24, indicated one of the interventions was, nurse to trim nails. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the care plan should have been followed and verified if it was implemented because the care plan directed the care provided to the residents. A review of the facility's policy titled, care Plans, Comprehensive Person- Centered, revised 3/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to [NAME] the resident's physical .and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan: a. includes measurable objectives .b. describes the services that are to be furnished to attaint or maintain the resident's highest practicable physical .well-being . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 131 was readmitted to the facility readmitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis that affects only one side of your body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) and that he needed assistance with personal care, per the facility's Admission Record. Resident 131's attending physician completed Resident 131's history and physical (H&P) dated 10/8/24. The H & P indicated Resident 131 did not have the capacity to understand and make decisions. On 2/24/25 at 9:17 A.M., an observation and an interview of Resident 131 was conducted in his room. Resident 131 laid in bed. Resident 131 was unable to express words and muttered incomprehensible words. Resident 131 had long fingernails with black materials underneath all fingernails. On 2/26/25 at 9:19 A.M., a follow up observation of Resident 131 was conducted in his room. Resident 131's hands were exposed with long fingernails and black materials underneath all fingernails. On 2/26/25 at 9:32 A.M., a joint observation of Resident 131 and an interview with Certified Nursing Assistant (CNA) 11 was conducted. CNA 11 stated Resident 131's fingernails were long and dirty. CNA 11 stated he had no idea who trim Resident 131's fingernails. On 2/26/25 at 2:28 P.M., a joint review of Resident 131's clinical record and an interview with Licensed Nurse (LN) 11 was conducted. LN 11 stated Resident 131's care plan dated 6/11/24, indicated one of the interventions was, Trim nails with bathing schedule. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the care plan should have been followed and verified if it was implemented because the care plan directed the care provided to the residents. A review of the facility's policy titled, care Plans, Comprehensive Person- Centered, revised 3/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to [NAME] the resident's physical .and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan: a. includes measurable objectives .b. describes the services that are to be furnished to attaint or maintain the resident's highest practicable physical .well-being .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility failed to provide treatment in accordance with the facility's policy and procedure when a Licensed Nurse (LN) 12 did not use warm, purified water and completely diluted a resident's (Resident 141) medications during the administration of medications via a gastrostomy tube (g-tube, a tube inserted through the belly that brings nutrition or medications [med/s] directly to the stomach). This failure had the potential for not meeting Resident 141's therapeutic needs and had the potential of clogging the g-tube. Findings: A review of Resident 141's Admission Record indicated Resident 141 was readmitted to the facility on [DATE], with diagnoses which included she had a g-tube for medications and nutrition. During a medication pass observation on 2/26/25, at 7:46 A.M., with Licensed Nurse 12 (LN 12), LN 12 was observed preparing four tablet medications and three liquid medications for Resident 141. LN 12 put gloves on, crushed Resident 141's meds and placed each med in a med cup. With gloved hands, LN 12 went to Resident 141's bathroom and filled the empty cups with water from the bathroom sink. After coming out from the bathroom, LN 12 proceeded with the task, disconnected the tube feeding from Resident 141's g-tube, checked Resident 141's g-tube placement, placed the 60 ml syringe to Resident 141's g-tube. LN 12 then flushed the g-tube with water, administered the orange liquid meds, and flushed with water. While the orange liquid meds and the water were being administered through gravity, LN 12 put some water to the crushed med from another med cup, swirled the crushed med with water, administered the crushed med in Resident 141's g-tube, and flushed with water. This time, the meds and the water did not go through the g-tube through gravity, LN 12 then pushed the med with the plunger, the meds and the water still did not go through. LN 12 aspirated the water from the syringe, then placed the water from the syringe back to the plastic cup. LN 12 stated Resident 141's g-tube was clogged. LN 12 then milked (compressing the tube with the fingers and moving them along the course of the tube) the tube towards the resident with an ointment. LN 12 aspirated the syringe and removed a small amount of administered crushed meds from the small tube of the g-tube. LN 12 then received a declogger (a safe, flexible threaded device that bores through occlusions to quickly restore nutrition and medication to patients with obstructed enteral tube), placed the declogger into Resident 141's g-tube and LN 12 maneuvered the declogger back and forth to the g-tube, then flushed the g-tube with water, until the water went through with gravity. LN 12 administered the remaining crushed meds by swirling the crushed meds with water in the med cup. One white powder medication remained in the bottom of the med cup. LN 12 stated that was the lactobacillus. On 2/26/25 at 10:56 A.M., an interview was conducted with LN 12. LN 12 stated she got the water from the bathroom sink and forgot to bring a spoon to stir the crushed meds to fully dissolve the meds. LN 12 stated it was important to completely dilute and fully dissolved the crushed meds because it could stay in the tubing, the resident would not able to get the complete med, the meds would clump, and the g-tube would clog. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the expectation was for LN 12 to mix the crushed meds with water, the water should not be coming from the bathroom and used a spoon to fully dissolve the medications to ensure the resident gets the right amount of meds and to prevent clogging the resident's g-tube. A review of the facility's policy, titled Administering Medications through an Enteral Tube, revised 11/2018, indicated. The purpose of this procedure is to provide guidelines for the safe administration of medication through an enteral tube .General Guidelines .6. Use warm, purified water for diluting medications and for flushing .Steps .3. Follow .procedures for crushing, diluting and/ or mixing prior to administration .9. Dilute medication .b. Dilute crushed (powdered) medication with at least 30 ml purified water (or prescribed amount).

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40610

Based on observation, interview, and record review, the facility failed to ensure two of four residents (Resident 90 & Resident 131), who were unable to carry out activities of daily living (ADL-self- care activities such as personal hygiene), received assistance with nail care (cleaning, trimming and/or filing of nails).

This failure resulted in Resident 98 and Resident 131 having long fingernails which had the potential to negatively impact the residents' hygiene, health and well-being.

Cross reference to F 656

Findings:

1.Resident 90 was readmitted to the facility on [DATE], with diagnoses which included parkinsonism (a brain disorder that causes unintended or uncontrollable movements) and that he needed assistance with personal care, per the facility's Admission Record.

Resident 90's attending physician completed Resident 90's history and physical (H&P) dated 12/16/24. The H & P indicated Resident 90 had the capacity to understand and make decisions.

Resident 90's minimum data set (MDS - a federally mandated resident assessment tool), completed 1/27/25, indicated Resident 90's brief interview for mental status (BIMS, ability to recall) score was 15/15 (a score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). Resident 90's MDS for functional abilities for personal hygiene indicated Resident 90 needed maximal staff assistance which meant the helper (staff) does more than half of the effort.

On 2/24/25 at 9:44 A.M., an observation and an interview of Resident 90 was conducted in his room. Resident 90 was watching a television show. Resident 90 had a contracted right hand with long fingernails. Resident 90 stated he was fine.

On 2/26/25 at 10:49 A.M., a follow up observation and an interview of Resident 90 was conducted in his room. Resident 90 was watching a television show. Resident 90 still had pointed long fingernails in his contracted right hand. Resident 90 stated his nails were cut couple of weeks ago.

On 2/26/25 at 2:28 P.M., a joint review of Resident 90's clinical record and an interview with Licensed Nurse (LN) 11 was conducted. LN 11 stated Resident 90's care plan dated 8/17/24, indicated one of the interventions was, nurse to trim nails. LN 11 stated the LNs were responsible to trim and clean the residents' nails for infection prevention, safety of the residents, for hygiene and for residents' dignity.

On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the expectation was for the nursing staff to keep residents' nail cleaned and trimmed for safety of the residents, for infection prevention, for their dignity, appearance and hygiene.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Activities of Faily Living (ADL), Supporting, revised 3/2018, indicated, . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good .grooming and personal .hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including appropriate support and assistance with: a. hygiene . 2. Resident 131 was readmitted to the facility readmitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis that affects only one side of your body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) and that he needed assistance with personal care, per the facility's Admission Record. Resident 131's attending physician completed Resident 131's history and physical (H&P) dated 10/8/24. The H & P indicated Resident 131 did not have the capacity to understand and make decisions. Resident 131's minimum data set (MDS - a federally mandated resident assessment tool), completed 1/9/25, indicated Resident 131's brief interview for mental status (BIMS, ability to recall) score was 0/15 (a score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). Resident 131's MDS for functional abilities for personal hygiene indicated Resident 131 needed maximal staff assistance which meant the helper (staff) does more than half of the effort. On 2/24/25 at 9:17 A.M., an observation and an interview of Resident 131 was conducted in his room. Resident 131 laid in bed. Resident 131 was unable to express words and muttered incomprehensible words. Resident 131 had long fingernails with black materials underneath all fingernails. On 2/26/25 at 9:19 A.M., a follow up observation of Resident 131 was conducted in his room. Resident 131's hands were exposed with long fingernails and black materials underneath all fingernails. On 2/26/25 at 9:32 A.M., a joint observation of Resident 131 and an interview with Certified Nursing Assistant (CNA) 11 was conducted. CNA 11 stated Resident 131's fingernails were long and dirty. CNA 11 stated he had no idea who trim Resident 131's fingernails. On 2/26/25 at 2:28 P.M., a joint review of Resident 131's clinical record and an interview with Licensed Nurse (LN) 11 was conducted. LN 11 stated Resident 131's care plan dated 6/11/24, indicated one of the interventions was, Trim nails with bathing schedule. LN 11 stated the LNs were responsible to trim and clean the residents' nails for infection prevention, safety of the residents, for hygiene and for residents' dignity. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the expectation was for the nursing staff to keep residents' nail cleaned and trimmed for safety of the residents, for infection prevention, for their dignity, appearance and hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Activities of Faily Living (ADL), Supporting, revised 3/2018, indicated, . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good .grooming and personal .hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including appropriate support and assistance with: a. hygiene . On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the care plan should have been followed and verified if it was implemented because the care plan directed the care provided to the residents. A review of the facility's policy titled, care Plans, Comprehensive Person- Centered, revised 3/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to [NAME] the resident's physical .and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan: a. includes measurable objectives .b. describes the services that are to be furnished to attaint or maintain the resident's highest practicable physical .well-being .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record review, the facility failed to ensure a smoking assessment was accurate on 1 out of 8 residents (Resident 54) reviewed for accidents. This failure had the potential to place Resident 54 at risk for injury. Findings: Resident 54 was admitted to the facility on [DATE] , with diagnoses which included chronic obstructive pulmonary disease (lung disease with difficulty of breathing) and dementia (progressive state of decline in mental abilities) per the Admission Record. On 2/27/25 at 9:55 A.M., an interview with Resident 54 was conducted. Resident 54 was alert and was seen on his way walking towards the patio. Resident 54 stated, I was going out to smoke outside, I have been smoking for years. A record review of Resident 54's Minimum Data Set (MDS- a federally mandated assessment tool) dated 2/1/25 with a Brief Interview for Mental Status (BIMS-Cognition assessment used by skilled nursing facilities) score of 09 which indicated Resident 54's cognition was moderately impaired. A record review of Resident 54's smoking assessment dated [DATE] indicated Resident 54 denied smoking or use of all tobacco products. A record review of Resident 54's history and physical dated 1/27/25 indicated Resident 54 was a smoker. A record review of the facility's smoking list dated 2/21/25 indicated Resident 54 was a smoker. An interview on 2/27/25 at 9:58 A.M., with Licensed Nurse (LN) 41 was conducted . LN 41 stated Resident 54 does smoke and goes out in the smoking area or patio. An interview on 2/27/25 at 10:00 A.M. with Hospitality Aide 42 (HA) was conducted. HA 42 stated she was assigned to Resident 54 to watched him and Resident 54 does go out to the patio/ smoking area to smoke cigarettes. A review of the facility's smoking policy dated October 2023 , indicated .#7 resident smoking status is evaluated upon admission .#9 a resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility staff failed to monitor and document urine output (UO) per the facility's policy, for one of three sampled residents (Resident 141) with a urinary catheter (a tube inserted into the bladder to aid in urine flow). This failure had the potential for Resident 141 to have urinary retention and developed urinary tract infection (UTI). Findings: Resident 141 was readmitted to the facility on [DATE], with diagnoses which included functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord) and UTI, per the facility's Admission Record. On 2/24/25 at 8:15 A.M., an observation of Resident 141 was conducted in her room. Resident 141 was connected to a breathing machine via a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe) tube. Resident 141 did not respond to her name. Resident 141 had a urinary catheter attached to the side of the bed rail with white sediments noted in the urinary tubing. On 2/26/25 at 11:11 A.M., a joint review of Resident 141's clinical record and an interview was conducted with Licensed Nurse (LN) 12. LN 12 stated Resident 141 was in a vegetative state (when a person is awake but shows no signs of awareness). LN 12 stated the attending physician for Resident 141 had an order for a urinary catheter for Resident 141. LN 12 stated there was no physicians order to monitor Resident 141's output. LN 12 stated urinary output was measured when a resident had a urinary catheter to ensure the catheter was functioning well. LN 12 stated Resident 141's urinary output was not measured. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the expectation was to make sure the urinary output was measured to ensure the resident had enough urine output. A review of the facility's policy titled, Catheter Care, Urinary, revised 8/2022, indicated, The purpose of this procedure is to prevent urinary catheter -associated complications, including urinary tract infections .Input/ Output, 1. Observe the resident's urine level for noticeable increases or decreases .2. Follow the facility procedure for measuring and documenting input and output .

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review the facility failed to restart Resident 39's (R39) continuous oxygen after transferring her from wheelchair to bed. This failure had the potential to affect the R39's respiratory health. Findings: Review of R39's Admission Record indicated that resident was admitted on [DATE] for diagnoses which include Chronic Obstructive Pulmonary Disease (COPD-a group of lung diseases that cause persistent airflow limitation and breathing problems) and Congestive Heart Failure (CHF-chronic condition where the heart muscle is weakened and cannot pump blood effectively.) Review of Minimum Data Set(MDS-Federally mandated assessment tool) section C indicated R39 has a Brief Interview for Mental Status (BIMS- a screening tool that assesses a person's cognitive impairment) Score of 10 which indicates moderate cognitive impairment. Review of physician order from 10/5/25 indicated O2 (Oxygen) 2 Liters NC (Nasal Cannula-a thin, flexible tube that delivers oxygen through the nose) continuous . Review of R39's Care Plan indicated, Focus .Oxygen: Resident requires use of oxygen, continuous, high concentration related to DX(Diagnosis): CHF .Interventions .Administer Oxygen as ordered . On 2/24/25 at 3:09 P.M., during initial pooling, an observation of R39's oxygen machine was conducted. Interview with R39 was attempted, but resident was nonverbal. R39 had nasal cannula in her nostrils, but oxygen machine was turned off. On 2/24/25 at 3:12 P.M., a concurrent interview with Licensed Nurse 21 (LN21) and observation of R39's oxygen machine was conducted. LN21 restarted oxygen for R39 at ordered rate of 2 Liters. LN21 stated that the expectation was for all staff to check oxygen after transfers, and it was responsibility of all staff to make sure oxygen was maintained as ordered. LN21 stated that the importance of maintaining oxygen as ordered was to make sure residents who need oxygen are not deprived of ordered oxygen. Review of Nurse's note from 2/24/25 at 3:15 P.M. indicated Resident was observed without supplemental oxygen for a period of 30 minutes . Review of policy titled OXYGEN ADMINISTRATION, dated 2001 indicated .Steps in the procedure .8. Turn on oxygen .10. Adjust oxygen delivery device so that it is comfortable for the resident and proper flow of oxygen is being administered .13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated .

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview and record review, the facility failed to ensure a resident was free from unnecessary medication when a resident (Resident 93) was receiving heparin (blood thinner that prevents blood clotting, one side effect is bruising or bleeding) and was not monitored for signs and symptoms of bruising/ bleeding for one of two sampled residents reviewed for anticoagulant. This failure could result in medication related adverse events from inconsistent and poor management of medication therapy for Resident 93. Findings: Resident 93 was readmitted to the facility on [DATE], with diagnoses which included functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), per the facility's Admission Record. On 2/24/25, a review of Resident 93's clinical record was conducted. There was a physician's order on 10/24/24 for heparin injection 5000 units (unit of measurement) with the direction to inject the resident 5000 units subcutaneously (injected under the layers of the skin) every 8 hours for prevention of blood clots. There was no physicians order and documentation of monitoring for signs and symptoms of bleeding or bruising related to heparin use. On 2/26/25 at 11:28 A.M., a joint review of Resident 93's clinical record and an interview was conducted with Licensed Nurse (LN) 12. LN 12 stated Resident 93 had been receiving heparin injection since 10/24/24. LN 12 stated there was no order for monitoring Resident 93 for bleeding and bruising. LN 12 stated Resident 93 should have been monitored for bruising and bleeding for resident's safety. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated when a resident received anticoagulation therapy, the nurses should monitor the resident for bruising and bleeding to ensure the side effect of the medication was addressed and the attending physician was notified for resident safety. A review of the facility's policy titled, Adverse Consequences and Medication Errors, dated 2/2023, indicated, The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions and side effects .1. An adverse consequence refers to an unwanted, uncomfortable or dangerous effect that a drug may have .An adverse consequence may include . b. Side effect .

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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 40610

Based on observation, interview, and record review, the facility failed to indicate the appropriate and measurable target behavior of antidepressant (medication used to treat depression, sad mood and lack of interest) for one of five sampled residents reviewed for unnecessary psychotropic (mind-altering medications) medication use (Resident 45).

This failure had the potential for unnecessary psychotropic medication use, its side effects, and a decline for residents psychological and mental well-being.

Findings:

Resident 45's Admission Record indicated Resident 45 was readmitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations [a false perception of objects or events involving your senses: sight, sound, smell, touch and taste] and delusions, and mood disorder symptoms, such as depression, and mania).

A review of Resident 45's physician order dated 12/26/24 indicated the following order:

- Mirtazapine tablet for depression. AEB [sic, as evidenced by]: verbalizes sadness.

- Mirtazapine - target behavior: depression AEB [sic, as evidenced by]: auditory hallucinations.

On 2/24/25 at 10:52 A.M., an observation and an interview with Resident 45 was conducted in her room. Resident 45 laid in her left side with both legs on the floor. Resident 45 stated she felt sleepy.

On 2/26/25 at 2:42 P.M., a joint review of Resident 45's clinical record and an interview with Licensed Nurse (LN) 11 was conducted. LN 11 stated Resident 45 sometimes was responsive and sometimes she ignored the staff. LN 11 stated Resident 45 was on mirtazapine for depression AEB verbalizing of sadness. LN 11 stated the target behavior in Resident 45's clinical record indicated Resident 45 was monitored for auditory hallucinations. LN 11 stated that was not the correct target behavior for the mirtazapine order. LN 11 stated it was important to monitor the correct target behavior to ensure the medication use was appropriate for its indication.

On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated Resident 45 could verbalize she was sad. The aDON stated the expectation was for the nurses to monitor the appropriate target behavior for the antidepressant used to ensure the medication was effective for its indication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Psychotropic Medication Use, revised 7/2022, indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition .1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior, 2. Drugs in the following categories are considered psychotropic medications and are subject to .monitoring, and review requirements specific to psychotropic medications .b. Anti-depressants .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review the facility failed to prevent a medication error for 1 of 38 residents, (Resident 390). This failure had the potential for harm to Resident 390 (R390) from unnecessary medication. Findings: Review of Admission Record for R390 indicated resident was admitted on [DATE] for diagnoses which include Type 2 Diabetes Mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), morbid obesity (a severe form of obesity characterized by a high body mass index (BMI-a calculation used to estimate body fat percentage based on height and weight) and significant health risks), cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to the death of brain cells), and aphasia (a language disorder that affects a person's ability to communicate effectively). Review of R390's physician orders dated [DATE] indicated Resident is incapable of Understanding Rights, Responsibilities, and Informed Consent. In addition, no insulin or fingerstick orders were indicated for R390. Review of R390's history and physical from [DATE] indicated R390 was alert and oriented x2 (Person and place) with general Left sided weakness. On [DATE] at 11:20 A.M. an interview with Daughter of R390 (DOR) was conducted in R390's room. DOR stated that on the morning of [DATE], R390 was given shot of insulin but was not ordered for R390. DOR stated her mother was okay, and no harm was done. DOR stated that her family reported to the head nurse the evening of [DATE] and that they had a meeting set for 1 P.M. on [DATE] for incident. Record review of License Nurse 25 (LN25) Nurse's Note dated [DATE] at 8:12 P.M. indicated Resident's son notified Writer that at 1100 resident's daughter stated med nurse gave resident 9 units of Aspart (Type of insulin) for BS (Blood Sugar) of 172. Informed resident's family that resident does not have an order for insulin. Notified RP (responsible party-Person responsible for healthcare decisions for patients who are unable to make decisions) and Physician 23(P23) of med error. On [DATE] at 8:15 A.M., a follow-up interview was conducted with DOR. DOR stated R390 had no ill effects of insulin after the medication error. In addition, she and her brother met with Assistant Director of Nursing (ADON)to discuss the medication error on [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:20 A.M., an interview was conducted with Licensed Nurse 24 (LN24). LN24 stated the process for administering insulin was as follows: Follow 5 rights of drug administration. 1. Right patient, 2. Right drug, 3. Right dose, 4. Right time, and 5. Right route. Draw up medication from vial, each vial is in pill container with resident's name. Check Identification (ID) band for resident, if no ID band or resident is confused need two nurses to confirm residents ID. When ID confirmed educate resident what drug is being administered and where they prefer. Clean site and inject. Make sure no side effects of administration, bleeding or low blood sugar. Dispose of needle safely. Hand sanitizer after. Document in Medication Administration Record (MAR). LN24 stated the process for medication error was as follows: Notify the physician, the RP, and the charge nurse. Stay with resident and take blood sugar every 15 minutes until resident BS is stable. If Blood sugar was low obtain order from physician to give glucagon. When stable document in change in condition note and alert charting for 72 hours. On [DATE] at 8:50 A.M. an interview with Unit Manager Nurse (UMN) was conducted. UMN stated that he reported that he was notified by the evening Licensed Nurse 25 (LN25) that the family of R390 reported that the day nurse, License Nurse 26(LN26) gave the resident insulin at 11 A.M., but R390 have no orders for insulin. UMN reported that LN25 charted the medication error, not the day nurse who made the error, LN26. LN25 wrote Change in Condition note, the nurse's progress note, and the alert charting. UMN stated that when he found out about medication error he reported to the ADON that incident had occurred. UMN stated the process for Insulin administration was as follows: Follow 5 rights of drug administration: 1. Right patient, 2. Right drug, 3. Right dose, 4. Right time, and 5. Right route. Check ID band for resident, if no ID band or resident is confused need two nurses to confirm residents ID. Draw up medication from vial, each vial is in pill container with resident's name. When ID was confirmed, LN needs to educate resident what drug is being administered and where they prefer the injection site. LN needs to clean the site and inject insulin. LN needs to make sure that there are no side effects of administration, bleeding or low blood sugar. Dispose of needle safely. Hand sanitizer after. Document in MAR. UMN stated that if insulin was given in error the process would be: Notify the physician, the RP, and the charge nurse. Stay with resident and take BS every 15 minutes until resident blood sugar was stable. If blood sugar was low get order from physician to give glucagon(a hormone that raises blood sugar levels). When blood sugar was stable document in change in condition note and alert charting for 3 days. On [DATE] at 10:12 A.M., an interview with LN26 was conducted. LN26 stated that she had R390 during the day shift on [DATE]. LN26 stated that she had two residents who had very similar profiles, both were new admissions and both had Diabetes Mellitus. LN26 stated that DOR had asked her about R390's blood sugar and she checked the order on the MAR on the wrong resident. LN26 stated she gave insulin based on the other resident's order. LN26 stated that she did not know she made the mistake until told later that evening by ADON. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LN26 stated the normal process for giving insulin was: Follow 5 rights of drug administration:1. Right patient, 2. Right drug, 3. Right dose, 4. Right time, and 5. Right route. Check ID band for resident, if no ID band or resident is confused need two nurses to confirm resident's ID. Draw up medication from vial, each vial is in pill container with resident's name. When ID confirmed educate resident what drug is being administered and where they prefer. Clean site and inject insulin. Make sure no side effects of administration, bleeding or low blood sugar. Dispose of needle safely. Hand sanitizer after. Document in MAR. LN26 stated the process if insulin was given in error would be: Notify the physician, the RP, and the charge nurse. Stay with resident and take BS every 15 minutes until resident blood sugar was stable. If blood sugar was low get order from physician to give glucagon (a hormone that raises blood sugar levels). When blood sugar was stable document in change in condition note and alert charting for 3 days. On [DATE] at 10:45 A.M. an interview with the ADON and the Acting Director of Nursing (aDON) was conducted. The ADON and aDON stated that the expectation is that prior to giving any medication, the resident's ID should be checked against ID band or if no ID present verify with two nurses and the documentation in MAR. The ADON and aDON stated the importance of correctly identifying a resident before administering medications is to prevent medication errors. Review of facility policy titled ADVERSE CONSEQUENCES AND MEDICATION ERRORS, dated 2001 indicated .1. A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders .2. Examples of medications errors include .Unauthorized use-a drug administered without a physician's order .4. Monitor the resident for medication-related adverse consequences when there is a (an): .f. Medication Error, e.g. wrong or expired medication .6. Promptly notify provider of any significant error. 7. Implemented the provider orders and monitor resident for 24 to 72 hours, or as directed .

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40610

Based on observation, interview, and record review, the facility failed to ensure:

1. The temperature was consistently monitored and documented for one of two medication (med/s) refrigerators, one of one utility room, and one of one utility refrigerator,

2. An opened multi dose flu vaccine was dated with an opened date and an opened inhaler was not labeled and dated,

3. discharged resident medications were kept after more than 30 days and commingled with active resident's medications, and,

4. Loose meds were found in the cycle drawer of the med cart.

These failures had the potential to affect the efficacy of medications and effectiveness of treatment, to affect residents to receive expired medications, to affect discharge residents to not have available meds on discharge, and residents' safety.

Findings:

1. On 2/24/25 at 3:50 P.M., a joint observation and an interview with Licensed Nurse (LN) 14 was conducted in station 4 med room. The temperature log for the med refrigerator, the utility room and the utility refrigerator had missed entries from July 2024 through December 2024. LN 14 stated the temperature for the med refrigerator was checked twice a day, the utility room once a day and the utility refrigerator was checked twice a day. LN 14 stated the utility room contained the tube feedings for the residents.

The missed temperature log entry indicated as follows:

Medication refrigerator:

7/1/24 and 7/2/24, 11/27/24, and 12/29/24 - AM shift,

7/1/24, 7/22/24, 7/27/24, 7/28/24, 8/2-8/3/24, 8/8-8/9/24, 8/14-8/15/24, 8/20-8/21/24, 8/26-8/27/24, 10/14/24, 8/19/24, 8/25-8/26-24, 8/31/24, 11/1/24, 11/6-11/7/24, 11/12-11/13/24, 11/18-11/19/24, 11/24/24, and 12/31/24 - PM shifts.

Utility room:

7/1/24, and 10/19/24.

Utility refrigerator:

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/1/24 and 7/2/24, 11/27/24, and 12/29/24 - AM shift, 7/1/24, 7/22/24, 7/27/24, 7/28/24, 8/2-8/3/24, 8/8-8/9/24, 8/14-8/15/24, 8/20-8/21/24, 8/26-8/27/24, 10/14/24, 8/19/24, 8/25-8/26-24, 8/31/24, 11/1/24, 11/6-11/7/24, 11/12-11/13/24, 11/18-11/19/24, 11/24/24, and 12/31/24 - PM shifts. LN 14 stated there were missed entry logs of the med refrigerator, the utility room and the utility refrigerator. LN 14 stated it was important to check the temperatures to ensure proper temperatures were maintained to ensure safety and potency of the medications and tube feedings. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the expectation was for the LNs to check the temperatures of the med refrigerator, the utility room and the utility refrigerator to ensure the range was within the target temperature to ensure proper storage of the meds and tube feedings and were safe to the residents. A review of the facility's undated, policy titled, Medication Storage, Storage of Medication, section 4.1, indicated, Medications and biologicals are store properly . to keep their integrity and to support safe, effective drug administration .10. Medications requiring storage at room temperature are kept at temperatures ranging from 15 degree Celsius to 25 degree Celsius .11. Medications requiring refrigeration .are kept in a refrigerator with a thermometer to allow temperature monitoring . A review of the facility's policy titled, Mediation Labeling and Storage, revised 2/2023, indicated, The facility stores all medications .under proper temperature . 2a. On 2/24/25 at 12:36 P.M., a joint observation and an interview with acting Director of Nursing (aDON) was conducted in station 4 medication (med) room. In the med room, there was a refrigerator containing medications and vaccines. In the door of the refrigerator, there was an opened multidose vial (MDV) of flu vaccine. There was no date in the vial and in the carton indicating the day the vial was opened. The aDON stated the LNs were supposed to date a MDV to know when to discard it for resident safety. The aDON stated it should be discarded after 30 days it was opened. A review of the facility's policy titled, Mediation Labeling and Storage, revised 2/2023, indicated, The facility stores all medications .5. Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days . 3. On 2/24/25 at 12:36 P.M., a joint observation and an interview with acting Director of Nursing (aDON) was conducted in station 4 medication (med) room. In the med room, there was an unlocked locker with an overfilled plastic bag which contained bottles of residents' personal medications. There were two residents' name identified in the medication bottles. One resident was active and one was inactive. The aDON stated the inactive resident was discharged to home on 12/1/24. The aDON stated the bottles of medications should have been separated and the LNs should have given the remaining medications of the resident who was discharged to home to ensure the resident could continue taking the meds. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the expectation was when the resident was discharged home, the LNs should gave the resident his medications to ensure they have their meds until they were seen by their primary care physician, A review of the facility's policy titled, Medications Brought to the Facility by the Resident/ Family, revised 4/2017, indicated .5. Medications brought into the facility that are not approved for the resident's use shall be returned to the family . 48270 Findings: 2b. Per the facility's admission record, Resident 8 was admitted to the facility on [DATE] with diagnoses that included asthma (chronic lung disease). A review of Resident 8's medication orders indicated on 8/8/24, the physician ordered Fluticasone Furoate Inhalation (medication used to treat asthma) .1 inhalation inhale orally one time a day . On 2/26/25 at 11:20 A.M., a joint observation and interview was conducted with LN 31 of medication (med) cart 3C in station 3. In the med cart, an opened box of Fluticasone furoate inhaler. The inhaler was found with no open date. LN 31 stated she opened the box today and forgot to label it. LN 31 stated it should be labeled with the opened date. On 2/27/25 at 2:30 P.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated it is their expectation that all opened multidose medications need to be dated with the opened date. A review of the facility's policy titled, Mediation Labeling and Storage, revised 2/2023, indicated, The facility stores all medications .5. Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days . 47466 Findings: 4. A joint observation and interview on 2/25/25 at 8:53 A.M., with Licensed Nurse (LN)43 was conducted. Three tablets of loose medications were found, 1 white oblong, 1 yellow round, 1 pink round pill found on the cycle drawer on the afternoon shift slot. LN 43 stated she does not know which card it belongs to and what medications they were. LN 43 then picked up the medications and placed them in a clear cup to be discarded in the red drug disposal bin. LN 43 stated it was important to not have loose medications anywhere in the medication carts for the safety of the residents. A joint interview on 2/27/25 at 3 P.M.,with the Acting Director of Nursing (aDON) and the Assistant Director of Nursing (ADON) was conducted. The ADON stated it was important not to have loose medications anywhere in the medication cart for residents safety, and to prevent drug diversion.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43518 Based on observation, interview, and record review the facility failed to ensure that food served during lunch was at a palatable temperature for the residents. This failure had the potential to prevent the residents from eating their meals and not receive their daily nutrition. Findings: Review of Resident Council Meeting Minutes from 2/20/25 indicated one resident council member stated . that the food is cold when served . On 2/24/25 between 10 A.M. and 11:15 A.M., a Resident Council Meeting was conducted with eight Resident Council members. At 11:03 A.M., a poll of Resident Council members present indicated seven out of eight members felt food was not hot enough. On 2/24/24 during initial pool screening, residents stated the following about the food: .I have meatball that is raw and felt funny . .I had hamburger- no steam, I touched the bun and it is cold .it frequently happens .I asked the nurse to put in microwave for two minutes- somewhat raw - the burger is still red very visible . .scrambled eggs sometimes cold .sometimes sausage and bacon are cold . On 2/25/25 at 11:45 A.M., an observation of lunch tray line and interview with [NAME] 27 (C27) was conducted. C27 stated that .they take temps prior to the tray line and in the middle of plating . C27 was observed taking the metal cover off the steam tray section with alternate meals which included turkey meatballs and eggrolls. Steam tray cover was not replaced during entirety of tray line. At 12:56 P.M.,tray line was completed, sample tray of regular diet and puree diet were made for the last tray on the last cart. At 12:56 P.M., temperature for eggroll was taken by Dietary Manager (DM) with the facility's thermometer; eggroll temperature= 97 F and for meatball temperature=97.4 F. At 1:00 P.M., the last station's cart (Station 3) was brought to the nurse's station for distribution. The last tray was distributed to final resident. On 2/25/25 At 1:09 P.M., a test tray was brought to Bistro Cafeteria by Dietary Manager(DM) and Registered Dietician (RD); temperatures were taken by DM for all entrees and sides for regular and puree diet trays. Temperatures were as follows: Puree tray- Mash Potatoes 130 F, Pureed bread 118 F, Pureed Brussel Sprouts 116 F, Pureed Roast beef 121 F, Milk 49.5 F, Apple Sauce 49 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regular tray-Roast beef 123 F, Mashed Potatoes 126 F, Brussel Sprouts 110 F, Juice 49 F, Cobbler 58 F Samples of each of the entrees and sides were tasted by DM, RD, and surveyor. Results were as followed: Taste of puree tray: flavor for all Pureed food all seasoned well, warm but not hot food. Taste of regular tray: flavor for all Regular tray items all seasoned well, warm but not hot food. On 2/26/25 an interview was conducted with DM. DM stated that the expectation for hot foods was that their temperature should be close to steam tray temperature of 135 F for main entree and hot sides, and 140 F for soups and hot cereal. DM stated that the importance of having hot foods at a palatable temperature was to promote residents' nutrition and satisfaction with their meals, and thereby promote their health and well-being. According to the 2022 Food and Drug Administration (FDA) Food Code, Section 3-501.16, titled Time/Temperature Control for Safety Food, Hot and Cold Holding, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) .135 degrees F or above .or .may be held at a temperature of .130 degrees F or above; .(2) At .41 F or less. According to the 2022 FDA Food Code, Section 3-403.11, titled Reheating for Hot Holding, .If food is held at improper temperatures for enough time, pathogens have the opportunity to multiply to dangerous numbers. Proper reheating provides a major degree of assurance that pathogens will be eliminated .

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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. 43518 Based on observation, interview, and record review the facility failed to store the following foods appropriately: 1. Grilled cheese 2. Soy sauce 3. Food thickener This failure had the potential for residents receiving spoiled or contaminated food. Findings: On 2/24/25 an initial tour of the kitchen with the Dietary Manager(DM) and the Registered Dietician (RD) was conducted. During an observation of the walk-in refrigerator at 7:56 A.M., a tray of prepared grilled cheese was observed with a large piece wax paper covering just the top of the grilled cheese on a tray with four small bottles of water weighing down the four corners of the waxed paper. The sides of the grilled cheese were uncovered and open to air. The wax paper was labeled For lunch Prep 2/24/25 for UB (use by) 2/24/25. The DM stated that the grilled cheese should have been sealed with plastic wrap and then disposed of the grill cheese in the trash. On 2/24/25 an initial tour of the dry storage room was conducted at 8 A.M. An opened soy sauce container, dated, opened 1/23/25, and UB date 2/23/25 was observed on sauce shelf. Soy sauce's label indicated Refrigerate after opening. In addition, the Food Thickener bin was observed with a crack extending up the side of the plastic lid, large enough for pests to crawl through. The DM stated the he would replace the broken bin. On 2/26/25 at 9:10 A.M., an interview was conducted with the DM. The DM stated that the expectation for foods prepared in advance such as grilled cheese, should be in a sealed container and labeled with prepared date and time and use by date. The DM stated that the importance of having prepared food in sealed containers is to prevent contamination by outside sources. The DM stated that the expectation for storage of sauces such as soy sauce, was to follow the manufacturer's guidelines on the label of the sauce. The DM stated the importance of following manufacturer's guideline was to maintain the quality of the food stored and prevent spoilage. In addition, the DM stated that the expectation for dry storage bins was that their lids should be completely sealed without any damage or gaps. The DM stated the importance of sealed storage bins was to maintain the quality of the food and to prevent contamination from outside sources. Review of facility document titled PROCEDURE FOR REFRIGERATED STORAGE, dated 2023 .5. Food should be covered . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility document titled STORAGE OF FOOD AND SUPPLIES, dated 2023, indicated .6. Dry bulk foods (.food thickener .) should be stored in seamless metal or plastic containers with tight covers .11. Liquid foods .which have been opened will be tightly closed, labeled and dated .Check food labels to verify if a food needs to be refrigerated once opened .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 47466 Based on interview and record review, the facility's Quality Assessment Performance improvement (QAPI-plan developed by the QAA (Quality Assessment and Assurance committee-committee that oversees facility conditons and trends) failed to identify deficient practices prior to their recertification survey which include; 1) Call light response time from staff and, 2) Identifying food concerns from resident interviews and during the resident council meeting. This failure had the potential for the facility to overlook trends in resident's health and quality of life. Cross reference : F804 A joint interview on 2/27/25 at 2:27 P.M., with the Administrator (ADM) and the Acting Director of Nursing (aDON) was conducted .The ADM stated they were not aware of the call light issues and food concerns. The ADM stated the expectation was the QAA committee should have identified the trends in the facility prior to being identified by the surveyors. A joint interview on 2/27/2025 at 2:27 P.M., with the ADM and the DON was conducted. The DON stated it was important to identify the residents food concerns to provide the highest quality of life for all residents in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review the facility failed to ensure infection control procedures were followed when a Licensed Nurse (LN) 12 did not perform hand hygiene (the practice of cleaning hands to remove germs, dirt, or other harmful substances) consistently after removing her gloves while passing medications (meds) during medication pass observation for 2 residents (Residents 141, 22). This failure had the potential for cross contamination and spread of infection between the residents. Findings: 1. A review of Resident 141's Admission Record indicated Resident 141 was readmitted to the facility on [DATE], with diagnoses which included functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord) and she had a gastrostomy tube (g-tube, a surgical opening fitted with a device to allow feedings/ meds to be administered directly to the stomach common for people with swallowing problems). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 7:46 A.M., an observation and an interview were conducted of Licensed Nurse (LN) 12 prepared medications for Resident 141. LN 12 stated she had been observed before. LN 12 put gloves on, crushed Resident 141's medications and placed each med in a med cup. LN 12 removed gloves and did not perform hand hygiene. Upon entering Resident 141's room, LN 12 picked up an alcohol swab from the floor, put on a gown and put gloves on without performing hand hygiene. With gloved hands, LN 12 went to Resident 141's bathroom and filled the empty cups with water from the bathroom sink. After coming out from the bathroom, LN 12 pulled the privacy curtain with gloved hands, retrieved two small boxes of facial tissue from another staff member, proceeded with the task, disconnected the tube feeding from Resident 141's g-tube, checked Resident 141's g-tube placement, placed the 60 ml syringe to Resident 141's g-tube. LN 12 then flushed the g-tube with water, administered the orange liquid meds, flushed with water. While the orange liquid meds and the water were being administered through gravity, LN 12 put some water to the crushed med from another med cup, administered the crushed med in Resident 141's g-tube, and flushed with water. This time, the meds and the water did not go through the g-tube through gravity, LN 12 then pushed the med with the plunger, the meds and the water still did not go through. LN 12 aspirated the water from the syringe, placed the water from the syringe back to the plastic cup. LN 12 stated Resident 141's g-tube was clogged. LN 12 removed gown and gloves asked another staff member to get some ointment for Resident 141. LN 12 then put on a new pair of gloves and gown without performing hand hygiene. LN 12 then milked (compressing the tube with the fingers and moving them along the course of the tube) the tube towards the resident with an ointment. LN 12 removed her gloves, then put on a new pair without performing hand hygiene, put the syringe back to the g-tube. LN 12 removed a small amount of administered crushed meds from the small tube of the gtube. LN 12 removed her gloves, put a new pair of gloves without performing hand hygiene. LN 12 then received a declogger (a safe, flexible threaded device that bores through occlusions to quickly restore nutrition and medication to patients with obstructed enteral tube) from another staff member, placed the declogger into Resident 141's g-tube and LN 12 maneuvered back and forth to the g-tube, then flushed the g-tube with water, until the water went through with gravity. LN 12 was not consistent in performing hand hygiene during the med pass observation. On 2/26/25 at 10:56 A.M., an interview was conducted with LN 12. LN 12 stated she was not consistent in performing hand hygiene during the med pass. LN 12 stated it was important to perform hand hygiene during med pass for infection control. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated the expectation was for LN 12 to perform hand hygiene in between tasks to prevent infection to the resident. 48270 2. Per the facility's admission record, Resident 22 was admitted on [DATE] with diagnoses that included epilepsy (brain disorder characterized by recurrent, unprovoked seizures) and encephalopathy (general dysfunction of the brain). On 2/26/25 at 8:24 A.M., an observation and an interview were conducted of Licensed Nurse (LN) 21's preparation and administration of medications for Resident 22. LN 21 prepared Resident 22's into a medication cup. LN 21 then knocked on Resident 22's door, identified the resident, explained the procedure to the resident and administered the mediations. LN 21 then came out of the room and performed hand hygiene. LN 21 stated she was finished administering medication to Resident 22. LN 21 was observed not performing hand hygiene prior to administering medications to Resident 22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 8:44 A.M., an interview was conducted with LN 21. LN 21 stated she did not perform hand hygiene prior to administering medications to Resident 22. LN 21 stated it was important to perform hand hygiene to prevent the spread of infection. On 2/27/25 at 9:22 A.M., a joint interview with the acting Director of Nursing (aDON) and the Assistant DON (ADON) was conducted. The ADON stated it is their expectation that all nurses perform hand hygiene prior to administering medications. A review of the facility's policy titled, Administering Medications, revised 4/2019, indicated, Medications are administered in a safe .manner .25. Staff follows established facility infection control procedures (e.g. handwashing .gloves .) for the administration of medications .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 43518 Based on observation, interview, and record review, the facility failed to ensure water from the dishwashing sink drained appropriately onto the drain hole. This failure had the potential for accidents in the dishwashing area and a preventable flooding of the kitchen. Findings: On 2/25/25 at 8:45 A.M. a concurrent observation of dishwashing area and interview with Dietary Aide (DA) was conducted. While DA described the process for washing dishware, water was observed to be draining directly onto the floor beneath the dishwasher sink from the sink pipe and not directly into the drain hole. DA stated that he was not sure how long the water had been draining onto the floor. DA stated that the expectation was the drain water should empty directly into the drain hole and not onto the kitchen floor. DA stated the importance of functioning equipment was for safety of staff washing dishes, as they could slip on the water. On 2/25/25 at 8:50 A.M., a concurrent observation of dishwashing drainpipe and interview with the Dietary Manager (DM) was conducted. The DM stated he was not sure how long the pipe had been draining on the floor, and manually adjusted the pipe so it was emptying into the drain hole. On 2/26/25 at 9:20 A.M., an interview with the DM was conducted. The DM stated that the expectation was that the dishwashing sink should drain directly into the drain hole and not onto the kitchen floor. The DM stated that importance of a working drainpipe, was to prevent staff from slipping on the floor. Review of facility dietary policy titled ACCIDENT PREVENTION-SAFETY PRECAUTIONS, dated 2023, indicated .FALL PREVENTION PRACTICES .Keep floors clean, dry, and free of obstructions .BACKFLOW PREVENTION/AIR GAPS .equipment that discharge liquid waste or condensate shall be drained through an air gap into an open floor sink .