STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Regional Medical Center D/P Snf	14662 Newport Avenue Tustin, CA 92780

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident's Physician Orders for Life-Sustaining Treatment (POLST) was obtained and maintained in the medical record for one of 12 final sampled residents (Resident 22). This failure had the potential for the resident's decisions regarding his healthcare and treatment options to not be honored. Findings: Review of the facility's P&P titled Life Sustaining Treatment Physician Orders (POLST) revised 8/2023 showed all departments licensed by the facility will honor the POLST, a statewide mechanism for an individual to communicate his or her wishes about a range of life sustaining and resuscitative measures. Medical record review for Resident 22 was initiated on 2/26/24. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Patient Orders showed a physician's order dated 10/19/22, for a Full Code, and to obtain POLST. Review of Resident 22's medical record failed to show a copy of Resident 22's POLST was obtained and maintained in the resident's medical record. On 2/27/24 at 1431 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the findings and stated there was no POLST in the resident's medical record and would ask the resident's family member to fill out a POLST. On 2/27/24 at 1520 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 acknowledged the findings and stated POLST should have been in the medical record for when something happened, they would know the resident's code status and what their wishes were. RN 2 further stated if the POLST was not in the resident's medical record, the resident was considered full code.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 12 final sampled residents (Residents 8 and 24) were free from the physical restraints. * The facility failed to conduct an assessment, obtain an informed consent and a physician's order, and implement the least restrictive interventions prior to applying the seat belt and chest strap restraints for Residents 8 and 24 when the residents were up in the wheelchair. In addition, the facility failed to monitor and document the use of seat belt and chest straps restraints in the wheelchair. These failures posed the risk of compromising the residents' independence and psychosocial well-being. Findings: Review of the facility's P&P titled Restraints-Physical/Postural support, Safety revised 9/2021 showed the facility would complete the form Physical Restraint Assessment by the DON/Charge Nurse. The use of restraints should have been discussed with the resident and/or the responsible party. The nurse will contact the physician for a restraints order and initiate the verification of informed consent process. The nurse's documentation requirements for the use of restraints includes the assessment for the use of restraints weekly evaluation to determine the continuation or discontinuation of the restraints. 1. Medical record review for Resident 8 was initiated on 2/26/24. Resident 8 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 8 was assessed for using a side rail restraint in bed. However, the assessment failed to indicate for the use of Resident 8's seat belt and chest strap restraints in the wheelchair. Review of Resident 8's Orders dated 2/26/24, the physician's orders failed to show an order for the use of the seat belt and chest strap restraints in the wheelchair. Further review of Resident 8's medical record failed to show an informed consent was obtained, an assessment was conducted, and a least restrictive interventions were implemented prior to the use of seat belt and chest strap restraints in wheelchair. In addition, the medical record failed to show the documentation and monitoring for the use of the seat belt and chest strap restraints in the wheelchair. On 2/27/24 at 1157 hours, an observation and concurrent interview for Resident 8 was conducted with CNA 5. Resident 8 was observed up in wheelchair with the seat belt and chest strap restraints in place. CNA 5 stated Resident 8 was up in the wheelchair for the activity and wears a seat belt and chest strap restraints due to Resident 8's moved a lot while in the wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/24 at 0900 hours, an observation and concurrent interview for Resident 9 was conducted with RCP 1. RCP 1 was observed working with Resident 8 while up in wheelchair for his respiratory care and needs. RCP 1 stated Resident 8 was using the wheelchair seat belt and chest straps restraints because Resident 8 was able to lean forward and to prevent Resident 8 from falling. On 2/28/24 at 0843 hours, an interview and concurrent medical record review for Resident 8 was conducted with LVN 5. LVN 5 verified Resident 8 was using the seat belt and chest strap restraints in the wheelchair. On 2/28/24 at 0901 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 2. RN 2 verified Resident 8 was wearing a seat belt and chest strap in the wheelchair due to Resident 8 tendency on leaning forward. RN 2 verified there were no informed consent obtained, physician's order, assessment, and documentation for the monitoring of Resident 8's use of seat belt and chest strap restraints in the wheelchair. Cross reference to F 657, example #3. 2. Medical record review for Resident 24 was initiated on 2/27/24. Resident 24 was admitted to the facility on [DATE]. On 2/26/24 at 1044 hours, Resident 24 was observed up in the wheelchair with the seat belt and chest strap restraints in place. Review of the MDS dated [DATE], showed Resident 24 was assessed for using a side rail restraint in bed. However, the assessment failed to indicate for the use of Resident 24's seat belt and chest strap restraints in the wheelchair. Review of Resident 24's Orders dated 2/26/24, the physician's orders failed to show an order for the use of the seat belt and chest strap restraints in wheelchair. Further review of Resident 24's medical record failed to show an informed consent was obtained, an assessment was conducted, and a least restrictive interventions were implemented prior to the use of seat belt and chest strap restraints in wheelchair. In addition, the medical record failed to show the documentation and monitoring for the use of the seat belt and chest strap restraints in the wheelchair. On 2/27/24 at 1143 hours, an interview for Resident 24 was conducted with CNA 5. CNA 5 verified Resident 24 were wearing the seat belt and chest strap restraints in the wheelchair. On 2/27/24 at 1515 hours, an interview and concurrent medical record review for Resident 24 was conducted with LVN 5. LVN 5 stated Resident 24 was up in wheelchair during daytime and was wearing the seat belt and chest strap restraints. On 2/28/24 at 0930 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 2. RN 2 verified Resident 24 was wearing the seat belt and chest strap restraints in the wheelchair. RN 2 verified there were no informed consent obtained, physicians order, assessment, and documentation for the monitoring for Resident 24's use of seat belt and chest strap restraints in the wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/24 at 1543 hours, an interview and concurrent medical record review for Residents 8 and 24 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F657, example #4.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127 Based on interview, medical record review, and facility P&P review, the facility failed to notify the Office of the State Long-Term Care Ombudsman (a person who routinely visits the facility and advocated for the residents) of Resident 25's discharge to another SNF. This failure had the potential for the Ombudsman not knowing about the resident's discharge to another SNF. Findings: Closed medical record review for Resident 25 was initiated on 2/29/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's closed medical record showed the resident was discharged to another SNF on 12/19/23. Review Resident 25's Physician's Discharge summary failed to show documented evidence the Office of the State Long-Term Care Ombudsman was notified of the resident's discharge from the facility. On 2/29/24 at 1610 hours, an interview and concurrent closed medical record review was conducted with the facility's assigned Ombudsman. When asked if Ombudsman 1 was notified of Resident 25's discharge, Ombudsman 1 stated no, she did not get any discharge notification. She stated she did not know of any discharges and had not received any notifications of any discharges this year or last year. RN 3 verified there was no documented evidence the Ombudsman office was notified of the resident's discharge. On 2/29/24 at 1622 hours, an interview was conducted with Ombudsman 1. Ombudsman 1 stated she called and spoke to Ombudsman 2 this afternoon, and Ombudsman 2 told her the facility did not provide any discharge notifications to the Office of the State Long-Term Care Ombudsman for this year.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview and medical record review, the facility failed to ensure the comprehensive plans for four of the 12 final sampled residents (Residents 3, 8, 16, and 24). * The facility failed to develop the comprehensive care plans for Residents 3 and 16's use of padded side rails for safety/injury protection. * The facility failed to ensure Residents 8 and 24's plans of care were revised to address Residents 8 and 24's use of seat belt and chest strap restraints in the wheelchair. These failures posed the risk of not providing the appropriate, consistent, and individualized care to the residents. Findings: 1. Review of the facility's P&P titled Care Plan, Resident; Pediatric Sub- Acute revised 9/23 showed all residents admitted to the Pediatric Sub-Acute will have a Plan of Care developed and implemented based on individual resident care needs. Comprehensive Care Plans are to include measurable objectives and timetables to meet each resident's medical, nursing and mental and psychosocial needs identified in the comprehensive assessment. The Plan of care will be reviewed each shift for appropriateness and interventions in progress. Medical Record review for Resident 3 was initiated on 2/27/24 at 1443 hours. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's History and Physical examination dated 9/8/23 showed the resident had history of seizure disorder (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain). Review of Resident 3's physician's order dated 9/8/23, showed an order to apply seizure pads to the side rails times four for safety/injury protection. Review of Resident 3's care plans addressing the resident's risk for falls and harm to self dated 2/12/24, failed to show the use of padded side rails was included as an intervention to the resident's plan of care. On 2/29/24 at 0848 hours, an interview and concurrent record review for Resident 3 was conducted with RN 4. RN 4 stated the padded side rails for safety/injury protection should be included in Resident 3's care plan. 2. Medical Record Review for Resident 16 was initiated on 2/26/24 at 1004 hours. Resident 16 was admitted to the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 16's History and Physical examination dated 5/25/20, showed the diagnosis included seizure disorder. Review of Resident 16's physician's order dated 3/2/23, showed an order for side rails up times three and padded side rails times three while in bed for safety; and may release during activities and supervised visits. Review of Resident 16's care plan problem addressing the resident's risk for falls dated 2/2/24, failed to show the interventions included the use of padded side rails. On 2/29/24 at 0850 hours, interview and concurrent record review for Resident 16 was conducted with RN 4. RN 4 verified the care plan for Resident 16 should include the padded side rails for safety. 39670 3. On 2/27/24 at 1157 hours, Resident 8 was observed up in the wheelchair with the seat belt and chest strap restraints in place. Medical record review for Resident 8 was initiated on 2/26/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's plan of care showed a care plan problem dated 2/14/24, addressing Resident 8's risk for fall. The plan of care was not revised to reflect Resident 8's use of seat belt and chest strap restraints in the wheelchair. On 8/28/24 at 0901 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 2. RN 2 stated all the licensed nurses were responsible to formulating and updating the care plans. RN 2 stated the facility had a schedule for updating the care plans. RN 2 was asked about the plan of care for the use of Resident 8's seat belt and chest strap in the wheelchair, RN 2 was able to provide the care plan addressing the risk for fall. However, RN 2 verified the care plan interventions did not include the use of seat belt and chest strap restraint in the wheelchair. Cross reference to F604, example #1. 4. Medical record review for Resident 24 was initiated on 2/27/24. Resident 24 was admitted to the facility on [DATE]. On 2/26/24 at 1044 hours, Resident 24 was observed up in the wheelchair with the seat belt and chest strap restraints were in place. Review of Resident 24's plan of care showed a care plan problem dated 2/16/24, addressing Resident 24's risk for fall. The plan of care was not revised to reflect Resident 24's use of seat belt and chest strap restraints in the wheelchair. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	On 8/28/24 at 0930 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 2. RN 2 was asked about the plan of care for the use of Resident 24's seat belt and chest strap in the wheelchair, RN 2 was able to provide the care plan addressing the risk for fall. However, RN 2 verified the care plan failed to show the interventions for the use of the seat belt and chest strap restraint in the wheelchair. Cross reference to F604, example #2.

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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** 49324 Based on observation, interview, and facility document review, the facility failed to ensure the environment was free from accident hazards for two of 12 final sampled residents (Residents 3 and 16). This failure had the potential to negatively affect the residents' well-being and increased the risk of accidents or injuries to the residents. Findings: 1. On 2/26/24 at 0927 hours, an observation of Resident 3 was conducted. Resident 3 was in bed with billateral upper and lower siderails elevated without padding. On 2/28/24 at 1114 hours, an observation of Resident 3 was conducted. Resident 3 was in bed with bilateral upper and lower siderails elevated without padding. Medical record review for Resident 3 was initiated on 2/27/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Patient Orders showed a physician's order dated 9/8/23, to apply the seizure pads to all four side rails for safety/injury protection. Review of Resident 3's H&P examination dated 9/8/23, showed the resident had a history of seizure disorder. On 2/28/24 at 1113 hours, an observation, interview, and concurrent medical record review was conducted with LVN 3. LVN 3 verified the findings and stated Resident 3's siderails should have been padded. 2. On 2/26/24 at 0856 hours, an observation of Resident 16 was conducted. Resident 16 was in bed with bilateral upper siderails elevated, and one lower siderail elevated without padding. Medical record review for Resident 16 was initiated on 2/26/24. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's Patient Orders showed a physician's order dated 3/2/23, to put the padded side rails up while in bed for safety and may release during the activities and supervised visits. Review of Resident 16's H&P examination dated 5/25/20, showed a diagnosis of seizure disorder. On 2/29/24 at 0850 hours, an observation, interview, and concurrent medical record review was conducted with RN 4. Resident 16 was observed in bed with bilateral upper siderails elevated and one lower siderail elevated without padding. RN 4 verified the padded siderails for Resident 16 was an active physician's order and Resident 16's siderails should have been padded for safety.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and medical record review, the facility failed to ensure three of 12 final sampled residents (Residents 13, 14, and 24) remained free from accident hazards associated with the use of elevated side rails. * The facility failed to assess Residents 13, 14, and 24 for the risk of entrapment from elevated side rails. This failure had the potential to place the residents at risk for entrapment and serious injury. Findings: Review of the FDA issued Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails showed the residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc., that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. 1. Medical record review for Resident 13 was initiated on 2/26/24. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's physician's order dated 3/2/23, showed an order for side rails elevated when Resident 13 was left in bed unattended. Review of Resident 13's care plan titled physical mobility dated 2/16/24, showed Resident 13 had impaired mobility related to decreased muscle endurance, strength, cognitive impairment, and neuromuscular impairment. On 2/26/24 at 1247 hours, an observation of Resident 13 was conducted. Resident 13 was observed lying in bed with bilateral side rails elevated at the head of the bed. On 2/27/24 at 1108 hours, an observation of Resident 13 was conducted. Resident 13 was observed lying in bed with bilateral side rails elevated at the head of the bed. Review of Resident 13's medical record failed to show Resident 13 was assessed for the risk of entrapment from the elevated side rails. On 2/27/24 at 1424 hours, an observation and concurrent medical record review was conducted with RN 3. Resident 13 was observed lying in bed with bilateral side rails elevated at the head of the bed. RN 3 reviewed Resident 13's medical record and verified Resident 13's medical record failed to show Resident 13 was assessed for the risk of entrapment from the elevated side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 14 was initiated on 2/26/24. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's Monthly Bed Review dated 2/15/24, showed Resident 14 had diagnoses which included seizure disorder and spasticity. On 2/26/24 at 0940 hours, an observation was conducted of Resident 14. Resident 14 was observed lying in bed with bilateral side rails elevated at the head of the bed, and one side rail elevated at the foot of the bed. Review of Resident 14's medical record failed to show Resident 14 was assessed for the risk of entrapment from the elevated side rails. On 2/27/24 at 0925 hours, and interview was conducted with RN 3. RN 3 verified Resident 14's bed had elevated side rails. RN 3 reviewed Resident 14's medical record and verified Resident 14's medical record failed to show Resident 14 was assessed for the risk of entrapment from the elevated side rails. 39670 3. On 2/27/24 at 0903 hours, Resident 24 was observed in bed with the four side rails elevated and padded. Medical record review for Resident 24 was initiated on 2/27/24. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's MDS dated [DATE], showed Resident 24 was severely impaired cognitively and dependent to staff on all ADL cares. Review of Resident 24's plan of care failed to show documented evidence a care plan problem was developed to address the use of the side rails. Review of Resident 24's medical record failed to show Resident 24 was assessed for the risk of entrapment from the elevated side rails. On 2/27/24 at 1143 hours, an interview for Resident 24 was conducted with CNA 5. CNA 5 verified Resident 24's side rails were up while in bed. On 8/28/24 at 0930 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 2. RN 2 verified there was no assessment for the risk of entrapment in bed for Resident 24.

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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** 39670 Based on observation, interview, and medical record review, the facility failed to ensure one of 12 final sampled residents (Resident 24) was free from the unnecessary psychotropic medications. * The facility failed to ensure the physician's order for the quetiapine medication (a medication use to treat symptoms of schizophrenia or bipolar disorder) had a behavior indication for it's use, and the behavior and side effects were monitored related to the use of quetiapine. In addition, Resident 24's medical record failed to show monthly psychotropic summaries related to the use of quetiapine were completed and a plan of care was formulated for the use of the medication. These failures had the potential for the resident to have adverse complications from the medications and the potential of not providing the correct data to the prescriber to adjust the dose of the psychotropic medications for the resident. Findings: Medical record review for Resident 24 was initiated on 2/27/24. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's MDS dated [DATE], showed Resident 24 had severely impaired cognitively. Review of Resident 24's Physician's History & Physical examination dated 7/28/23, showed Resident 24 had issues with neurostorming (a hyperactive response of the sympathetic nervous system - the division of the nervous system controlling response to environmental changes and stress) and agitation requiring sedation. Resident 24 was on quetiapine 25 mg at bedtime. Review of Resident 24's Orders showed a physician's order dated 8/30/23, to administer quetiapine 25 mg via GT at bedtime for neuro irritability. The physician's order failed to show a manifestations behavior, behavior monitoring and side effects monitoring for the use of quetiapine medication. Review of Resident 24's medical record failed to show a specific monitoring of the manifestation behavior and side effects for the quetiapine medication. Further medical record review for Resident 24 did not show documented evidence the IDT Care Conference for Behavior and Psychotropic Management were completed for the use of quetiapine medication, where a possible gradual dose reduction for psychotropic medications were discussed and recorded. Review of Resident 24's Plan of Care failed to show a care plan problem addressing Resident 24's use of quetiapine medication. On 2/29/24 at 1140 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 3. RN 3 verified Resident 24 was on quetiapine fumarate medication and did not have a specific behavior monitoring for the use of quetiapine medication. RN 3 further verified Resident 24 did not have the monitoring of the side effects documented for quetiapine fumarate medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/24 at 1543 hours, an interview and concurrent medical record review for Resident 24 was conducted with the DON. The DON was informed and verified the above findings.

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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. 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 8%. One licensed nurse (LVN 3) was found to have made errors during the medication administration observation. * Resident 3 had a physician's order for ocular lubricant ophthalmic solution and chlorhexidine (antiseptic) mouthwash which were scheduled at 0800 hour; however, LVN 3 failed to administer the medications as scheduled. This failure had the potential to negatively effect the resident's health. Findings: Review of the facility's P&P titled Medication Orders and Management revised 9/2021 showed the medications shall be administered within one hour before the prescribed time and within one hour after the prescribed time for a total of a two hour window. On 2/28/24 at 0834 hours, a medication administration observation for Resident 3 was conducted with LVN 3. LVN 3 prepared and administered Resident 3's medications. On 2/28/24 at 1129 hours, LVN 3 was observed administering two medications to Resident 3, chlorhexidine 0.12% mouthwash 15 ml and ocular lubricant ophthalmic solution one drop to both of Resident 3's eyes. A medical record review was then conducted with LVN 3. Review of Resident 3's active physician's orders showed the chlorhexidine 0.12% mouthwash 15 ml and ocular lubricant ophthalmic solution one drop to both eyes were scheduled to be administered at 0800 hours. LVN 3 verified the medications were scheduled for 0800 hours and should have been administered within one hour of the scheduled administration times. LVN 3 verified the medications were not administered within one hour of the scheduled medication time. LVN 3 verified Resident 3's Medication Administration History showed LVN 3 documented he administered Resident 3's chlorhexidine 0.12% mouthwash 15 ml (scheduled for 0800 hours) at 1119 hour and Resident 3's ocular lubricant ophthalmic solution one drop to both eyes (scheduled for 0800 hours) at 1121 hours.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were properly stored and labeled. * The facility failed to ensure the safe storage and dispose of Resident 16's expired medication found on his bedside table. * Resident 1 had a physician's order for vitamin D. Resident 1's vitamin D liquid bottle was observed with an unknown substance accumulated on the outside of the bottle. These failures had the potential to negatively impact the residents' well being. Findings: 1. Review of the facility's P&P titled Medication Storage date revised 9/21 showed all medications should be stored in a locked cabinet or room inaccessible to the residents and visitors. Drugs should not be kept on hand after the expiration date on the label. Medical record review for Resident 16 was initiated on 2/26/24 at 1004 hours. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's physician's order dated 4/3/23, showed an order for fluticasone (steroid medication) nasal 50 mcg/inh, 50 mcg/dose to administer one spray to both nostrils two times a day. On 2/26/24 at 0856 hours, an initial tour was conducted for Resident 16's room. The medication Flonase (brand name for fluticasone) 0.05 mg/inh nasal spray with labeled open date of 1/14 and expiration date of 2/14 was observed to be on the resident's bedside table. On 2/26/24 at 0906 hours, an observation and concurrent interview was conducted with CNA 4. CNA 4 acknowledged the Flonase 0.05 mg spray was observed on the bedside table of Resident 16. According to CNA 4, he did not knew about the medication at Resident 16's bedside table and he should have informed the licensed nurses. On 2/26/24 at 0917 hours, an observation and concurrent interview was conducted with RN 5. RN 5 acknowledged the medication should not be left on the bed side table of Resident 16 and all the medications should be stored in the medication cart and expired medications should be disposed. 37726 2. Medical record review for Resident 1 was initiated on 2/26/24. Resident 1 was admitted to the facility on [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's physician's order showed an order dated 1/1/24, for vitamin D (supplement) liquid 1000 IU via GT daily. On 2/28/24 at 0823 hours, an inspection of Medication Cart A was conducted with LVN 3. Resident 1's vitamin D (400 IU/ml, 50 ml solution) bottle was observed stored inside of Medication Cart A. The outside of Resident 1's vitamin D bottle was observed with an unknown substance accumulated on the outside of the bottle. LVN 3 verified the findings and stated the build up of the unknown substance on the outside of Resident 1's vitamin D bottle was a potential infection control concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were not worn out. * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the microwave utilized to warm up the residents' food was in sanitary condition and free of food residue. * The facility failed to ensure the plumbing for the ice machine in the kitchen had an air gap. * The facility failed to ensure the test strip to measure the pH of the chemical sanitizing solution used to wash raw fruits and vegetables were not expired. * The facility failed to ensure the pH value of the chemical sanitizing solution used to wash raw fruits and vegetables was within normal range. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's census and verified by the RN 2 on [DATE], showed one of 37 residents in the facility received food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section ,d+[DATE].12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. Review of the facility's P&P titled Cleaning of Food and Nonfood Contact Surfaces revised ,d+[DATE] showed the food contact surfaces are in good condition, made of non-toxic materials and are easily cleanable. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial kitchen tour on [DATE] at 0830 hours, a concurrent observation and interview was conducted with the DSS. The green and white cutting boards were observed with deep groves, heavily marred, and discolored. The DSS acknowledged the findings and stated it should have been replaced. 2. According to the USDA Food Code 2022 Section ,d+[DATE].11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts ,d+[DATE] and ,d+[DATE] or shall be discarded. According to the USDA Food Code 2022, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. Review of the facility's P&P titled Cleaning of Food and Nonfood Contact Surfaces revised date ,d+[DATE] showed discard any food contact surfaces with chips, nicks or broken pieces, such as fryer baskets or skimmers that have damaged, loose or broken wires, strainers, pans, skillets, and knives, which cannot be cleaned properly. On [DATE] at 0830 hours, a concurrent observation and interview was conducted with the DSS. The following was identified and verified by the DSS: - Two rubber spatulas with red handles were cracked, chipped at the edges, discolored, and worn off with brownish discoloration (rubber part) which resembled burn mark. The DSS stated the spatulas were a safety hazard, the chipped parts of the spatulas can get mix with the food. - One white butter brush was observed with a frayed bristle, partially melted, and discolored. The DSS stated it should have been replaced. - Two ladles with black handles and one slotted ladle with green handle was observed with worn out handles, peeling, and discolored. The DSS stated it was an infection control issue and safety concern. - Two stainless strainers were observed discolored which resembles rust, and deformed. The DSS stated it was not safe to used and should have been replaced. 3. According to the USDA Food Code 2022, ,d+[DATE].11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, ,d+[DATE].13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Cleaning of Food and Nonfood Contact Surfaces revised ,d+[DATE] showed the iced tea dispensers and self-service utensils such as tongs and scoops used with non-potentially hazardous foods, such as bulk candy must be cleaned and sanitized at least once a day. Utensils that are used to serve potentially hazardous foods must be cleaned and sanitized at least every four hours. The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. On [DATE] at 0830 hours, a concurrent observation and interview was conducted with the DSS. The following was identified: - One stainless tong was observed dirty with dry food particle and dry water spots. - One scoop with gray handle and one scoop with blue handle was observed dirty with dry food residue and blue handle worn out and discolored. - One stainless spoon was observed dirty with dry food particle and dry water spots. - One black slotted spatula had oily, sticky, crusted food residue. - One stainless whisk was observed dirty with dry, crusted black residue. - Four stainless measuring cups used for food portioning were observed dirty with dry food particles. The DSS verified the above findings and stated it should have been washed properly because it could cause cross contamination. It was an infection control issue and a safety concern. 4. According to the USDA Food Code 2022 Section ,d+[DATE].11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. Review of the facility's P&P titled Area and Equipment Cleaning revised ,d+[DATE] showed the facility's Maintenance Department is scheduled to clean equipment that requires special training and equipment, such as the ice maker, refrigeration coils and exhaust hood. During the initial kitchen tour on [DATE] at 0830 hours, a concurrent observation and interview was conducted with the DSS. Brownish, yellowish dirt residue was observed on the kitchen hood. The DSS verified the findings and stated the dietary staff were supposed to clean the hood weekly, a dirty hood was a fire hazard, and dirty oil residue could drip down on the food. 5. According to the USDA Food Code 2017, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0830 hours, an observation and concurrent interview was conducted with the DSS. The microwave at a countertop table was observed dirty with dry, crusted, brownish debris inside the microwave and on the microwave's door. The DSS stated the microwave was cleaned by the dietary staff twice a week. The DSS acknowledged the findings and verbalized the microwave should have been cleaned to prevent cross contamination. 6. According to the FDA Food Code Annex 2022: ,d+[DATE].11 Backflow Prevention. Improper plumbing installation or maintenance may result in potential health hazards such as cross connections, back siphonage or backflow. These conditions may result in the contamination of food, utensils, equipment, or other food-contact surfaces. According to the FDA Food Code 2022, Section ,d+[DATE].11 Backflow Prevention. Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. During the initial tour of the kitchen with the DSS on [DATE] at 0915 hours, one white pipe draining water from the ice machine was observed below the flood level of the floor drain and touching the drain. The DSS acknowledged the findings and stated a work order had been placed to cut the drainpipe. The DSS stated it was dangerous, an infection control issue, and could cause cross contamination when water from the drain backflows. 7. According to the USDA Food Code 2022, ,d+[DATE].12, Manual Ware Washing, the three- compartment requirement allows for the proper execution of the three-step manual ware washing procedure. If properly used, the three compartments reduce the chances of contaminating the sanitizing water and therefore diluting the strength and efficacy of the chemical sanitizer that may be used. Alternative manual ware washing equipment, allowed under certain circumstances and conditions, must provide for accomplishment of the same three steps: application of cleaners and the removal of soil, removal of any abrasive and removal or dilution of cleaning chemicals, and sanitization. During the initial tour of the kitchen with the DSS on [DATE] at 0830 hours, Hydrion test strip used to test the pH of the chemical sanitizing solution was observed with an expiration date of [DATE]. The DSS verified the findings and stated it must have been overlooked and expired test strip could give inaccurate reading. 8. Review of the facility's P&P titled Food Handling Guidelines revised ,d+[DATE] showed under the Preparation of Produce section, to verify the pH of the solution with the test strip. The acceptable pH range is 3.5 or lower. If the dispenser is out of calibration (the pH is greater than 3.5), do not use the dispenser. During the initial kitchen tour on [DATE] at 0830 hours, a concurrent observation and interview was conducted with the DSS. The pH value of the chemical sanitizing solution used to wash raw fruits and vegetables was above the acceptable range (4XXX,d+[DATE].5). The DSS verified the findings. On [DATE] at 1351 hours, an interview was conducted with the Director of Food Services. The Director of Food Services acknowledged the above findings and stated a technician came and recalibrated the chemical solution. Furthermore, the Director of Food Services stated it was important for a pH to be within range to breakdown the bacteria residue from the fruits and vegetables for safe consumption.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview, medical record review, and facility P&P, the facility failed to ensure the medical record for one of 12 final sampled residents (Resident 19) was complete and accurate. This failure had the potential for the resident's care needs not being met as the medical information was incomplete and inaccurate. Findings: Review of the facility's P&P titled Physician Order - End of Month Recaps revised 9/23 showed to ensure accuracy of renewal orders for medications and treatments. Medical record review for Resident 19 was initiated on 2/28/24. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's medical record showed the following physician's orders: - for Posey Bed Enclosure with the physician's signature dated 1/30/24, but no time was documented. - for bilateral No-No Posey Sleeves with the physician's signature dated 1/30/24, but no time was documented. - for Posey Bed Enclosure with the physician's signature dated 2/5/24, but no time was documented. - for bilateral No-No's Posey Sleeves with the physician's signature dated 2/5/24, but no time was documented. On 2/28/24 at 0849 hours, an interview and record review was conducted with the RN Charge Nurse and DON. The RN Charge Nurse stated the physician's orders should be signed, dated, and timed.

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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** 50127 Based on observation, interview, and facility P&P review, the facility failed to ensure the appropriate infection control practices designed to provide the safe and sanitary environment were implemented. * The facility failed to record all the residents with infection on the facility's Infection Surveillance Tool. The facility's Infection Surveillance Tool did not include all the residents identified with infections. Only the residents with positive culture results were identified as having infection and were listed on the surveillance list. * The facility failed to ensure the laundry room's soap bucket was kept clean and failed to keep the soap bucket off the floor surface. * The facility failed to remove the isolation signage after the neutropenic precaution order was discontinued for Resident 5. These failures posed a risk for transmission of disease causing microorganisms and infections and incorrect notification of infection control practices. Findings: Review of the facility's P&P titled Pediatric Sub-Acute Infection Prevention Program Plan revised 2023 showed the Peds Subacute Infection Control plan covers the care, treatment, and services for the facility subacute care. The plan uses sound epidemiologic principles to implement, evaluate, and improve infection prevention and control strategies. Surveillance, epidemiological investigation, consultation, and education are critical components of the program. Prevention and control efforts will include, but are not limited to: 1. Identifying, managing, and reporting persons with transmissible diseases as mandated by the state communicable disease regulations 2. Identifying infections in patients present on admission or occurring thereafter, and infections present in staff upon initial employment or occurring as a result of an exposure 3. Measuring, monitoring, evaluating, and reporting program effectiveness The P&P also showed the IP committee meets minimally four times yearly, with additional meetings as necessary. The IP Committee reports to the MEC and governing board of directors (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 2/29/24 at 0826 hours, an interview and concurrent record review were conducted with the Administrator and IP. When asked who was responsible for the facility's infection control surveillance, the Administrator stated, I am. When asked what listed on the facility's surveillance list, the Administrator stated all of the positive cultures and the NSHN guidelines to see if it met the true infection of HAI. The surveillance was only for the residents with positive cultures. When asked the records for the other residents with signs and symptoms of possible infections, the Administrator state if there was no positive culture, they did not put in the surveillance. When asked about the residents that were symptomatic and did not have antibiotic or positive cultures as to whether they included in the surveillance list, the Administrator stated, no, I don't, we discuss in the IDT meeting every week. On 2/29/24 at 1031 hours, an interview and concurrent record review was conducted with the Administrator, DON, and Director of Infection Control. When asked if the facility included on their Infection Surveillance form for the residents with identified infections who met the McGeers but did not have a positive culture. The Administrator stated only residents with positive culture results were identified as having infection and listed on the surveillance list. The surveillance forms did not include all residents whom were identified with infections and placed on antibiotics. The Administrator verified only the residents with positive culture results were listed on the Infection Surveillance form and all the residents with or without a positive culture result should have been listed on the surveillance form. The DON was informed and acknowledged the above finding. According to the Director of Infection Control, the facility was only logged in the infection control surveillance for the residents with positive cultures. When asked him where they documented the information about the residents with infections who met the Mcgeer's but did not have positive cultures but showed true infections, he stated they were not looking at that and not tracking them on the surveillance forms, but the doctors were looking at it. 2. On 2/29/24 at 1314 hours, an observation and concurrent interview was conducted with the DPO. During the tour to the laundry room, the laundry soap bucket in the laundry room was observed directly on the floor surface with accumulated dirt and dust attached to the base and perimeter of the laundry soap bucket. The lid of the laundry soap bucket had a rust colored sludge film with accumulated dirt and dust. The DPO verified the findings and stated it was dirty. The DPO stated we would clean it and place it above the floor. 49644 3. Review or the facility's P&P titled Ped-Isolation Precautions: Standard and Transmission-Based (Contact, Droplet, Airborne), Enhanced, Neutropenic revised 5/2020 showed to protect neutropenic patient by attempting to reduce contact with microorganisms from other patients, personnel, or visitors, yet minimize the psychological deprivation for the long-term patient. Transmission-based precautions signage will be posted to alert any person prior to entering the room. On 2/27/24 at 0930 hours, RN 1 was observed going inside Resident 5's room wearing a surgical mask. A Contact Isolation precautions signage was posted on the door with instructions to wear gown and gloves when entering the room. RN 1 was not wearing gown and gloves when she entered Resident 5's room. (continued on next page)

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	555730	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Regional Medical Center D/P Snf	14662 Newport Avenue Tustin, CA 92780

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/24 at 0933 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified there was a contact isolation signage on the door. RN 1 stated she only wore a surgical mask because Resident 5 was not on contact isolation. RN 1 further stated Resident 5 was on Reverse Isolation (the practices used for protecting vulnerable persons with weakened immune system for contracting an infection from other people) . Medical record review for Resident 5 was initiated on 2/27/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's form titled Patient Orders showed a physician's order dated 4/15/20, for Protective Neutropenic Chemotherapy Precautions. However, further review of Resident 5's Patient Orders showed the Protective Neutropenic-Chemotherapy Precautions order was discontinued on 2/19/24. On 2/29/24 at 1025 hours, an observation and concurrent interview was conducted with the DON. The DON verified the contact isolation signage posted on Resident 5's door and stated the isolation posting should have been removed. The DON stated the charge nurse and licensed nurses were responsible for removing the isolation signage when it was discontinued.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127 Based on interview, medical record review, and facility P&P review, the facility failed to implement their Antibiotic Stewardship Program when: * The facility failed to conduct an assessment for the McGeer's criteria for one of 12 final sampled residents (Resident 15), and two nonsampled residents (Residents 17 and 676) * The facility failed to notify the physicians regarding the McGeer's criteria were not met for true infection for two of 12 final sampled residents (Residents 3 and 19) and one nonsampled residents (Resident 12) These failures had the potential for inaccurately identifying for true infections and potentially inhibited the residents' physicians from discontinuing the unnecessary antibiotics. Findings: According to the Centers for Disease Control and Infection, an estimated 70% of nursing home residents receive one or more courses of antibiotics during a year. Studies have shown that 40% to 75% of the antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Frail and older adults are at significant risk of harm from antibiotic overuse including increased adverse drug events, increased drug interactions and infection with antibiotic-resistant organisms. The World Health Organization cites antibiotic resistance as one of the biggest threats to human health. Review of the facility's P&P titled Antimicrobial Stewardship Program, Subacute revised 10/2023 showed in part: - III. Policy: all antimicrobrial use will be monitored through the Antimirobial Stewardship Program. - IV. Procedure: B. Antibicrobial Stewardship Committee will monitor the antibiotic use based on the established policies and protocols. 1. The McGeer's Criteria. - Nursing staff shall use the McGeer's Criteria to assess the need of antimicrobial therapy for residents suspected to have an infection and communicate the clinical signs to a provider. 1. Review of the facility's Drug Therapeutic Class Report dated 9/1-2/29/24, showed a list of residents who were prescribed antibiotics. Review of the report included Residents 15, 17, and 676 who were prescribed antibiotics as follows: - Resident 15 had a physician's order dated 11/10/23, for amoxicillin 250 mg/5 ml. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident 17 had physician's orders dated 2/22/24, for cefepime 1 gm and ciprofloxacin HCL. - Resident 676 had a physician's order dated 1/11/24, for nitrofurantoin 100 mg capsule. Review of the medical records for Residents 15, 17, and 676 was initiated on 2/28/24, and showed the following: - Resident 15 was admitted to the facility on [DATE]. - Resident 17 was admitted to the facility on [DATE]. - Resident 676 was admitted to the facility on [DATE]. Review of the facility's McGeer's binder failed to show documented evidence the McGeer's assessments were conducted to assess for true infection for the antibiotics prescribed for Residents 15, 17, and 676. On 2/29/24 at 1530 hours, an interview and concurrent medical record review was conducted with the Director of Infection Control. The Director of Infection Control verified Residents 15, 17, and 676 were prescribed the antibitoics; however, no McGeer's assessments were conducted for the residents. 2. Review of the facility's McGeer's binder and concurrent interview was conducted with the Infection Control Coordinator. Review of the McGeer's Criteria for Surveillance Checklist showed the Skin and Soft Tissue Infection Surveillance Definitions (SSTI) which included the criteria as follows: at least four symptoms needed to be met from the list of heat (warmth) at affected site; redness (erythema) at affected site; swelling at affected site; tenderness or pain at affected site; serous drainage at the affected site; and at least one of the following: fever, leukocytosis; acute change in mental status; acute functional decline. Further review showed the following residents had the McGeer's Criteria for Surveillance Checklist filled out showing the residents did not meet the McGeer's criteria as follows: - Resident 3's McGeer's Criteria for Surveillance Checklist dated 2/20/24, showed the SSTI section with McGeer's criteria was only checked for one symptom which was redness (erythema) at affected site. The McGeer's assessment showed SSTI criteria was not met. Resident 3 was prescribed with Bacitracin BID x 7 days. - Resident 12's McGeer's Criteria for Surveillance Checklist dated 9/22/23, showed the SSTI section with the McGeer's criteria was only checked for one symptom which was redness (erythema) at affected site. The McGeer's assessment showed SSTI criteria was not met. Resident 12 was prescribed with Keflex 400 mg every eight hours x 7 days. - Resident 19's McGeer's Criteria for Surveillance Checklist dated 1/26/24, showed the SSTI section with the McGeer's criteria was only checked for two symptoms which were redness (erythema) and tenderness or pain at affected site. The McGeer's assessment showed SSTI criteria was not met. Resident 19 was prescribed with Bacitracin BID x 7 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical records for Residents 3, 12, and 19 was initiated on 2/28/24, and showed the following: - Resident 3 was admitted to the facility on [DATE]. - Resident 12 was admitted to the facility on [DATE]. - Resident 19 was admitted to the facility on [DATE]. On 2/28/24 at 1013 hours, an interview was conducted with the Infection Control Coordinator. When asked regarding the process of McGeer's assessment, the Infection Control Coordinator stated the facility needed to fill out the McGeer's form and to see if the resident qualified for the use of antibiotics. The Infection Control Coordinator stated the McGeer's criteria were for antibiotics use and kept in the binder for a period from 2023 until current. When asked how the facility proceeded if the resident did not meet the McGeer's criteria the Infection Control Coordinator stated the physician needed to be notified. On 2/29/24 at 1323 hours, a follow-up interview was conducted with the Infection Control Coordinator. The Infection Control Coordinator verified Residents 3, 12, and 19 were prescribed antibiotics by their physicians and the McGeer's criteria were not met. The Infection Control Coordinator also verified there was no documentation showing the facility had notified the physicians of Residents 3, 12, and 19's symptoms with prescribed antibiotics not meeting the McGeer's criteria and to inquire whether to continue or not the antibiotics ordered.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127 Based on interview and medical record review, the facility failed to ensure the COVID-19 vaccinations were administered to one of 12 final sampled residents (Resident 9) after receiving the consent from Resident 9's responsible party. This failure placed the resident at risk to acquire COVID-19 infection. Findings: Medical record review for Resident 9 was initiated on 2/29/24. Resident 9 was admitted to the facility on [DATE]. Review of Resident 19's COVID-19 VACCINE CONSENT form showed on 1/6/23, Resident 19's responsible party consented for Resident 19 to receive the COVID-19 vaccination. Review of Resident 19's Immunization Record failed to show documented evidence of the administration of COVID-19 vaccination. On 2/29/24 at 1323 hours, an interview and concurrent medical record review was conducted with the Infection Control Coordinator. The Infection Control Coordinator verified Resident 9's responsible party had signed the consent form on 1/6/23. However, the Infection Control Coordinator stated the charge nurse who obtained the signature placed the consent form in the medical records basket instead of giving the consent form to the charge nurse. Therefore, Resident 19's physician was not notified to give an order for the COVID-19 vaccination and Resident 19 never received the COVID-19 vaccination.