STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555682	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Post-Acute	1617 Ramirez Street Marysville, CA 95901

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45849 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that 1 (Resident #38) of 4 residents reviewed for medication administration was assessed for their ability to self-administer medications. Specifically, Resident #38 expressed a desire to self-administer their medications, and without first assessing the resident to determine if they were clinically appropriate and safe to do so, the facility allowed the resident to self-administer a nebulizer treatment while unsupervised by staff and denied the resident the right to self-administer their inhaler. Findings included: A facility policy titled, Self-Administration of Medications, reviewed 10/2024, indicated, Residents have the right to self-administer medications when it is clinically appropriate and safe for the resident to do so. The policy specified, 1. As part of their overall evaluation, resident's mental and physical abilities will be considered to determine whether self-administering medications is clinically appropriate for the resident. Resident #38's Admission Record indicated the facility admitted the resident on 05/21/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, acute and chronic respiratory failure with hypoxia (low oxygen level), and muscle weakness. Resident #38's Care Plan Report included a focus area, initiated 05/21/2024 and revised 02/23/2025, that indicated the resident had an alteration in their respiratory system with acute symptoms and had a high risk for the development of cardio-pulmonary symptoms, respiratory distress, and functional decline related to a diagnosis of COPD. Interventions dated 05/21/2024 directed staff to administer medications and nebulizer treatments as ordered. Resident #38's Care Plan Report did not include any focus areas addressing the resident's ability to self-administer medications. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/24/2025, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated Resident #38 did not have a functional limitation in range of motion in their upper or lower extremities. Resident #38's Order Summary Report revealed the following orders: (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an order dated 02/11/2025 for ipratropium-albuterol solution 0.5-2.5 milligrams per 3 milliliters (mg/3mL) to be inhaled via a nebulizer every 6 hours as needed for shortness of breath or wheezing; -an order dated 02/04/2025 for Xopenex nebulization solution 0.63 mg/3mL to be inhaled via a nebulizer every 6 hours for COPD or wheezing; - an order dated 02/04/2025 for Spiriva HandiHaler inhalation capsule 18 micrograms (mcg) inhaled orally one time a day for COPD; and - an order dated 03/24/2025 for Breo Ellipta inhalation aerosol powder 100-25 micrograms per actuation (mcg/act) inhaled orally one time a day for COPD. The Order Summary Report did not contain orders addressing the resident's ability to self-administer medications. An observation on 03/31/2025 at 10:28 AM revealed Resident #38 had a nebulizer treatment in progress. No staff member was present in Resident #38's room. During an interview on 03/31/2025 at 1:45 PM, Resident #38 stated that they had an inhaler ordered, and they wanted to be able to keep it with them so they could administer it when needed, but the facility would not allow them to keep the medication and administer it themselves. Resident #38 stated when staff provided their nebulizer treatment, staff handed the treatment to the resident and left the room. During an interview on 04/02/2025 at 1:44 PM, Licensed Vocational Nurse (LVN) #1 stated that if a resident requested to self-administer medications, he would tell them that per the facility's policy, medications had to be administered by a nurse and that it was not possible for the resident to keep their medications themselves. LVN #1 stated that no resident in the facility self-administered medications. During an interview on 04/02/2025 at 3:40 PM, LVN #2 stated that if a resident wanted to self-administer medications, the nurse still gave the medications and stayed with the resident to supervise the resident while they administered the medications. LVN #2 stated residents could not keep medications in their room and take the medications themselves. LVN #2 further stated there were no residents in the facility that had orders for self-administration of their medications. During an interview on 04/02/2025 at 3:53 PM, the Respiratory Therapist (RT) stated the nurses administered inhalers and nebulizers. The RT stated a nurse was supposed to stay in the room with a resident while administering a nebulizer treatment to monitor for any adverse reactions. The RT stated she would not be surprised to hear that Resident #38 was administering their own nebulizer treatment, but had not seen the resident self-administer their nebulizer very often. The RT stated Resident #38 had requested to self-administer medications, but it was not allowed. The RT further stated they did not make the rules, they just followed them. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/2025 at 9:05 AM, the Director of Nursing (DON) stated that due to having residents who were confused and wandered, the facility tried not to have any residents self-administer medications. The DON stated that there were currently no residents in the facility that self-administered their medications. During an interview on 04/03/25 at 9:24 AM, the Administrator stated self-administration of medications was a clinical issue that he expected nursing staff to manage.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 28193 Based on interview, record review, facility policy review, and review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure a resident's Minimum Data Set (MDS) assessment was accurately coded for pressure ulcers and restraints for 1 (Resident #62) of 21 sampled residents. Findings included: A facility policy titled, Resident Assessments, revised 10/2024, revealed, A comprehensive assessment of each resident is completed at intervals designated by OBRA [Omnibus Budget Reconciliation Act] regulations and PPS [Perspective Payment Plan] requirements. The section of the policy titled, Policy Interpretation and Implementation included 6. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.19.1, dated 10/2024, revealed, M0210: Unhealed Pressure Ulcers/Injuries, specified Coding Instructions Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days. - Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers. Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. The manual further revealed Section P: Restraints and Alarms, defined Physical Restraints as Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP). The manual revealed the Coding Instructions, directed staff to After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back period or it was used but did not meet the definition. Code 1, used less than daily: if the item met the definition and was used less than daily during the observation period. Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period. Resident #62's Admission Record indicated the facility admitted the resident on 10/10/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, essential hypertension (high blood pressure), depression, and anxiety. A quarterly MDS, with an Assessment Reference Date (ARD) of 02/20/2025, revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident required partial/moderate assistance with rolling left and right while in bed. The MDS revealed M0210 was coded to indicate the resident had one or more unhealed pressure ulcers/injuries, however, M0300 A through M0300 G indicated the resident did not have any pressure ulcers/injuries. The MDS indicated that the resident used bed rails as a restraint daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #62's Care Plan Report included a focus area initiated on 10/11/2023, that indicated the resident was at risk for activity of daily living (ADL)/mobility decline and required assistance related to cognitive impairment. Interventions indicated the resident used one-quarter length bilateral bed rails (initiated 10/11/2023 and revised 06/20/2024). The Care Plan Report revealed a focus area initiated on 02/21/2025, which was after the MDS ARD, that indicated Resident #62 had a pressure ulcer to their left heel and was at risk for further breakdown and/or slow, delayed healing. During an interview on 04/02/2025 at 1:47 PM, the MDS Coordinator stated she had been working at the facility for eight years. She stated the MDS should be accurate and stated that it was her responsibility to ensure the MDS was accurate. She stated Resident #62's side rails were used for mobility and should not have been marked as a restraint on the MDS; it was an error . The MDS Coordinator stated she could see on the resident's MDS that it had been coded to indicate Resident #62 had existing pressure ulcers, but each type of pressure ulcer had been marked to indicate the resident did not have any. The MDS Coordinator stated the resident's MDS was not correct. During an interview on 04/03/2025 at 9:21 AM, the Director of Nursing (DON) stated her expectation was for the MDS assessments to be accurate. She stated the nurse who was completing the MDS needed to go section by section to ensure the assessment was correct before it was transmitted. During an interview on 04/03/2025 at 9:45 AM, the Administrator stated his expectation for the MDS process going forward was for the MDS Coordinator to review each MDS section by section to ensure the accuracy prior to transmitting them to Center for Medicare and Medicaid Services (CMS).