STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555684	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Post Acute Care	1790 Muir Road Martinez, CA 94553

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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 - Few	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. 49498 Based on interview and record review the facility failed ensure that one of six sampled residents' (Resident 69) medical record contained a current copy of Advance Directive (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual is incapacitated). This failure had the potential for Resident 69 to be placed at risk of receiving unwanted treatment and not receiving appropriate care based on his wishes. Findings: During a review of Resident 69's undated Admission Record, the Admission Record printed on 1/8/25 indicated, Resident 69 was admitted in the facility 12/2024 with an admission diagnosis of cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die). During a record review of Resident 69's Minimum Data Set (MDS- an assessment used to guide plan of care) dated 12/9/24, MDS indicated Resident 69's Brief Interview of Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score was 15 out of 15, indicating intact mental status. During a concurrent interview and record review on 1/8/25 at 9:29 a.m. with the Social Services Director (SSD) in the SSD's office, Resident 69's Physician Orders for Life-Sustaining Treatment (POLST, a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration.) dated 12/3/24 was reviewed. The POLST indicated, Resident 69's undated Advance Directive was available and reviewed. SSD stated Resident 69's Advance Directive copy was not uploaded in the Electronic Health Record. During a concurrent observation and interview on 1/8/25 at 9:33 a.m. with the SSD in the nursing station, SSD flipped through Resident 69's paper chart looking for the copy of Advance Directive. SSD stated the copy of Resident 69's Advance Directive was not in the paper chart. SSD stated, the Medical Records Director (MRD) audits the POLST and follows up getting a copy of Advance Directive from the family. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/8/25 at 9:37 a.m. with MRD in MRD's office, MRD checked Resident 69's EHR and paper chart. MRD stated, the copy of Resident 69's Advance Directive was not in the EHR nor in the paper chart. During a follow up interview on 1/8/25 at 2:12 p.m. with SSD, SSD stated, the copy of Resident 69's Advance Directive was emailed today by his wife. SSD stated the purpose of having a copy of the Advance Directive in the facility for the facility to know who the healthcare decision maker for the resident in case of emergency. During an interview on 1/9/25 at 9:00 a.m. with Resident 69 in Resident 69's room, Resident 69 stated, it was important for the facility to have a copy of his Advance Directives as it would serve as a guideline to staff of what he wants if something suddenly happened to him. During an interview on 1/9/25 at 9:12 a.m. with Registered Nurse (RN) 2, RN 2 stated, it was important to have the copy of Advance Directive accessible to staff as fast as possible to know what to do for the resident during an emergency. During a review of the facility's policy and procedure (P&P) titled Advance Directives, dated 12/16, the Advance Directive indicated, 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family member and/or his or her legal representative, about the existence of any written advance directive.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 43771 Based on observation, interview, and record review the facility nursing staff did not accurately complete one out of three residents' (Resident 73) discharge assessment when the wrong discharge disposition was entered. This failure to accurately encode (to enter information into the facility MDS software in the computer) Resident 73's assessment had the potential to not effectively monitor and keep track of resident's progress or decline over time and also cause delay in providing resident information for payment and quality measure purposes. Findings: During a review of Resident 73's Face Sheet, (undated), the Face Sheet indicated Resident 73 was admitted to the facility in 2024 with included diagnoses of Acute Osteomyelitis right ankle and foot (osteomyelitis - a serious bone infection that happens after an infection spreads to the bone marrow and bones through bloodstream). During a review of Resident 73's Minimum Data Set (MDS - a resident assessment tool use to guide care) dated 10/12/2024, the MDS indicated Resident 73 was discharged to a Short-Term General Hospital (acute care hospital). During an interview on 01/08/2025 at 10: 23 A.M. with Minimum Data Set Coordinator (MDSC), MDSC stated Resident 73 was discharge to home and not to the hospital. MDSC further stated the entry coded in MDS was an error entry and she will correct it. During a review of Resident 73's Interdisciplinary Treatment (IDT) Discharge Summary notes, dated 10/11/2024, the discharge summary notes indicated Resident 73 was discharged to home. During a review of Resident 73's Physician Discharge Summary dated 10/12/2024, and signed by Physician 10/17/2025, Physician Discharge Summary indicated Resident 73 to be discharged home . During a review of Resident 73's Physician Order Summary dated 10/10/2024, the Physician Order Summary indicated Resident 73 to be discharge on 10/12/2024; Where To: home; To be followed by: PT, OT, RN, HHA, Durable Medical Equipment: no DME one time only for Discharge until 10/12/2025 23:59. During an interview 01/08/2025 10: 25 AM with Director of Nursing (DON), DON stated it is important to have correct encoding for accuracy reasons. DON further stated facility would modify the incorrect entry. During a review of facility's policy and procedure (P & P), title Resident Assessment Instrument, dated 2010, page 20, the PNP indicated, the purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49498 Based on interview and record review, the facility failed to provide a written summary of the baseline care plan to one of five sampled residents (Residents 59) when Resident 59 did not receive a copy of the summary. This failure resulted in Resident 59 to be uninformed of the initial plan of care and services. Findings: During a review of Resident 59's undated Admission Record, the Admission Record printed on 1/8/25 indicated, Resident 59 was admitted in the facility on 12/15/24 with an admission diagnosis of metabolic encephalopathy (a brain dysfunction that occurs when there's an imbalance of chemicals in the blood, usually due to an underlying medical condition.). The record indicated, Resident 59 was their own responsible party (RP or legal guardian). During a record review of Resident 59's Minimum Data Set (MDS- an assessment used to guide plan of care) dated 12/21/24, the MDS indicated Resident 59's Brief Interview of Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score was 14 out of 15, indicating intact mental status. During an interview on 1/8/25 at 12:18 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, the baseline care plan summary was discussed to the resident and RP during the Interdisciplinary Team (IDT) Care Conference. LVN 2 stated, copy of the baseline care plan summary was provided to residents or RP upon request. During a concurrent interview and record review, on 1/8/25 at 12:36 p.m. with the Minimum Data Set Coordinator (MDSC) 1, Resident 59's Interdisciplinary Team (IDT) Care Conference Notes dated 12/18/24 was reviewed, the IDT Care Conference Notes indicated, Baseline Plan of Care was not given to the resident and/or RP. The MDSC 1 stated, Resident 59's daughter attended the IDT Care Conference via telephone. The MDSC 1 stated, the Baseline Care Plan Summary was not provided to Resident 59's daughter because she did not request a copy. During a review of Resident 59's Baseline Care Plan Summary dated 12/15/24, indicated, resident or RP acknowledging the summary was received was unsigned and undated. During an interview on 1/9/25 at 9:14 a.m. with Resident 59 in Resident 59's room, Resident 59 stated, they did not receive a copy of the baseline care plan summary nor signed the form. During a review of the facility's policy and procedure titled Care Plans-Baseline, dated 3/17, indicated, 4. The resident and/or representative are offered a copy of the baseline care plan.

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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. 26917 Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate below five percent (5%). During the medication pass on 01/07/25, three medication errors were observed out of twenty-six opportunities for two out of five residents, resulting in an error rate of 11%. This failure had the potential to result in harm in the health and safety of residents. Findings: 1. A review of the manufacturer's insert for Breyna (Budesonide-Formoterol) indicated that Breyna is a medication used to help people with asthma and COPD (chronic obstructive pulmonary disease) breathe easier. The insert emphasizes that it is essential to hold the breath for 10 seconds after administration to ensure the medication is properly absorbed. Omitting this instruction could compromise the medication's effectiveness and potentially impact the resident's treatment outcomes. During an observation on 1/7/25, at 8:15 AM, it was noted that RN1, while administering Breyna to Resident 31, did not instruct the patient to hold their breath for at least 10 seconds after inhalation. RN1 handed the inhaler to Resident 31, and although he held his breath, he did not hold it for the recommended 10 seconds as specified by the manufacturer. According to the manufacturer's website, when administering two puffs of Breyna, patients should wait at least one minute between puffs to ensure proper medication delivery and effectiveness. This waiting time is crucial for allowing each dose to disperse and be absorbed by the lungs, maximizing the therapeutic benefits of the medication. Waiting one minute between puffs also helps prevent potential side effects associated with incorrect medication administration, such as local irritation or systemic absorption of the medication. During an observation on 1/7/25, at 8:15 AM, it was noted that RN1 did not wait between puffs when administering two puffs of Breyna to Resident 31. Allowing sufficient time between each puff is crucial for the medication to disperse effectively in the respiratory system. By not waiting, the delivery of the medication may have been hindered, potentially affecting the treatment's efficacy. It's important to follow proper techniques when administering inhaled medications to ensure the best possible therapeutic outcomes for the patient. During an interview conducted on 1/7/25, at 8:30 AM, RN 1 acknowledged that she did not instruct Resident 31 to hold their breath for at least 10 seconds after using the Breyna inhaler. Additionally, she admitted that she did not wait the recommended one-minute interval between puffs when administering the inhaler. RN 1 stated that she will adhere to these proper administration guidelines in the future. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review on 1/7/25, of the manufacturer's insert for Dorzolamide (Dorzolamide is an eye drop used to lower high pressure inside the eye in people with open-angle glaucoma or ocular hypertension) indicated that the tip of the bottle should not make contact with any surface, including the eye or surrounding area. This precaution is essential to maintain sterility and prevent contamination of the medication, which could potentially lead to adverse effects such as eye infections. Proper administration technique, as outlined by the manufacturer, is critical for ensuring the safety and efficacy of the medication. During an observation on 1/7/25, at 9:15 AM, Licensed Vocational Nurse 1 (LVN1) administered one drop of dorzolamide in each eye to Resident 35. However, LVN1's technique was flawed, as they held the bottle's tip too close to the resident's eyelashes. Consequently, the eyedrop made contact with the eyelashes rather than landing directly in the eye as intended. Proper administration of eyedrops requires maintaining a short distance between the dropper and the eye to ensure the medication reaches the intended target. During an interview conducted on 1/7/25, at 9:30 AM, LVN 1 admitted that she accidentally touched the tip of the eye drop bottle to Resident 35's eyelashes. She stated that she will ensure this does not happen again and that she will be more careful in the future. 3. A review on 1/7/25 of the manufacturer's insert for QVAR, proper administration involves instructing the patient to fully exhale before inhaling the medication from the inhaler. After inhalation, the patient should be advised to hold their breath for at least 5 to 10 seconds. This practice ensures effective absorption of the medication into the lungs, optimizing its therapeutic benefits. Healthcare professionals must adhere to these guidelines to maximize the medication's benefits and minimize the risk of potential adverse effects. QVAR is an inhaler medication used to prevent asthma attacks by reducing inflammation in the airways. During an observation on 1/7/25 at 9:15 AM Licensed Vocational Nurse 1 (LVN1), administered QVAR inhaler to Resident 35. It was observed that LVN1 did not instruct the resident to exhale before inhaling the medication. As a result, the resident did not exhale prior to inhaling the medication. Additionally, LVN1 did not instruct Resident 35 to hold their breath for 5 to 10 seconds after inhalation, which is an essential step to ensure proper absorption. Consequently, Resident 35 did not hold their breath for the recommended duration, potentially compromising the medication's effectiveness. Adhering to proper administration techniques is crucial for optimal therapeutic outcomes, as outlined by the manufacturer's instructions and professional guidelines. During an interview conducted on 1/7/25, at 9:30 AM, LVN 1 stated that she did not instruct Resident 35 to exhale prior to using the inhaler or to hold their breath for 5-10 seconds after inhalation. She acknowledged the oversight and stated that she will adhere to proper administration techniques in the future.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26917 Based on observations, interviews, and record reviews conducted during the assessment, it was identified that the facility did not maintain the medication refrigerator within the required temperature range of 36 F to 46 F, as outlined in their policy. This failure potentially exposes medications to an environment where their efficacy may be compromised due to improper storage conditions. Findings A review of the facility policy, effective December 1, 2007, titled Storage and Expiration Dates of Medications, Biologicals, Syringes, and Needles, indicates that the facility should ensure that medications are stored at appropriate temperatures. Medications requiring refrigeration should be maintained between 36 F and 46 F. During an observation at 9:21 AM on 01/08/25, it was noted at the nursing station medication refrigerator that multiple medications, including insulin, vaccines, eye drops, and a refrigerated emergency kit containing various medications, were stored at a temperature of 34 F, as indicated by the thermometer. A review conducted on 01/08/25, of the medication refrigerator temperature logs revealed that for the month of January, there were four documented instances where the temperature was recorded as 32 F. Additionally, for the months of December and November 2024, there were a total of seven instances where temperatures were supposed to be documented but were either missing or not recorded. During an interview on 01/08/25, at 9:25 AM, the Assistant Director of Nursing acknowledged that the temperature of 34 F in the medication refrigerator was too low. She further noted that the refrigerator contained vaccines, eye drops, insulin, and multiple medications, including an emergency refrigerator kit with several medications. As a corrective measure, she mentioned that she would adjust the thermostat to a higher setting and closely monitor the temperature to ensure it remains within the acceptable range of 36 F to 46 F. The Assistant Director also admitted that she was previously unaware of the refrigerator's temperature being excessively low and acknowledged the facility's policy of maintaining refrigerator temperatures between 36 F and 46 F.

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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** 43771 Based on observation, interview, and record review the facility failed to follow their infection prevention control policy and protocol when nursing staff did not transport one out of five residents' (Resident 21) personal clothes in a clean linen cart used for transportation. The failure had the potential to cause cross contamination and spread of infection among the residents. Findings: During an observation on 1/8/2025 at 12:18 p.m. in the hallway near the laundary room, adjacent to room [ROOM NUMBER], Housekeeper/Laundary Staff (HKLS) held residents clothing, without gloves, about 5 to 6 of them, on clothes hangers, close to his body and walked down the hallway from the laundry room to Resident 21's room. There were other staff, two residents seated in their wheelchairs in the hallway, a housekeeper cleaning cart and a lunch tray cart in the hallway. During an observation on 1/6/2025 at 10:32 a.m., Resident 25, Resident 70, Resident 55, Resident 15, Resident 1, and Resident 4 were on Enhanced Barrier Precautions in the same hallway as Resident 21. During a review of the facility's list of Residents on Enhanced Barrier Precautions on 1/8/2025 at 1:00 p.m, the facility's list of Enhance Barrier Preacaution indicated 12 Residents on Enhanced Barrier Precautions, which included Residents 25, 70, 55, 15, 1, 4, and 33. During an interview on 1/8/2025 at 10:29 a.m, with Infection Control Preventionist (IP) Nurse, IP stated the facility had a COVID outbreak from around December 1, 2024 to January 7, 2025. IP further stated facility had 32 residents and 15 staff test positive for COVID, and the facility was still waiting to get cleared by the County. During an interview on 1/8/2025 at 12:26 p.m. with HKLS, HKLS stated he has been trained to handle clean laundry without using clean laundry transport cart. HKLS stated this is how he does it and also stated the clothes he was transporting were room [ROOM NUMBER] A's clothing. During an interview on 1/8/2025 at 12:33 p.m., with HouseKeeper/Maintenance Supervisor HKS, HKS stated the residents' clean laundry should be transported in a cart, covered during transport. During an interview on 1/8/2025 at 12:45 p.m. with IP and Director of Staffing Development (DSD) , both DSD and IP stated laundry should be separated by soiled laundry and clean laundry. DSD further stated clean resident laundry should be transported to the resident's room in a clean cart. During an observation on 1/8/2025 at 12:55 p.m., HKS walked into the facilty from the parking lot with his laundry apron on and walked down the hallway heading towards the laundry room. During an observation on 1/9/2025 at 08:57 a.m., HKS walked out of the facilty to the parlking lot with his laundry apron on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/9/2025 at 09:17a.m., HKS walked back into the facility with the same laundry apron on and resumed work.