

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555723	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2025
NAME OF PROVIDER OR SUPPLIER  Santa Fe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 247 E. Bobier Drive Vista, CA 92084	
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)		
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>35314</p> <p>Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure residents had access to their personal funds after hours and on weekends for 3 (Residents #20, #27, and #38) of 6 sampled residents reviewed for personal funds.</p> <p>Findings included:</p> <p>A facility policy titled, Management of Residents' Personal Funds, revised 03/2021, revealed, Our facility manages the personal funds of residents who request the facility to do so.</p> <p>During an observation on 04/29/2025 at 2:08 PM and 05/01/2025 at 3:21 PM, the surveyor noted a signed posted outside the business office which specified, the resident trust banking hours were Monday - Friday 11:00am - 2:00pm Closed on Weekends and Holidays.</p> <p>A facility document titled, Trial Balance, which indicated balances of 05/01/2025, revealed the facility managed 53 resident trust accounts.</p> <p>1. An Admission Record revealed the facility admitted Resident #20 on 05/12/2020.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/09/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment.</p> <p>During an interview on 05/01/2025 at 2:34 PM, Resident #20 stated they were not able to access their personal funds during the weekend because the facility did not allow it. Resident #20 said they would like to have access to their funds on the weekend.</p> <p>2. An Admission Record revealed the facility admitted Resident #27 on 04/24/2014.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/2025, revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.</p> <p>During an interview on 05/01/2025 at 2:31 PM, Resident #27 stated they were not aware they could receive their funds during non-banking hours or on the weekend. Resident #27 stated they would like to have access to their funds during the weekend.</p> <p>(continued on next page)</p>		

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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. An Admission Record revealed the facility admitted Resident #38 on 06/02/2021.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/29/2025, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>During an interview on 05/01/2025 at 2:47 PM, Resident #38 stated they received funds from the business office weekly. Resident #38 stated the office was only open five days a week and they were not able to get their funds during non-banking hours or the weekend.</p> <p>During an interview on 05/01/2025 at 3:55 PM, Receptionist #18 stated if there were any resident requests for their personal funds during non-banking hours, she would inform the resident that they would have to wait until the business office reopened.</p> <p>During an interview on 05/01/2025 at 10:16 AM, the Business Office Manager (BOM) stated business office staff were the only ones with access to residents' personal funds. The BOM stated there were no funds available for residents located on the nurses' cart or any place at the facility when she was not in the office. The BOM stated for residents to access their funds during the weekend, the residents or family members had to leave a request to have the funds provided during the weekend. She said residents were not informed that they could access personal funds outside of the posted hours.</p> <p>During an interview on 05/02/2025 at 8:33 AM, Licensed Vocational Nurse (LVN) #6 stated if residents requested personal funds during the weekend, she would not have access to the funds and would inform the residents they must wait until Monday to access their funds.</p> <p>During an interview on 05/02/2025 at 9:35 AM, the Director of Nursing stated her expectation was that facility staff followed the federal guidelines regarding the residents having access to their personal funds.</p> <p>During an interview on 05/02/2025 at 10:16 AM, the Executive Director (ED) stated there was no system in place for residents to access their personal funds on the weekend. The ED stated he expected facility staff to follow the facility protocol and allow residents access to their funds on the weekends.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>51749</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 (Resident #130) of 3 sampled residents reviewed for preadmission screening and resident review (PASRR).</p> <p>Findings included:</p> <p>A facility policy titled, Certifying Accuracy of the Resident Assessment, revised 11/2019, indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The policy revealed, 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. 3. The information captured on the assessment reflects the status of the resident during the observation period for that assessment. Different items on the MDS may have different observation periods. 4. The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the resident assessment coordinator, who is a registered nurse.</p> <p>An Admission Record revealed the facility admitted Resident #130 on 11/22/2023. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia, depression, anxiety disorder, and persistent mood affective disorder.</p> <p>An admission MDS, with an Assessment Reference Date (ARD) of 11/26/2023, revealed Resident #130 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability, or a related condition.</p> <p>Resident #130's Care Plan Report revealed a focus area initiated 11/09/2024, that indicated the resident had impaired cognitive status and impaired thought processes related to impaired decision making, schizophrenia, depression, and anxiety.</p> <p>An annual MDS, with an ARD of 11/22/2024, revealed Resident #130 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability, or a related condition.</p> <p>A letter from the State of California - Health and Human Services Agency Department of Health Care Services dated 11/17/2023, indicated Resident #130's level I screening was conducted followed by a level II evaluation, which indicated the resident required nursing facility services due to a medical and/or mental health condition.</p> <p>During an interview on 05/01/2025 at 4:11 PM, the MDS Director stated Resident #130's admission and annual MDS were inaccurate because the resident did have a Level II evaluation at admission that indicated the resident had a serious mental illness.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/01/2025 at 9:10 AM, the Director of Nursing stated Resident #130's admission MDS with an ARD of 11/26/2023 was inaccurate.</p> <p>During an interview on 05/02/2025 at 11:35 AM, the Executive Director stated he expected MDS assessments to be accurate.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45645</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a person-centered care plan that addressed the exit-seeking behavior for 1 (Resident #47) of 5 sampled residents reviewed for accidents.</p> <p>Findings included:</p> <p>A facility policy titled, Wandering and Elopements, revised 03/2019, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The policy revealed, 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>An Admission Record indicated the facility admitted Resident #47 on 12/27/2024. According to the Admission Record, the resident had a medical history that included diagnoses of hepatic encephalopathy (a brain dysfunction due to liver disease), schizophrenia, and bipolar disorder.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2025, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment.</p> <p>Resident #47's Care Plan Report with an admitted [DATE], revealed no care plan to address the resident's exit-seeking behavior.</p> <p>Resident #47's Social Services Progress Note, dated 03/13/2025 at 11:31 AM, indicated the resident exhibited multiple episodes of wanting to leave the facility and aggression.</p> <p>Resident #47's Behavior Note, dated 03/13/2025 at 11:34 AM, indicated the resident attempted to elope and hit staff, with redirection being ineffective.</p> <p>During an observation on 04/28/2025 at 10:01 AM, Resident #47 attempted to leave the secured, locked unit twice and staff retrieved the resident.</p> <p>During an observation on 04/28/2025 at 10:42 AM, Resident #47 left the secured, locked unit and staff had to go and return the resident to the secured unit.</p> <p>During an observation 04/29/2025 at 12:31 PM, Resident #47 walked toward the alarmed door, became agitated, and screamed when staff stopped the resident.</p> <p>During an observation on 04/29/2025 at 3:22 PM, Resident #47 was outside the secured, locked unit. Staff caught up to Resident #47 and guided the resident back to the unit.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/29/2025 at 12:23 PM, Certified Nursing Assistant (CNA) #7 stated Resident #47 often tried to exit the unit, especially in the afternoons. CNA #7 stated the resident's exit-seeking behavior occurred almost daily, and staff tried to redirect the resident.</p> <p>During an interview on 04/29/2025 at 12:30 PM, CNA #3 stated Resident #47 had exit-seeking behaviors and was able to move quickly and reached the door several times a day.</p> <p>During an interview on 04/29/2025 at 12:33 PM, Licensed Vocational Nurse #1 stated Resident #47 tried to go through the exit door, and if it was a bad day for the resident, the attempts were constant.</p> <p>During an interview on 04/30/2025 at 2:06 PM, Registered Nurse (RN) #11 stated Resident #47's behaviors included exit-seeking behaviors. Per RN #11, the behavior, while consistent, got worse in the afternoon until dinner. RN #11 stated Resident #47's exit-seeking behaviors were not addressed on their care plan.</p> <p>During an interview on 04/30/2025 at 8:28 AM, the MDS Director stated he had heard Resident #130 wandered but had not heard the resident left the secured, locked unit. The MDS Director stated the nurses should have developed a care plan with interventions to address the resident's behavior.</p> <p>During an interview on 04/30/2025 at 2:28 PM, the Social Services Director agreed Resident #130 exhibited wandering behaviors and did not have a care plan to address their wandering.</p> <p>During an interview on 05/02/2025 at 8:27 AM, the Director of Nursing stated the expectation was for nurses to develop a care plan that reflected appropriate interventions to maintain the safety of the residents.</p> <p>During an interview on 05/02/2025 at 9:15 AM, the Executive Director stated Resident #47 exhibited behaviors that qualified them as high risk for elopement and, as such, should have had a care plan in place.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>51680</p> <p>Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to provide necessary services to maintain personal hygiene for 3 (Residents #16, #73, and #58) of 5 sampled residents reviewed for activities of daily living (ADLs).</p> <p>Findings included:</p> <p>A facility policy titled, Activities of Daily Living (ADLs), Supporting, revised 03/2018, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>1. An Admission Record indicated the facility admitted Resident #16 on 02/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, hemiplegia and hemiparesis following cerebral infarction, and type 2 diabetes mellitus.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/06/2025, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff assistance for toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>Resident #16's Care Plan Report, included a focus area initiated 12/14/2024, that indicated the resident was at risk for altered ADL self-care performance deficit. Interventions directed staff to check nail length and trim and clean on bath day and as necessary and report any changes to the nurse and provide grooming and hygiene daily.</p> <p>During a concurrent observation and interview on 04/28/2025 at 2:38 PM, Resident #16's fingernails were observed long with uneven edges and a brown substance under the nails. Resident #16 stated staff would not clip their nails because the resident was diabetic.</p> <p>During a concurrent observation and interview on 04/29/2025 at 9:33 AM, Resident #16's fingernails were long, uneven, chipped, and with a brown substance underneath each nail. Resident #16 said they asked staff to clip their nails on 04/29/2025, because they had sustained self-inflicted scratches due to their nails being jagged.</p> <p>During an interview on 04/30/2025 at 8:34 AM, Certified Nursing Assistant #14 stated Resident #16 had long nails, and nail clipping was to be done by a nurse as the resident was diabetic.</p> <p>During an interview on 05/02/2025 at 10:58 AM, the Director of Nursing (DON) stated the expectation was to a resident's keep nails trimmed and cleaned. The DON said nursing staff were responsible to complete nail care or refer the resident for appropriate outside assistance, if needed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/02/2025 at 11:12 AM, the Executive Director stated the expectation was for staff to follow policy and ensure residents' dignity.</p> <p>2. An Admission Record indicated the facility admitted Resident #73 on 05/26/2023. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, age-related osteoporosis, and monoplegia of upper limb affecting the right dominant side.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2025, revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff assistance for toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>Resident #73's Care Plan Report included a focus area initiated 09/03/2024, that indicated the resident was at risk for altered ADL self-care performance deficit. Interventions directed staff to provide grooming and hygiene daily.</p> <p>During an observation on 04/28/2025 at 1:23 PM and 04/29/2025 at 10:14 AM, Resident #73 had obvious facial hair on their upper lip and chin.</p> <p>During an interview on 05/01/2025 at 8:53 AM, Certified Nursing Assistant #13 stated she showered Resident #73, but did not have time to shave the resident.</p> <p>During an interview on 05/02/2025 at 10:54 AM, the Director of Nursing stated the expectation was for staff to provide grooming and hygiene as needed and if unable to request assistance to complete tasks.</p> <p>During an interview on 05/02/2025 at 11:10 AM, the Executive Director stated the expectation was for staff to follow policy and ensure residents' dignity.</p> <p>52219</p> <p>3. An Admission Record revealed the facility admitted Resident #58 on 03/25/2024 . According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and the need for assistance with personal care.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2025, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for oral and personal hygiene.</p> <p>Resident #58's Care Plan Report included a focus area initiated 11/21/2024, that indicated the resident was at risk for altered ADL self-care performance deficit. Interventions directed staff to check nail length, to trim and clean the nails on bath day and as necessary, and to report changes to the nurse (initiated 11/21/2024) and provide grooming and hygiene daily (initiated 11/21/2024).</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>52219</p> <p>Based on interview and record review, the facility failed to clarify a physician order related to a resident's fluid restriction and failed to ensure staff did not provide more than the ordered fluids for 1 (Resident #98) of 2 sampled residents reviewed for dialysis.</p> <p>Findings included:</p> <p>An Admission Record revealed the facility admitted Resident #98 on 01/11/2024. According to the Admission Record, the resident had a medical history that included the diagnoses of end stage renal disease, dependence on renal dialysis, hypertensive heart and chronic kidney disease without heart failure, and dysphagia oropharyngeal phase (difficulty swallowing).</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/18/2025, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident required set up or clean up assistance for eating.</p> <p>Resident #98's Care Plan Report included a focus area initiated 08/12/2024 and revised 12/08/2024, that indicated the resident was at risk for dehydration, weight changes, nausea, vomiting, loss of appetite, fatigue and weakness, changes in the amount of urine production and output, swelling in their feet and ankles, and shortness of breath. Interventions directed staff to adhere to fluid restrictions as ordered (initiated 08/12/2024). The Care Plan Report included a focus area initiated 08/08/2024 and revised 12/08/2024, that indicated the resident was at risk for complications such as dry itchy skin, altered vital signs, poor circulation, fluid volume deficit/overload, weight changes, abnormal laboratory values, and excessive bleeding/bruising at the access site. Interventions directed staff to monitor for edema, shortness of breath, chest pain, or increased blood pressure as they might indicate fluid overload (initiated 08/08/2024) and monitor the resident's intake and output as ordered (initiated 08/08/2024). The Care Plan Report also included a focus area initiated 08/08/2024 and revised 02/20/2025, that indicated the resident was at risk for altered nutritional status and dehydration related to end stage renal disease and was on hemodialysis and required a mechanically altered diet and thickened liquids related to dysphagia. Interventions indicated the resident was on a fluid restriction of 1,000 milliliters (mL) (initiated 02/20/2025).</p> <p>Resident #98's Order Summary Report, with active orders as of 04/29/2025, revealed an order dated 02/20/2025, for a fluid restriction of 1,000 mL per day. The order indicated nursing was to administer 300 mL of fluids three times a day and dietary was to administer 700 mL of fluids, with 360 mL at breakfast, lunch 240 180 mL and 160 mL for dinner.</p> <p>Resident #98's meal tray card revealed the resident was on a renal diet and had a fluid restriction of a total of 1,000 mL per day, with the breakdown of 360 mL for breakfast, 180 mL for lunch, and 160 mL for dinner.</p> <p>Resident #98's medication administration record (MAR), for the timeframe from 03/01/2025 through 03/31/2025, revealed nursing documented the following:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Santa Fe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 247 E. Bobier Drive Vista, CA 92084	
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 03/01/2025, Resident #98 received 360 mL during the morning shift, 360 mL during the evening shift, and 360 mL during the night shift, for a total of 1,080 mL of fluid that day.</p> <p>- On 03/04/2025, Resident #98 received 480 mL during the morning shift, 360 mL during the evening shift, and 360 mL during the night shift, for a total of 1,200 mL of fluid that day.</p> <p>- On 03/05/2025, Resident #98 received 360 mL during the morning shift, 360 mL during the evening shift, and 360 mL during the night shift, for a total of 1,080 mL of fluid that day.</p> <p>- On 03/06/2025, Resident #98 received 360 mL during the morning shift, 360 mL during the evening shift, and 360 mL during the night shift, for a total of 1,080 mL of fluid that day.</p> <p>Resident #98's MAR, for the timeframe from 04/01/2025 to 04/30/2025, revealed nursing documented the following:</p> <p>- On 04/03/2025, Resident #98 received 360 mL during the morning shift, 360 mL during the evening shift, and 360 mL during the night shift, for a total of 1,080 mL of fluid that day. - On 04/05/2025, Resident #98 received 480 mL during the morning shift, 480 mL during the evening shift, and 480 mL during the night shift, for a total of 1,440 mL of fluid that day.</p> <p>- On 04/06/2025, Resident #98 received 480 mL during the morning shift, 480 mL during the evening shift, and 120 mL during the night shift, for a total of 1,080 mL of fluid that day.</p> <p>- On 04/08/2025, Resident #98 received 480 mL during the morning shift, 320 mL during the evening shift, and 320 mL during the night shift, for a total of 1,120 mL of fluid that day.</p> <p>Resident #98's Task tab on the electronic medical record for Nutrition-Fluids revealed certified nursing assistants (CNAs) documented the following:</p> <p>- On 04/03/2025, Resident #98 received 240 mL of fluid at 1:06 PM and 480 mL at 10:59 PM.</p> <p>- On 04/05/2025, Resident #98 received 360 mL at 8:55 PM.</p> <p>- On 04/06/2025, Resident #98 received 380 mL of fluid at 2:59 PM and 360 mL at 8:59 PM.</p> <p>Resident #98's Progress Notes, for the timeframe from 03/01/2025 to 04/30/2025, revealed no documented communication between nursing staff and the physician or the dialysis physician related to the resident exceeding the fluid restriction or clarification of the fluid restriction order. There was also no documentation to indicate the resident or their family were noncompliant with the ordered fluid restrictions.</p> <p>During an interview on 04/30/2025 at 8:53 AM, Licensed Vocational Nurse (LVN) #25 stated Resident #98 was on a fluid restriction. She stated the physician-ordered fluid restriction was for 1,000 mL per day. LVN #25 stated the breakdown was on the MAR and that it showed how much dietary staff and nursing staff were to provide. LVN #25 reviewed the resident's April 2025 MAR and confirmed that for the dates of 04/03/2025, 04/05/2025, 04/06/2025, and 04/08/2025 the documented amount of fluids the resident received exceeded the ordered amount. She stated Resident #98 received more fluids than they were supposed to.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up interview on 05/01/2025 at 10:14 AM, LVN #25 stated if a resident's MAR showed the resident received more fluid than what the resident should have received, the doctor was supposed to be notified.</p> <p>During an interview on 05/02/2025 at 7:38 AM, LVN #26 stated Resident #98 was able to receive 1,000 mL per day. LVN #26 stated that for 04/03/2025, the fluids recorded on the night shift for the resident put the resident over the 1,000 mL. According to LVN #26, with an overage of fluids, the resident could have shortness of breath.</p> <p>During a follow-up interview on 05/02/2025 at 8:13 AM, LVN #26 confirmed Resident #98 received over the ordered amount of fluids on 03/05/2025.</p> <p>During an interview on 05/01/2025 at 10:39 AM, Registered Nurse (RN) #8 stated Resident #98 was supposed to have 300 mL from nursing staff and 700 mL from dietary staff, for a total of 1,000 mL per day. RN #8 stated that for dietary staff, the numbers on the physician's order were not correct. RN #8 stated the facility needed clarification for what they were supposed to administer.</p> <p>During an interview on 05/01/2025 at 3:33 PM, Registered Dietician (RD) #27 reviewed the fluid restriction order for Resident #98 and stated that the order was not correct. She stated Resident #98's tray card indicated 360 mL for breakfast, 180 mL for lunch, and 160 mL for dinner. RD #27 stated the extra 240 mL listed in the order was a mistake and did not belong. She stated the number documented by nursing on the MARs for fluid was a combination of what nursing and dietary gave the resident. She stated too much fluid could be a factor for the resident because the resident was on dialysis.</p> <p>During a follow-up interview on 05/01/2025 at 3:41 PM, RD #27 reviewed the total amounts of fluids provided to Resident #98 on each shift for 04/05/2025 and stated the fluid provided was above what was ordered.</p> <p>During an interview on 05/02/2025 at 11:55 AM, Medical Doctor (MD) #29 stated he did not recall being contacted by the facility. MD #29 stated if ordered fluid restrictions were not followed, a resident could have heart failure and edema.</p> <p>During an interview on 05/02/2025 at 10:21 AM, the Director of Nursing stated she expected staff to be aware of a fluid restriction order and follow it. She stated that if a fluid restriction order could not be followed, then staff needed to notify the entities that needed to be aware of it, such as the physician, the RD, and the responsible party, so the plan of care could be adjusted.</p> <p>During an interview on 05/02/2025 at 12:13 PM, the Executive Director stated he expected staff to follow the order and make sure they did not exceed a resident's ordered fluid restriction.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45645</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure medications were not left unattended and the medication cart was not left unlocked with out of sight of the medication nurse for 1 (Cart A Hall A Station 1 medication cart) of 8 medication carts.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised 04/2019, indicated, 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The medication must be clearly visible to the personnel administering medications.</p> <p>During an observation on 04/29/2025 at 8:34 AM, the surveyor noted Cart A Hall A Station 1 medication cart was unattended and unlocked. A certified nursing assistant stated she would get the nurse. At 8:43 AM, a nurse appeared and was shown the unlocked medication cart. On top of the medication cart was a glucometer and lancets in an opened tray. The nurse stated the medication cart should always be locked when not in a nurse's sight in an attempt to protect everyone.</p> <p>During an interview on 04/29/2025 at 8:45 AM, Licensed Vocational Nurse #2 stated she could not see the medication cart from room [ROOM NUMBER] where she was.</p> <p>During medication administration observation on 04/29/2025 at 8:49 AM, a nurse left the medications on top of the medication cart, which was left unlocked when they entered Resident #26's room to administer medication(s). At 8:55 AM, the nurse stated they should not leave medications on top of the medication cart as someone might have taken the medications and it was not safe. The nurse also acknowledged they were behind the resident's privacy curtain and could not see the medication cart. When the nurse entered Resident #26's room to administer the medications, the resident refused the medication. The nurse then placed the medication in a plastic bag and placed the plastic bag on top of the medication cart. The nurse left the medication unsecured on top of the medication cart and stated she had to go to the bathroom. The surveyor noted the medication cart was also unlocked.</p> <p>During an interview on 04/29/2025 at 9:13 AM, the Director of Nursing (DON) stated medication(s) should not be left unattended and the medication cart should not be left unlocked when out of the nurse's sight. Per the DON, the facility had eight medication carts.</p> <p>During an interview on 05/02/2025 at 9:22 AM, the Executive Director stated medication carts must be locked when out of sight and medications should not be left unattended.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35314</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to implement enhanced barrier precautions (EBPs) for 1 (Resident #54) of 4 sampled residents reviewed for pressure ulcers and/or urinary catheters.</p> <p>Findings included:</p> <p>A facility policy titled, Enhanced Barrier Precautions, dated 08/2022, revealed, 1. Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). The policy specified, 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. [et cetera, and other similar things]); and h. wound care (any skin opening requiring a dressing).</p> <p>An Admission Record revealed the facility admitted Resident #54 on 01/28/2025. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes, a stage 4 pressure ulcer of the right hip, and obstructive and reflux uropathy.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/2025, revealed Resident #54 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had modified independence in cognitive skills for daily decision-making. The MDS indicated Resident #54 was dependent on staff with all activities of daily living. The MDS indicated Resident #54 had an indwelling catheter and a stage 4 pressure ulcer.</p> <p>Resident #54's Care Plan Report included focus area initiated 01/29/2025, that revealed the resident had an indwelling urinary catheter. The Care Plan Report also included a focus area initiated 01/29/2025, that indicated the resident had a stage 4 pressure ulcer on their left hip.</p> <p>During an observation on 04/29/2025 at 10:31 AM, Certified Nursing Assistant (CNA) #19 entered Resident #54's room, spoke with the resident about the upcoming procedure, washed her hands, and donned gloves. CNA #19 removed the resident's urinary catheter from the privacy bag and emptied the contents of the urinary catheter bag into a measuring container CNA #19 did not wear a gown during this observation.</p> <p>During an interview on 04/30/2025 at 11:11 AM, CNA #19 stated she was not required to wear a gown when she completed catheter care.</p> <p>During an interview on 04/30/2025 at 11:37 AM, the Infection Preventionist stated EBPs were required for any resident with a catheter, a gastrostomy tube, or wound.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of wound care for Resident #54 on 05/01/2025 at 5:07 AM, Licensed Vocational Nurse (LVN) #20 did not wear a gown when she provided wound care for the resident.</p> <p>During an interview on 05/01/2025 at 11:46 AM, LVN #20 acknowledged a gown was not used during wound care treatment for Resident #54.</p> <p>During an interview on 05/02/2025 at 9:45 AM, the Director of Nursing stated EBP was required for residents with catheters, wounds, and gastrostomy tubes and she expected the staff to follow EBPs.</p> <p>During an interview on 05/02/2025 at 10:10 AM, the Executive Director stated he expected EBPs to be followed.</p>