| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555730 | A. Building<br>B. Wing | 02/03/2025 |

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

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| F 0625<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to notify one of two final sampled residents (Resident 8) reviewed for hospitalization of his rights to a bed hold (holding or reserving a resident's bed while the resident in the acute care hospital) policy upon the transfer to the acute care facility in writing. This failure had the potential for the resident and/or his representative to be unaware of their rights to request a bed hold upon transfer.<br><br>Findings:<br><br>Review of the facility's P&P titled Bed Hold revised 9/2024 showed the residents will be informed upon admission of their right for a bed hold in the event the resident must be transferred to an acute facility or during therapeutic leave. The resident or representative will be given notice of the rights to a bed hold at the time of transfer or leave.<br><br>Medical record review for Resident 8 was initiated on 1/29/25. Resident 8 was admitted to the facility on [DATE].<br><br>Review of Resident 8's H&P examination dated 10/16/24, showed Resident 8 had global developmental delay (a significant delay in two or more domains of development, including activities of daily living as well as motor, cognitive, speech/language, and personal/social skills).<br><br>Review of Resident 8's Notice of Transfer or discharge date d 10/4/24, showed Resident 8 was transferred to the acute care hospital.<br><br>On 1/31/25 at 1408 hours, an interview and concurrent medical record review was conducted with RN 1. When asked to show the bed hold notification for Resident 8, RN 1 stated she did not know where to find the bed hold notification.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0625<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | On 1/31/25 at 1417 hours, an interview and concurrent medical record review was conducted with the Pediatric Social Worker. The Pediatric Social Worker verified he did not provide a written copy of the bed hold notification to Resident 8's representative. The Pediatric Social Worker further stated the Notice of Transfer or Discharge form included the seven-day hold notification. The Pediatric Social Worker stated the nurse called Resident 8's family member and he faxed the Notice of Transfer or Discharge form to the Ombudsman. The Pediatric Social Worker stated he never gave a copy of the Notice of Transfer or Discharge form to Resident 8's representative because the form did not have an instruction to provide a copy to the resident's representative.<br><br>On 1/31/25 at 1621 hours, an interview was conducted with the CNO and Director of Quality and Risk. The CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0638<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Assure that each resident's assessment is updated at least once every 3 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on interview and medical record review, the facility failed to ensure the quarterly MDS assessment was completed for one final sampled resident (Resident 6) and one nonsampled Resident (Resident 13). This had the potential to not provide appropriate care when there was no MDS assessment information available.<br><br>Findings:<br><br>1. Medical record review for Resident 6 was initiated on 1/29/25. Resident 6 was admitted to the facility on [DATE].<br><br>Further review of Resident 6's medical record showed the last quarterly MDS assessment was completed on 9/6/24. However, there was no documented evidence a quarterly MDS assessment was completed after 9/6/24.<br><br>2. Medical record review for Resident 13 was initiated on 1/30/25. Resident 6 was admitted to the facility on [DATE].<br><br>Further review of Resident 13's medical record showed the last annual MDS assessment was completed on 9/6/24. However, there was no documented evidence a quarterly MDS assessment was completed after 9/6/24.<br><br>On 1/30/25 at 1440 hours, an interview and concurrent medical record review for Residents 6 and 13 was conducted with the MDS Coordinator/DSD. The MDS Coordinator/DSD verified Residents 6 and 13's last MDS assessments were completed on 9/6/24, and there was no quarterly MDS assessment in December 2024. The MDS Coordinator/DSD acknowledged it was missed and stated it was due to a discrepancy in the date of submission on her calendar.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO and Director of Quality and Risk . The CNO stated she expected the MDS Coordinator to complete and submit each MDS assessment on time. The CNO was informed and acknowledged the above findings. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on interview and medical record review, the facility failed to ensure the MDS was coded accurately for one of nine final sampled residents (Resident 6). This failure had the potential for the resident's negative health outcome as the information was not accurate.<br><br>Findings:<br><br>Medical record review for Resident 6 was initiated on 1/29/25. Resident 6 was admitted to the facility on [DATE].<br><br>Review of Resident 6's Patient Orders, showed the following physician's orders:<br><br>- dated 1/31/25, to administer aspirin (anti-inflammatory medication) 40.5 mg chewable tablet via GT daily. The indication for the use of the aspirin medication showed anticoagulation.<br><br>- dated 3/20/24, and discontinued on 1/28/25, to administer aspirin 40.5 mg chewable tablet via GT daily. The indication for the use of the aspirin medication showed anticoagulation.<br><br>Review of Resident 6's Quarterly MDS dated [DATE], showed Resident 6 was coded for the use of an anticoagulant.<br><br>On 1/30/25 at 1440 hours, an interview and concurrent medical record review for Residents 6 was conducted with the DSD/MDS Coordinator. The DSD/MDS Coordinator verified the above findings and agreed although the indication for the use of the aspirin medication was for anticoagulation, the aspirin medication was not an anticoagulant medication. The DSD/MDS Coordinator stated she coded the MDS assessment incorrectly.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO and the Director of Quality and Risk. The CNO stated she expected the DSD/MDS Coordinator to complete and submit each MDS assessment timely and accurately. The CNO was informed and acknowledged the above findings. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for two of nine final sampled residents (Residents 7 and 18).<br><br>* The facility failed to develop a comprehensive person-centered care plan to address Resident 18's nutritional oral gratification and GT feeding. In addition, the facility failed to develop a comprehensive care plan for the use of the abdominal binder.<br><br>* The facility failed to develop a comprehensive person-centered care plan to address Resident 7's GT feeding.<br><br>These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents.<br><br>Findings:<br><br>Review of the facility's P&P titled Resident Care Plan revised 7/2024 showed all the residents will have an individualized comprehensive person-centered care plan developed and implemented based on residents individual care needs and includes all problems, goals, and interventions will be documented.<br><br>1a. On 1/29/25 at 0901 hours, Resident 18 was observed up in the baby chair and assisted by the family member with eating the baby food using a small rubberized spoon.<br><br>Medical record review for Resident 18 was initiated on 1/30/25. Resident 18 was admitted to the facility on [DATE].<br><br>On 1/30/25 1011 hours, Resident 18 was observed on a wheelchair with the GT feeding infusing at 37 ml per hour.<br><br>Review of Resident 18's physician's order dated 1/29/25, showed to provide a pureed diet with instructions for Resident 18 to eat baby food one to two times a day for oral gratification, to be fed by family member only, and to continue with routine Jejunostomy (surgical opening in the small intestine from the outside of the body) tube feeding. Another physician's order dated 1/21/25, showed to provide tube feeding with Elecare 26 kcal at 37 ml per hour for 22 hours and to stop for oral feeding.<br><br>Review of Resident 18's plan of care did not show documented evidence a care plan was developed to address the nutritional problem of Resident 18. There was no documented evidence the care plan was formulated for the oral gratification and tube feeding.<br><br>On 1/30/25 at 1058 hours, an interview for Resident 18 was conducted with CNA 3. CNA 3 verified Resident 18's family member assisted the resident with eating the baby food and Resident 18 was on tube feeding.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. Review of Resident 18's physician order dated 9/27/24, showed to apply the abdominal binder continuously for GT dislodgement prevention, and with instructions to use elastic bandage with self closure and cut to the appropriate size when resident was not wearing snappable clothing, and to check the skin every two hours.<br><br>Review of Resident 18's plan of care did not show documented evidence a care plan was developed to address the use of the abdominal binder to prevent GT dislodgement for Resident 18.<br><br>On 1/30/25 at 1058 hours, an interview for Resident 18 was conducted with CNA 3. CNA 3 verified Resident 18 had an abdominal binder on to prevent the resident from pulling out the tubes on her abdomen.<br><br>On 2/03/25 at 0849 hours, and interview and concurrent medical record review for Resident 18 was conducted with RN 2. RN 2 verified Resident 18 was on oral feeding and the family member was able to assist the resident with eating. RN 2 verified Resident 18 moved a lot and the licensed nurses applied the elastic bandage as an abdominal binder. RN 2 verified Resident 18 had a physician's order for the elastic bandage to apply as an abdominal binder and to perform a skin checks every two hours. RN 2 stated the licensed nurses checked the placement of the elastic bandage. RN 2 was asked if there was a plan of care formulated for the GT feeding, oral feeding, and the use of the abdominal binder. RN 2 verified there was no care plan formulated for the the GT feeding, oral feeding and the use of the abdominal binder for Resident 18.<br><br>On 2/03/25 at 1418 hours hours, an interview and concurrent medical record review for Resident 18 was conducted with the CNO. The CNO was informed and verified the above findings.<br><br>44175<br><br>2. On 1/29/25 at 0842 hours, Resident 7 was observed lying in bed. Resident 7's tube feeding was observed running at 118 ml per hour.<br><br>Medical record review for Resident 7 was initiated on 1/29/25. Resident 7 was admitted to the facility on [DATE].<br><br>Review of Resident 7's H&P examination dated 6/2/24, showed Resident 7 was dependent on GT (a thin, flexible tube inserted through the abdominal wall and into the stomach) feeding.<br><br>Review of the Resident 7's Patient Orders, showed a physician's order dated 7/12/24, to promote with fiber tube feeding at 118 ml per hour via the GT.<br><br>Review of Resident 7's plan of care failed to show documented evidence a care plan addressing Resident 7's GT feeding was initiated.<br><br>On 1/31/25 at 1345 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 1. RN 1 verified the above findings and stated the facility did not initiate a person centered care plan to address the resident's enteral feeding. RN 1 stated she used her standard professional practice to care for the residents with tube feeding.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/31/25 at 1621 hours, the CNO and Director of Quality and Risk was informed and acknowledged the above findings. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the treatment was provided to two of nine final sampled residents (Residents 4 and 12).<br><br>* The facility failed to assess and check the skin of Residents 4 and 12 every two hours when the splint device was applied as ordered by the physician. In addition, the plans of care to address the function and mobility of Residents 4 and 12 were not included in the interventions for skin assessments every two hours when the splint device was applied. These failures had the potential to affect the residents well being while wearing the splint device.<br><br>Findings:<br><br>Review of the facility's P&P titled Splint Application revised 7/2024 showed the supportive devices will be applied to the resident as per physician's order. Prior and after application of the splint device, skin and site will be visually viewed for any changes. Document the application and removal of the splint device on the residents record.<br><br>a. On 1/29/25 at 1234 hours and 1/30/25 at 0825 hours, Resident 4 was observed with contractures on both upper and lower extremities, no splint device was in place for the upper and lower extremities.<br><br>Medical record review for Resident 4 was initiated on 1/30/25. Resident 4 was admitted to the facility on [DATE].<br><br>Review of Resident 4's physician's order dated 9/14/24, to apply the bilateral splint to both upper extremity WHFO for four to six hours or as tolerated with every two hours skin check during the day shift six times per week for 90 days. Another physician's order dated 12/27/24, to apply the bilateral splint AFO's as tolerated for six to 10 hours during the day shift, six times per week for 90 days and perform the skin checks every two hours.<br><br>Review of Resident 4's plan of care showed a care plan problem dated 11/18/24, to address Resident 4's impaired physical mobility. However, there was no documented evidence in the interventions included to perform the skin assessments every two hours when the splint device was applied.<br><br>On 1/30/25 at 1425 hours, an interview and concurrent medical record review was conducted for Resident 4 with RNA 1. RNA 1 verified Resident 4 had an RNA order and stated Resident 4 had a WHFO for the upper extremity and AFO for the lower extremity, to be applied for six to 10 hours or as tolerated. RNA 1 was asked for the documentation of the application of the splint device. RNA 1 reviewed Resident 4's treatment record flowsheet. RNA 1 documented the WHFO and AFO were applied and removed. RNA 1 verified she did not document the exact time because she had no time to check every two hours on all the resident who was wearing a splint device.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/30/25 at 1441 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 1. LVN 1 stated she observed the RNA's provided the treatment to Resident 4 including the application of the splint device on both upper and lower extremity of Resident 4. LVN 1 stated the RNA document the treatment provided for Resident 4 on the treatment record flowsheet including the skin assessment of the resident every two hours. LVN 1 verified there was no documentation of the exact time the RNA's checked the skin of the resident when the splint devices were applied.<br><br>b. On 1/29/25 at 0927 hours and 1/30/25 at 0927 hours, Resident 12 was observed in bed asleep, and had contractures on both upper and lower extremities. No splint device was in place at this time.<br><br>Medical record review for Resident 12 was initiated on 1/30/25. Resident 12 was admitted to the facility on [DATE].<br><br>Review of Resident 12's physician's order dated 1/17/25, to apply the bilateral splint to both upper extremity WHFO for four to six hours or as tolerated with every two hours skin check during the day shift, six times per week for 90 days.<br><br>Review of Resident 12's plan of care showed a care plan problem dated 11/4/24, to address Resident 12's impaired physical mobility. However, there was no documented evidence in the interventions included to perform the skin assessment every two hours when the splint device was applied.<br><br>On 1/30/25 at 1121 hours, an interview and concurrent medical record review for Resident 12 was conducted with RNA 1. RNA 1 verified Resident 12' use of splint device on upper extremities have the WHFO applied daily for four to six hours or as the resident tolerated. RNA 1 was asked for the documentation of the application of the splint device. RNA 1 reviewed Resident 12's treatment record flowsheet. RNA 1 documented the WHFO was applied and removed. RNA 1 verified she did not document the exact time because she had no time to check every two hours on all the resident who was wearing a splint device.<br><br>On 1/30/25 at 1354 hours, an interview and concurrent medical record review for Resident 12 was conducted with LVN 4. LVN 4 verified Resident 12's physician's order for the RNA treatment and stated she had seen the RNA's providing treatment and application of the splint to Resident 12. LVN 4 stated she assisted the RNA on checking the resident's skin when providing care and also when the splint device was placed. LVN 4 was asked where did the RNA documented for the assessment of the skin every two hours while the splint device was applied. LVN 4 stated in the flowsheet, the LVN reviewed the flowsheet for the RNA and verified there was no documentation of Resident 12's skin was assessed every two hours by the RNA. In addition, LVN 4 was asked for the care plan of Resident 12's problem of function and mobility. LVN 4 was able to show the long term care plan of the resident, however, there was no intervention on applying the splint device on the resident and assessment of the skin every two hours when the splint device was applied.<br><br>On 2/3/25 at 0916 hours, an interview and concurrent medical record review for Residents 4 and 12 was conducted with RN 2. RN 2 verified Residents 4 and 12 had an order for the splint device and was applied to the resident by the RNAs. RN 2 verified there was no documentation by the RNA for the skin assessment was performed on Residents 4 and 12 when the split devices were applied. RN 2 verified there was a care plan for Residents 4 and 12 to address the problem of function and mobility; however, the application of the splint device was not included in the interventions including the skin assessments every two hours.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/3/25 at 1418 hours, an interview and concurrent medical record review for Residents 4 and 12 was conducted with the CNO. The CNO informed of the findings and verified the above findings. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure appropriate care and services for the use of a GT for two of nine final sampled residents (Residents 7 and 12) and two nonsampled residents (Residents 1 and 9).<br><br>* The facility failed to ensure LVN 1 elevated Resident 9's HOB at a 30 degree angle or above prior to the administration of medication via the GT, to reduce the risk of aspiration.<br><br>* The facility failed to ensure LVN 3 elevated Resident 12's HOB at a 30 degree angle or above prior to the administration of the medication via the GT, to reduce the risk of aspiration.<br><br>* The facility failed to ensure Resident 1's HOB was elevated at a 30 degree angle or above during the enteral feeding via the GT.<br><br>* The facility failed to ensure Resident 7's HOB was elevated at a 30 degree angle or above when Resident 7 was receiving the enteral feeding via the GT.<br><br>These failures posed the risk for complications related to use of the GT for Residents 1, 7, 9, and 12.<br><br>Findings:<br><br>Review of the facility's P&P titled Enteral Nutrition and Medication Administration revised 2/2018 showed during enteral feeding, keep the patient's head of the bed at a 30 degree angle to promote optimal flow of feeding.<br><br>1. Medical record review for Resident 9 was initiated on 1/30/25. Resident 9 was admitted to the facility on [DATE].<br><br>Review of Resident 9's H&P examination dated 2/10/23, showed Resident 9 was a GT dependent.<br><br>Review of Resident 9's MDS dated [DATE], showed Resident 9 had a feeding tube.<br><br>On 1/30/25 at 1532 hours, during a medication administration observation with LVN 1, LVN 1 was observed administering Resident 9's medication with the HOB at a 20 degree angle.<br><br>On 1/30/25 at 1538 hours, an interview and concurrent observation was conducted with LVN 1. LVN 1 stated for the administration of the medications via the GT, the HOB should be elevated at a 30 degree angle or more. LVN 1 was asked how she checked to ensure the HOB was at an appropriate angle, LVN 1 stated the beds had a leveler which indicated the angle of the HOB. LVN 1 checked the leveler on Resident 9's bed and verified the HOB was at a 20 degree angle. LVN 1 was then observed raising Resident 9's HOB.<br><br>(continued on next page) |

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| Foothill Regional Medical Center D/P Snf | 14662 Newport Avenue<br>Tustin, CA 92780 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Medical record review for Resident 12 was initiated on 2/3/25. Resident 12 was admitted to the facility on [DATE].<br><br>Review of Resident 12's H&P examination dated 4/28/21, showed Resident 12 was a GT dependent.<br><br>Review of Resident 12's MDS dated [DATE], showed Resident 12 had a feeding tube.<br><br>On 2/3/25 at 0928 hours, during a medication administration observation with LVN 3, LVN 3 was observed elevating the HOB of Resident 12's bed before administering the medications. However, the indicator on Resident 12's bed showed the HOB was between 15 and 30 degree angle.<br><br>On 2/3/25 at 0954 hours, an interview and concurrent observation was conducted with LVN 3. LVN 3 was asked about the facility's practice for the administration of medications via the GT. LVN 3 stated for the administration of medication via the GT, the HOB should be at a 45 to 60 degree angle, to prevent the risk of aspiration. When asked how LVN 3 determined the appropriate angle for the HOB during the medication administration, LVN 3 stated it was per her visual judgement. When asked about the HOB indicator on Resident 12's bed, LVN 3 stated she did not use the indicator and was not aware of its function. LVN 3 verified the indicator showed the angle was less than 30 degrees.<br><br>On 2/3/25 at 1321 hours, an interview was conducted with the DSD/MDS Coordinator. The DSD/MDS Coordinator stated for the administration of medications via the GT, the HOB should be maintained above a 30 degree angle. The DSD/MDS Coordinator stated some of the beds had indicators to show the angle of the HOB. The DSD/MDS Coordinator further stated if the beds had the indicators on them, the licensed nurses should check the indicator to ensure the HOB was at the appropriate angle prior to the administration of the medication via the GT, to prevent aspiration.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO and Director of Quality and Risk. The CNO stated the facility's practice for the administration of the medications via the GT, was for the HOB to be at a 30 degree angle or more, to prevent aspiration. The CNO stated the indicators/levelers on the beds indicated the angle of the HOB. The CNO further stated, the nurses should check the indicator prior to the administration of the medications via the GT, to ensure the HOB was at the appropriate level. The CNO was informed and acknowledged the above findings.<br><br>49644<br><br>3. Review of the Foundations and Adult Health Nursing published 2023 showed when administering medication through the nasogastric tubing, place the patient in high Fowler's position (upper body elevated at a 60-90 degree angle).<br><br>On 1/29/25 at 0940 hours, during the initial facility tour, Resident 1 was observed lying in bed with the HOB elevated less than 30 degrees and receiving tube feeding.<br><br>Medical record review for Resident 1 was initiated on 1/29/25. Resident 1 was admitted to the facility on [DATE].<br><br>Review of Resident 1's H&P examination dated 12/10/22, showed Resident 1 had hypoxic ischemic encephalopathy (a disorder in which clinical manifestations indicate brain dysfunction).<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 1's Patient Orders (displayed orders) dated 1/30/25, showed a physician's order dated 7/18/24, to administer Jevity (enteral feeding) 1.2 calorie tube feeding at 105 ml/hour via GT every day.<br><br>On 1/29/25 at 1050 hours, an observation and concurrent interview was conducted with LVN 1. The HOB angle indicator on Resident 1's bed showed Resident 1's HOB was at a 20 degree angle, while the tube feeding was infusing. LVN 1 verified Resident 1's HOB was at a 20 degree angle. LVN 1 stated the HOB should have been at a 30 degree angle, to prevent aspiration pneumonia (an infection caused by inhaling something other than air into the lungs).<br><br>On 1/31/25 at 1621 hours, an interview was conducted with the CNO and Director of Quality and Risk. The DON and Director of Quality and Risk were informed and acknowledged the above findings.<br><br>44175<br><br>4. On 1/29/25 at 0842 hours, Resident 7 was observed lying in bed. Resident 7's tube feeding was observed running at 118 ml per hour. Resident 7's HOB was not observed elevated at a 30 degree angle. The indicator on the bed showed the angle of the HOB was at a 15 degree angle.<br><br>Medical record review for Resident 7 was initiated on 1/29/25. Resident 7 was admitted to the facility on [DATE].<br><br>Review of Resident 7's H&P examination dated 6/2/24, showed Resident 7 was dependent on tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), gastrotomy tube.<br><br>Review of the Resident 7's Patient Orders, showed a physician's order dated 7/12/24, to promote with fiber tube feeding at 118 ml per hour via the GT.<br><br>On 1/29/25 at 0853 hours, a concurrent observation and interview was conducted with RN 4. RN 4 stated the HOB of the resident who was receiving the enteral feeding should be elevated at least at a 30 degree angle, to prevent complications of the tube feeding, including aspiration pneumonia. RN 4 verified the above observation and stated the HOB for Resident 7 should have been elevated to at least a 30 degree angle when the resident was receiving the enteral feeding. RN 4 was observed elevating the HOB for Resident 7 to a 30 degree angle.<br><br>On 1/31/25 at 1621 hours, the CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to obtain the informed consent for the use of side rails for one of three final sampled residents (Resident 11) reviewed for side rails. This failure posed the risk for Resident 11 and/or his representative to not be informed of his care and the risks for the padded bilateral upper and lower siderails.<br><br>Findings:<br><br>Review of the facility's P&P titled Side Rails revised 9/2023 showed all the residents shall have side rails in the full up position while in bed or crib. If the four siderails are required for the patient safety, a consent is required.<br><br>Review of the Foundations and Adult Health Nursing published 2023 showed under Informed Consent, the Patient Care Partnership establishes the patient's right to make decisions regarding his or her health care.<br><br>On 1/29/25 at 0823 hours, during the initial facility tour, Resident 11 was observed lying in bed with padded bilateral upper and lower siderails elevated.<br><br>Medical record review for Resident 11 was initiated on 1/29/25. Resident 11 was admitted to the facility on [DATE].<br><br>Review of Resident 11's H&P examination dated 4/30/20, showed Resident 11 had encephalopathy (a disturbance of brain function).<br><br>Review of Resident 11's Physician Order: Pediatric Subacute Restraints dated 1/25/25, showed a physician's order for padded siderails elevated times four.<br><br>Further review of Resident 11's medical record did not show documented evidence the informed consent for the use of the padded bilateral upper and lower siderails was obtained from Resident 11's representative.<br><br>On 1/30/25 at 1500 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 11's padded bilateral upper and lower siderails were elevated. CNA 1 stated Resident 11 moved in the bed and had side rails to prevent him from falling.<br><br>On 1/31/25 at 1357 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified there was no informed consent for the use of padded bilateral upper and lower side rails for Resident 11. RN 1 stated Resident 11's bed was changed to a bed with side rails last weekend and the informed consent was not done yet. RN 1 stated the licensed nurse should have obtained the informed consent prior to Resident 11 using the padded bilateral upper and lower side rails .<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/31/25 at 1621 hours, an interview was conducted with the CNO and Director of Quality and Risk. The CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>48882<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration and storage of the medications as evidenced by:<br><br>* The facility's medication error rate was 3.85%. One of four licensed nurses (LVN 4) who were observed during the medication administration was found to have an error. LVN 4 failed to administer the complete dose of one of Resident 3's medications when significant residual of the medication was observed in the medication cup after administering the multivitamin (supplement) via GT to Resident 3.<br><br>* The facility failed to ensure the electronic MAR for Resident 3 was not signed prior to the medication administration.<br><br>These failures had the potential to negatively affect the resident's health conditions and posed the risk for possible complications or delay in interventions.<br><br>Findings:<br><br>Review of the facility's P&P titled Medication Administration, General Guidelines revised 3/2024 showed all medication orders must be ordered for a specific patient and include the name of the drug, exact dosage, route, and frequency. The five rights shall be observed in the administration of all medications:<br><br>1. Right patient;<br><br>2. Right drug;<br><br>3. Right dose;<br><br>4. Right route; and<br><br>5. Right time.<br><br>Further review of the facility's P&P showed all the licensed nurses must administer and chart the medication prepared and given by them. The licensed nurse shall dispense the medication for one resident at a time and document immediately.<br><br>Review of the facility's P&P titled Enteral Nutrition and Medication Administration revised 2/2018 showed when the medications are administered via the enteral routes, the tube will be checked for placement/residual, flushed with a minimum of 10 ml of water, the medication given and then another fluid flush to follow before the feeding is resumed.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1a. On 1/30/25 at 0931 hours, a medication administration observation for Resident 3 was conducted with LVN 4. LVN 4 prepared and administered Resident 3's medications which included the following:<br><br>- one tablet of glycopyrrolate (anticholinergic medication, used for secretion control) 1 mg.<br><br>- one tablet of multivitamin (supplement).<br><br>- one 1/2 (half) tablet of famotidine (antacid) 10 mg.<br><br>- one tablet of calcium carbonate (supplement) 500 mg.<br><br>- one ml of cholecalciferol (vitamin D3) solution, equaling to 400 international units.<br><br>- one ocular lubricant ophthalmic ointment to each eye.<br><br>LVN 4 was observed administering the above medications to Resident 3 via the GT. After administering the medication, the medication cup labeled multivitamin was observed with significant amount of orange-colored medication residue.<br><br>On 1/30/25 at 0954 hours, an interview and concurrent observation was conducted with LVN 4. LVN 4 verified the above findings. LVN 4 was asked when there are noticeable medication residue in the medicine cup what should she do. LVN 4 stated she should add more water, stir the contents, and then administer the remaining residue.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO. The CNO stated medications should be administered as ordered by the physician, including the complete dose. The CNO stated for the administration of medication via the GT, if there was significant residue in the medicine cup, the nurse was expected to add water, mix the contents, and administer the dose. The CNO was informed and acknowledge the above findings.<br><br>1b. Review of the Resident 3's Patient Orders showed a physician's order dated 2/3/24, to administer saliva substitute oral gel 5 ml topically to the mouth every six hours for oral hygiene.<br><br>On 1/30/25 at 1047 hours, an interview and concurrent medical record review for Resident 3 was conducted with LVN 4. LVN 4 verified she did not administer the saliva substitute oral gel scheduled for 1000 hours during the medication administration observation. LVN 4 then stated she still had a one-hour window before and after the scheduled time to administer the medication. LVN 4 stated she would administer the medication now and was observed walking to her medication cart.<br><br>On 1/30/25 at 1100 hours, an interview was conducted with LVN 4. LVN 4 stated her cart did not have the saliva substitute oral gel and she had requested and obtained a new tube of the saliva substitute oral gel medication for Resident 3.<br><br>Review of Resident 3's Medication Administration History Visit showed the scheduled saliva substitute oral gel medication was documented as administered to Resident 3 on 1/30/25 at 1016 hours.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/30/25 at 1410 hours, an interview and concurrent medical record review for Resident 3 was conducted LVN 4. LVN 4 verified she signed the electronic MAR for the administration of the saliva substitute oral gel medication before she had administered the medication to Resident 3.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO and Director of Quality and Risk. The CNO stated the licensed nurses should sign the electronic MAR either during the administration of the medication in the resident's room, or right after administering and exiting the resident's room. The CNO further stated the licensed nurses should not sign the electronic MAR before actually administering the medication. The CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, and medical record review, the facility failed to ensure one of nine final sampled residents (Resident 4) were free from the unnecessary medications.<br><br>* The facility failed to ensure to document the monitoring of seizure activities and side effects related to Resident 4's use of clobazam, clonazepam, diazepam, lacosamide, lamotrigine, and levetiracetam (anticonvulsant medications to prevent seizure). This failure had the potential for Resident 4 to receive unnecessary medications and develop significant adverse effects, and risk for adverse effects from prolonged used of medications.<br><br>Findings:<br><br>Medical record review for Resident 4 was initiated on 1/30/24. Resident 4 was admitted to the facility on [DATE].<br><br>Review of Resident 4's physician's order showed the following orders:<br><br>- dated 2/23/24, to administer clobazam 10 mg via GT every day for seizure.<br><br>- dated 3/23/24, to administer clonazepam 0.5 mg via GT every eight hours for seizure.<br><br>- dated 4/15/24, to administer diazepam 7.5 mg via GT every six hours as needed for seizure.<br><br>- dated 3/23/24, to administer lacosamide 100 mg via GT three times a day for seizure.<br><br>- dated 3/23/24, to administer lamotrigine 100 mg via GT every eight hours for seizure.<br><br>- dated 11/1/24, to administer levetiracetam 1000 mg via GT every eight hours for seizure.<br><br>Further review of Resident 4's physician's orders failed to show documented evidence a physician's order to monitor for seizure activities and side effects of the anti-seizure medications were obtained.<br><br>On 2/03/25 at 1300 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 2. RN 2 verified Resident 4 had a seizure diagnosis and was on prescribed anti-seizure medications. RN 2 was asked to show the monitoring of the seizure episodes of Resident 4. RN 2 accessed the electronic medical record and stated 11/8/24 was the last recorded seizure activity for Resident 4 when Resident 4 had a seizure activity that lasted for about a minute according to the resident's mother. RN 2 was asked if there was a physician's order for the monitoring of the seizure activity and the side effects of the anti-seizure medications listed above. RN 2 verified there was no physician's order obtained for the monitoring of the seizure activity and the side effects of the anticonvulsant medications for Resident 4.<br><br>On 2/03/25 at 1418 hours, an interview and concurrent medical record review for Resident 4 was conducted with the CNO. The CNO was informed and verified the above findings. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175<br><br>Based on interview, and medical record review, the facility failed to ensure one of five final sampled residents (Resident 2) reviewed for unnecessary medications was free from the unnecessary psychotropic medication when:<br><br>* The facility failed to monitor the behaviors specific to the use of clonidine (antihypertensive and sedative medication) for Resident 2.<br><br>* The facility failed to ensure the informed consent was obtained from the resident representative for the use of the psychotropic medication (clonidine) when the route of administration, dose, and targeted behaviors were changed for Resident 2.<br><br>These failures had the potential for the residents to receive unnecessary medications and not effectively evaluate the effectiveness of the psychotropic medications, and had the potential for Resident 2's representative not being informed of his clonidine medication and potential effects from the changed routes of administration, doses and targeted behavior.<br><br>Findings:<br><br>Review of the article published in National Library of Medicine titled Clonidine dated 7/17/23, showed clonidine is an antihypertensive medication and has multiple off labels uses which included treating anxiety.<br><br>Medical record review for Resident 2 was initiated on 1/29/25. Resident 2 was admitted in the facility on 9/8/23.<br><br>Review of the Resident 2's MDS dated [DATE], showed Resident 2 had a memory problem and severely impaired cognitive skills for daily decision making.<br><br>Review of Resident 2's Patient Orders showed following orders:<br><br>- dated 1/29/25, to administer clonidine hydrochloride 0.1 mg tablet via GT at bedtime at scheduled administration times.<br><br>- dated 12/20/24, to administer clonidine hydrochloride 0.05 mg tablet via GT daily at scheduled administration times.<br><br>Further review of the above Patient Orders showed the indication for the use of the clonidine medication was irritability.<br><br>Further review of Resident 2's medical record failed to show if Resident 2's behavior of irritability was monitored.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/3/25 at 1035 hours, an interview was conducted with the Director of Pharmacy. The Director of Pharmacy stated if the clonidine was used to control the resident's behavior, then it was considered a psychotropic medication. The Director of Pharmacy further stated the effectiveness of the psychotropic medication and targeted behavior should be monitored.<br><br>On 2/3/25 at 1250 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 2. RN 2 stated Resident 2 had a behavior of irritability. RN 2 stated when Resident 2 had the episodes of irritability, he would resist care, move his body, and his facial expression would change with an increase in his heart rate. When RN 2 was asked if the facility monitored the episodes of Resident 2's irritability behavior to monitor the effectiveness of the medications prescribed, RN 2 stated the behavior should be monitored. RN 2 reviewed Resident 2's medical record and stated she was not able to show the documented evidence Resident 2's behavior of irritability was monitored for the use of the clonidine medication.<br><br>2. Review of the Resident 2's Psychoactive Medication Consent dated 9/8/23, showed for clonidine patch 0.2 mg every seven days. Under the section specific targeted behavior, showed agitation. Further review of the document showed the informed consent was obtained via telephone and was signed by the physician.<br><br>Further review of Resident 2's the medical record failed to show if the informed consent was obtained when the clonidine medication route of administration, dose (changed to tablet 0.1 mg at bedtime and 0.05 mg daily via GT) and the indication was changed to irritability.<br><br>On 1/31/25 at 1326 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 verified the Psychoactive Medication Consent showed the clonidine patch 0.2 mg every seven days for agitation. RN 1 stated Resident 2 was currently on clonidine 0.1 mg at bedtime and 0.05 mg daily for irritability via GT. RN 1 was not able show if the informed consent was obtained when the clonidine medication dose, route of administration, and targeted behavior were changed.<br><br>On 2/3/25 at 1009 hours, an interview was conducted with the Director of Quality and Risk. The Director of Quality and Risk stated the facility did not have the residents with psychiatric issues, so facility did not have the policy and procedures for the use of psychotropic medication.<br><br>On 2/3/25 at 1410 hours, the CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>48882<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the residents' medications were stored and labeled properly.<br><br>* The facility failed to ensure the medications were stored inside a locked medication cart and were not left unattended by the licensed nurse.<br><br>* Resident 12's simethicone (antiflatulence) medication was not labeled with the opened date.<br><br>These failures had the potential for medication diversion and resident exposure to the expired medications with questionable potency and efficacy.<br><br>Findings:<br><br>1. Review of the facility's P&P titled Medication Storage revised 9/2024 showed the drugs are stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding. All the medications and other drugs, including treatment items, are stored in a locked cabinet or room inaccessible to patients and visitors. Drugs are accessible only to the licensed personnel. The drugs of each resident are kept and stored in secure containers.<br><br>On 1/30/25 at 0931 hours, during a medication administration observation with LVN 4, LVN 4 was observed preparing for the medication administration for Resident 3. LVN 4 was observed taking the medication out of Medication Cart B.<br><br>On 1/30/25 at 0941 hours, LVN 4 was observed pushing her computer towards Resident 3's room in preparation for the medication administration. Medication Cart B was observed with the following medications left on top of the cart: one green bottle of refresh eye lubricant, four packets of polyethylene glycol (laxative), and three individual dose of the calcium carbonate (supplement) 500 mg tablets.<br><br>On 1/30/25 at 0957 hours, LVN 4 was observed returning to Medication Cart B, after the medication administration for Resident 3. The above items were observed on Medication Cart B. LVN 4 verified the above findings and stated the medications should be put away in the medication cart when the medication cart was left unattended. LVN 4 stated the potential risk of leaving the medications unattended on top of the medication cart included the risk of someone taking the medication or the potential for the medication to be administered to another resident.<br><br>2. Review of the facility's P&P titled Medication Administration, General Guidelines, revised 3/2024 showed once punctured, multi-dose vials have 28 days expiration. They must be labeled with the expiration date. If not labeled, return to the Pharmacy.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/3/25 at 0904 hours, during a medication administration observation with LVN 3, a bottle of simethicone was observed opened without an opened date on the label. LVN 3 verified Resident 12's bottle of simethicone had no open date written on the bottle. LVN 3 stated the nurse who first opened the medication, should have labeled the medication with an opened and expiration date.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO and Director of Quality and Risk. The CNO stated the medications in the medication carts should be inside the cart and locked when unattended, to prevent the risk of medication theft, cross-medication administration to another resident and unauthorized access of the medication to anyone walking by. The CNO also stated for the multi-dose medications, the licensed nurses were expected to label the medication with the opened date when it was first opened. The CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>44175<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when:<br><br>* The facility failed to ensure the kitchen equipment was maintained in a sanitary condition.<br><br>* The facility failed to ensure the food items was properly stored and maintained.<br><br>These failures had the potential to result in foodborne illnesses for the residents receiving kitchen services in the facility.<br><br>Findings:<br><br>Review of the facility's untitled document for diet orders for the residents dated 1/29/25, showed one of 18 residents was receiving food prepared from the kitchen.<br><br>1. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils. Equipment food - contact surfaces and utensils shall be clean to sight and touch.<br><br>According to FDA Food Code 2022, Section 4-501.12, Cutting Surfaces, 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.<br><br>On 1/29/25 at 0748 hours, an observation and concurrent interview was conducted with the CDM. The following was observed in the clean dish storage area:<br><br>- Seven black cups was observed with white stain inside the cup.<br><br>- A plastic container lid was observed with dust.<br><br>- A white tray with multiple ceramics cups was observed with brown stain and dust.<br><br>The CDM verified the above findings and stated the seven black cups with white stain, plastic container lid, and the white tray with ceramic cups needed to be washed again. The CDM was observed taking all of the above items to the dish washing area for cleaning.<br><br>On 1/30/25 at 0751 hours, an observation and concurrent interview was conducted with the CDM. Two green, and three red cutting boards were observed to be heavily marred with whitish discoloration. The CDM verified the observation and stated the above cutting boards needed to be replaced.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the facility's P&P titled Food and Supply Storage Dated 1/2024 showed all the food, non-food items, and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Must, but not all, products contain an expiration date. The words sell by, best by, enjoy by or use by should precede the date. Food pass the use by, sell by, or best by or enjoy by date should be discarded. Further review of the P&P showed cover, label and date unused portions and open packages. Under the section refrigerated storage, showed unused portion of canned fruits and vegetables must be transferred to clean, approved storage container, do not store in open cans, remove any serving utensils and cover tightly, and label and date the container.<br><br>On 1/29/25 at 0748 hours, an observation and concurrent interview was conducted with the CDM. The following was observed:<br><br>- Meat in a clear plastic bag on a tray was observed on the second shelf from the bottom of the walk-in refrigerator, with good through date of 1/28/25. The CDM verified the observation and stated the meat needed be discarded.<br><br>- On the second shelf from the top of the walk-in refrigerator, one plastic container was observed with black beans and a good through date of 1/27/25, and another plastic container was observed with pineapples with good through date of 1/23/25. The CDM verified the observation and stated the canned black beans and the pineapples in the plastic containers needed to be discarded.<br><br>- A piece of cake in multiple plastic containers were observed with no label in the walk-in refrigerator. The CDM verified the observation and stated the staff member should have labeled and dated each of the cake in the multiple plastic containers.<br><br>- A bin with flour was observed with no label. The CDM verified the observation and stated the bin with flour should have been labeled and dated.<br><br>- In a dry food storage area, a plastic container containing corn was observed with no use by date. The CDM verified the observation and stated the corn in the plastic container should have been labeled when the packaged was opened from the original packaging with the use by date.<br><br>The CDM verified all the above findings. |

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| F 0814<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>44175<br><br>Based on observation and interview, the facility failed to ensure the garbage and refuse were properly stored in one of one garbage dumpster and compactor. Litter, and dark liquid collected with odor was observed under and around the garbage dumpster and compactor. This failure had the potential to harbor pests or rodents which carry diseases.<br><br>Findings:<br><br>According to FDA Food Code 2022, 5-501.115, Maintaining Refuse Areas and Enclosures, A storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items, and clean.<br><br>On 1/30/25 at 0915 hours, a concurrent observation and interview was conducted with the Plant Operations Director . A dumpster connected with the compactor was observed with pieces of disposable cups, papers, cardboard boxes, pieces of wood, and dark water with odor was observed under and the surrounding area of the dumpster and compactor. The Plant Operations Director verified the observation and stated the dumpster area should be free of surrounding litter. The Plant Operations Director further stated the dumpster and compactor area needed to be cleaned.<br><br>On 2/3/25 at 1410 hours, the CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644<br><br>Based on observation, interview, facility document review, 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.<br><br>* 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.<br><br>* The facility failed to ensure Resident 8's water pitcher was clean.<br><br>* LVN 1 failed to disinfect the stethoscope after use on Resident 9 and prior to exiting the room.<br><br>* LVN 4 failed to disinfect the stethoscope after use on Resident 12 and prior to exiting the room; additionally, LVN 4 failed to don proper PPE during the administration of the medications to Resident 12 via the GT.<br><br>* The facility failed to ensure RCP 2 wore proper PPE when providing suctioning through tracheostomy for Resident 7.<br><br>* The facility failed to ensure LVN 2 wore proper PPE when administering medication through the GT for Resident 14.<br><br>These failures posed a risk for transmission of disease-causing microorganisms and infections and incorrect notification of infection control practices.<br><br>Findings:<br><br>1. Review of the facility's P&P titled Pediatric Sub-Acute Infection Prevention Program Plan revised 1/2023 showed the Peds Subacute Infection Control plan covers the care, treatment, and services for the facility subacute care. The Peds Sub-Acute Infection Prevention Program 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:<br><br>* Identifying, managing, and reporting persons with transmissible diseases as mandated by the state communicable disease regulations<br><br>* 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<br><br>* Measuring, monitoring, evaluating, and reporting program effectiveness<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's infection surveillance list did not show a record of all the residents with infection. Only the residents with positive culture results were listed on the surveillance list.<br><br>On 1/30/25 at 1018 hours, an interview and concurrent record review was conducted with the Director of Infection Prevention. The Director of Infection Prevention stated he was responsible for the infection control surveillance in the Subacute unit. When asked if the facility included on their infection surveillance form the residents with identified infections who met the McGeer's criteria but did not have a positive culture, the Director of Infection Prevention stated they were only tracking the residents with positive culture results and listed on the surveillance list. The Director of Infection Prevention verified the surveillance forms did not include all the residents identified with infection and only the residents with positive culture results were listed on the infection surveillance form. The Director of Infection Prevention stated he followed the NHSN guidelines to see if it met the true infection of HAI.<br><br>2. Review of the facility's P&P titled Pediatric Sub-Acute Infection Prevention Program Plan revised 1/2023 showed the Pediatric Sub-Acute Infection Prevention Program Plan established by the facility provides a multidisciplinary systemic approach to promoting quality patient care, emphasizing risk reduction of disease transmission in the healthcare environment.<br><br>During the initial facility tour on 1/29/25 at 0829 hours, Resident 8's water pitcher was observed on top of the side table. The cover of Resident 8's water pitcher was dirty and had yellowish powder and stain.<br><br>Medical record review for Resident 8 was initiated on 1/29/25. Resident 8 was admitted to the facility on [DATE].<br><br>Review of the Physician H&P General dated 10/16/24, showed Resident 8 had global developmental delay (a significant delay in two or more domains of development, including activities of daily living as well as motor, cognitive, speech/language, and personal/social skills).<br><br>On 1/29/25 at 1114 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified the cover of Resident 8's water pitcher was dirty and had yellowish powder and stain. LVN 2 stated the staff member used the water from the water pitcher during the medication administration. LVN 2 stated the staff member should have changed Resident 8's water pitcher for infection control.<br><br>On 1/31/25 at 1621 hours, an interview was conducted with the CNO and Director of Quality and Risk. The DON and Director of Quality and Risk were informed and acknowledged the above findings.<br><br>48882<br><br>3. On 1/30/25 at 1524 hours, during the medication administration observation for Resident 9, LVN 1 was observed using a stethoscope and syringe to check for the GT placement and then placing the stethoscope around her neck. After completing Resident 9's medication administration, LVN 1 was observed performing hand hygiene and exited Resident 9's room. LVN 1 did not disinfect the stethoscope prior to exiting Resident 9's room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/30/25 at 1540 hours, an interview and concurrent observation was conducted with LVN 1 in the hallway. LVN 1 stated the stethoscope should be disinfected after each use and prior to exiting the resident's room. LVN 1 verified she did not disinfect her stethoscope after using the stethoscope to check Resident 9's GT placement, and prior to exiting Resident 9's room.<br><br>4.a. On 2/3/25 at 0928 hours, during the medication administration observation for Resident 12, LVN 4 was observed using a stethoscope and syringe to check for the GT placement and then placing the stethoscope around her neck. After completing Resident 12's medication administration, LVN 4 removed her gloves, washed her hands, and exited Resident 12's room. LVN 4 did not disinfect the stethoscope prior to exiting Resident 12's room.<br><br>On 2/3/35 at 0955 hours, an interview was conducted with LVN 3. LVN 3 stated after using the stethoscope to check for GT placement, the stethoscope should be disinfected prior to exiting the resident's room to prevent the transmission of organisms to other residents. LVN 3 verified she did not disinfect her stethoscope after using the stethoscope to check Resident 12's GT placement and prior to exiting Resident 12's room.<br><br>On 2/3/25 at 1024 hours, an interview was conducted with the Infection Control Coordinator. The Infection Control Coordinator stated the licensed staff are expected to disinfect the stethoscope after each use on the resident and the stethoscope should be disinfected before leaving the resident's room to prevent cross contamination and the transmission of organisms to others.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO. The CNO stated the stethoscope should be disinfected with the appropriate disinfectant after each use and before leaving the resident's room to prevent the cross contamination and transmission of infections. The CNO was informed and acknowledged the above findings.<br><br>b. Review of the CDC'S Long-Term Care Facilities: Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug- resistant Organisms (MDROs), dated 4/2/24, showed multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following:<br><br>- Wounds or indwelling medical devices, regardless of MDRO colonization status<br><br>- Infection or colonization with an MDRO.<br><br>Review of the CDC's Enhanced Barrier Precaution sign showed providers and staff must also:<br><br>wear glove and gown for the following high- contact resident care activities:<br><br>- dressing<br><br>- bathing/showering<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - transferring<br><br>- changing linens<br><br>- providing hygiene<br><br>- changing briefs or assisting with toileting<br><br>- device care or use: central line, urinary catheter, feeding tube, tracheostomy<br><br>- wound care: any skin opening requiring a dressing.<br><br>Medical record review for Resident 12 was initiated on 2/3/25. Resident 12 was admitted to the facility on [DATE].<br><br>Review of Resident 12's H&P examination dated 4/28/21, showed Resident 12 was a GT dependent.<br><br>Review of Resident 12's MDS dated [DATE], showed Resident 12 had a feeding tube.<br><br>On 2/3/25 at 0928 hours, during a medication administration observation with LVN 3. LVN 3 was observed administering Resident 12's medication via GT. LVN 3 was not observed wearing a gown during the medication administration.<br><br>On 2/3/25 at 0955 hours, an interview was conducted with LVN 3. LVN 3 was asked about the proper PPE during the administration of medications to a resident with a GT. LVN 3 stated for the residents who did not have an active infection, and have a GT, she did not don a gown during the medication administration. LVN 3 further stated Resident 12 was not under any isolation. LVN 3 verified she did not don a gown during the medication administration observation. LVN 3 was asked about the enhanced barrier precautions and LVN 3 stated she was not familiar with the precautions.<br><br>On 2/3/25 at 1024 hours, an interview was conducted with the Infection Control Coordinator. The Infection Control Coordinator was asked about her understanding of the enhanced barrier precautions. The Infection Control Coordinator stated when the staff member were providing care for a resident with a GT, the staff member must don a gown and gloves. The Infection Control Coordinator further stated a gown and gloves were required when providing a direct resident care and when administering medications via the GT. The Infection Control Coordinator was asked if the licensed nursed were aware of the enhanced barrier precautions guidelines, the Infection Control Coordinator stated the facility practice was that the residents who did not have an order for isolation and did not have an active infection, the licensed nurses were using standard precautions during the medication administration via the GT and when providing care.<br><br>On 2/3/25 at 1409 hours, an interview was conducted with the CNO and Director of Quality and Risk. The CNO was informed and acknowledged the above findings.<br><br>44175<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. Review of the CMS's QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes dated 3/20/24 and effective 4/1/24, showed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The QSO further showed EBP recommendations now include use of EBP for the residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.<br><br>On 1/31/25 at 0848 hours, RCP 2 was observed entering the room and performing hand hygiene donned gloves. RCP 2 proceeded to suction the Resident 7 through the tracheostomy tube. RCP 2 was not observed wearing gown while performing suctioning of the Resident 7 through the tracheostomy tube. No EBP sign was observed outside the room.<br><br>On 1/31/25 at 0850 hours, an interview was conducted with RCP 2. RCP 2 verified the observation and stated Resident 7 was not on any isolation precautions, so he was not required to wear gown while performing suctioning to the resident through tracheostomy. When asked RCP 2 if he was aware about the EBP, he stated he did not know about EBP and had not received any training on EBP.<br><br>Medical record review for Resident 7 was initiated on 1/29/25. Resident 7 was admitted to the facility on [DATE].<br><br>Review of the H&P examination dated 6/2/24, showed Resident 7 was dependent on tracheostomy (an opening surgically created through the neck into the trachea {windpipe} to allow air to fill the lungs), gastrotomy tube (a thin, flexible tube inserted through the abdominal wall and into the stomach), and mechanical ventilator ( A mechanical ventilator is a machine that takes over the work of breathing when a person is not able to breathe enough on their own).<br><br>Review of the Resident 7's Patient Orders, showed the following orders:<br><br>- dated 7/12/24, for Promote with fiber tube feeding to give 118 ml per hour via GT.<br><br>- dated 7/1/24, for tracheostomy tube change and mechanical ventilation.<br><br>6. On 1/31/25 at 0904 hours, LVN 2 was observed performing hand hygiene, donning gloves and entering the room of Resident 14 with the medication on her hand. LVN 2 was observed administering the medication through the GT. LVN 2 was not observed wearing gown before entering the room and administering the medication through the GT.<br><br>On 1/31/25 at 0909 hours, an interview was conducted with LVN 2. LVN 2 verified the observation and stated Resident 14 was not on any isolation precautions, so she was not required to wear gown while administering medication through the GT. LVN 2 was asked if she was aware about the EBP, she stated she did not know about EBP and had not received any training on EBP.<br><br>Medical record review for Resident 14 was initiated on 1/31/25. Resident 14 was admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Resident 14's Patient Orders showed an order dated 1/12/25, for tube feeding, Nutramigen (children's formula feeding) at 90 ml per hour via GT for nine hours from 2000 to 0500 hours.<br><br>On 1/31/24 at 1448 hours, an interview was conducted with the Infection Control Coordinator. The Infection Control Coordinator stated EBP was not practiced in the facility, and she recently became aware about the residents with tracheostomy, GT, indwelling urinary catheters, central lines, colostomy, wounds needed the standard EBP precautions, including the use of gown and gloves during direct care,and medication administration for the residents with GT. The Infection Control Coordinator was informed of the above findings and stated the staff member should have wore gown in addition to the gloves while providing suctioning to Resident 7, and while administering medication through the GT for Resident 14.<br><br>On 2/3/25 at 1410 hours, the CNO and Director of Quality and Risk were informed and acknowledged the above findings. |

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|---|---|---|---|
| | 555730 | A. Building<br>B. Wing | 02/03/2025 |

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

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the COVID-19 immunization was offered and administered to three of five sampled residents (two final sampled residents, Residents 17 and 6; and one nonsampled resident (Resident 1) reviewed for COVID-19 immunization. This failure placed the residents at risk to acquire COVID-19 infection.<br><br>Findings:<br><br>Review of the facility's P&P titled Coronavirus Disease (COVID-19) Mitigation Plan: 2019, 2020, 2021, 2022, 2023 dated 9/2023 showed the Infection Prevention will maintain a listing of the residents eligible for vaccination. Consent will be obtained from resident or responsible person after education is provided. Consent will be maintained in the medical record. The resident or responsible party has the right to refuse vaccination and refusal will be documented and placed in the medical record.<br><br>Review of the COVID-19 Vaccine information sheet dated 10/17/24, showed COVID-19 vaccine can prevent COVID-19 disease. The vaccine information sheet further showed the updated 2024-2025 COVID-19 vaccine is recommended for everyone six months of age and older.<br><br>1.a. Medical record review for Resident 1 was initiated on 1/30/25. Resident 1 was admitted to the facility on [DATE].<br><br>Review of Resident 1's Immunization Record failed to show documented evidence of the administration of COVID-19 vaccination.<br><br>On 1/31/25 at 0908 hours, an interview and concurrent medical record review was conducted with the Director of Staff Development (DSD)/MDS Coordinator. The Director of Staff Development (DSD)/MDS Coordinator acknowledged she did not offer to Resident 1's responsible party the COVID-19 vaccination for Resident 1. The Director of Staff Development (DSD)/MDS Coordinator stated the residents could get COVID-19 if they did not receive the vaccination.<br><br>b. Medical record review for Resident 17 was initiated on 1/30/25. Resident 17 was admitted to the facility on [DATE].<br><br>Review of Resident 17's Immunization Record failed to show documented evidence of the administration of COVID-19 vaccination from year 2023 to year 2025.<br><br>On 1/31/25 at 0908 hours, an interview and concurrent medical record review was conducted with the Director of Staff Development (DSD)/MDS Coordinator. The Director of Staff Development (DSD)/MDS Coordinator verified she did not offer to Resident 17's responsible party the COVID-19 vaccination for Resident 17. The Director of Staff Development (DSD)/MDS Coordinator stated the residents could get COVID if they did not receive vaccination. The Director of Staff Development (DSD)/MDS Coordinator stated COVID-19 should be offered to the residents.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/31/25 at 1326 hours, an interview was conducted with the Director of Infection Prevention. The Director of Infection Prevention acknowledged the findings.<br><br>2. Medical record review for Resident 6 was initiated on 1/30/25. Resident 6 was admitted to the facility on [DATE].<br><br>Review of Resident 6's COVID-19 Vaccine Consent form showed on 1/6/23, Resident 6's responsible party consented for Resident 6 to receive the COVID-19 vaccination.<br><br>Review of Resident 6's Immunization Record failed to show documented evidence of the administration of COVID-19 vaccination.<br><br>On 1/31/25 at 0908 hours, an interview and concurrent medical record review was conducted with the Director of Staff Development (DSD)/MDS Coordinator. The Director of Staff Development (DSD)/MDS Coordinator verified Resident 6's responsible party signed the consent for COVID-19 vaccination but the vaccine was not administered to Resident 6. The Director of Staff Development (DSD)/MDS Coordinator stated it was an oversight and the COVID-19 vaccination should have been given at that time to Resident 6.<br><br>On 1/31/25 at 1326 hours, an interview and concurrent medical record review was conducted with the Director of Infection Prevention. The Director of Infection Prevention acknowledged the findings. The Director of Infection Prevention stated the Director of Staff Development (DSD)/MDS Coordinator should have followed up and administered the COVID-19 vaccination to Resident 6.<br><br>On 1/31/25 at 1621 hours, an interview was conducted with the CNO and Director of Quality and Risk. The DON and Director of Quality and Risk were informed and acknowledged the above findings. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>44175<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the dish machine was repaired in a timely manner to ensure the dish machine final water temperature reached a minimum of 180 degrees Fahrenheit (F) as per manufacturer instruction. This failure had the potential to cause foodborne illness for residents using dishes that were not properly sanitized.<br><br>Findings:<br><br>Review of the facility's untitled document for diet orders for the residents dated 1/29/25, showed one of 18 residents was receiving food prepared from the kitchen.<br><br>According to the USFDA Food Code 2022 Annex 3, Equipment 4-501.11 Good Repair and Proper Adjustment, proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk.<br><br>Review of the facility's P&P titled Dishmachine Temperature revised 1/2024, under the section High Temperature Machine showed multi tank, conveyor, multi-temperature machine: wash temperature should be 150 degrees F, pumped rinse temperature should be 160 degrees F and final rinse temperature should be 180 degrees F- 190 degrees F. Further review of the P&P showed for high temperature dishmachine- record on Dish Machine Temperature Record form during each period of use . in the event of inappropriate temperature director to determine if reading is due to malfunctioning of gauge or inappropriate temperature, makes management decision concerning adequacy of sanitation of service ware, contact sources of repair and document action taken on the back of form.<br><br>On 1/20/25 at 0751 hours, an observation and concurrent interview was conducted with the CDM. The CDM stated the facility used high temperature dish washing machine. Upon observation of the dish machine, the water temperature gauze for the final rinse temperature showed E. The instruction on the dish machine showed for final rinse temperature should be 180-195 degrees F. The CDM was observed using the waterproof thermometer to check for the surface temperature of the utensils, showed 162 degrees F. The CDM verified the observation and stated the dish washing machine had not been showing final rinse temperature and he had submitted work order to the engineering department; however, it has not been fixed yet. The CDM further stated to ensure the sanitization of the service ware facility had been using pot sink (three compartment manual dish washing) for sanitation.<br><br>Review of the facility's document titled Dish Machine Temp Log showed following:<br><br>- On 1/2025, daily final rinse temperature showed less than 180 degrees F. In the column corrective action taken and manager weekly review did not show any entry.<br><br>- On 12/2024, daily final rinse temperature showed less than 180 degrees F. In the column corrective action taken and manager weekly review did not show any entry.<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - On 11/2024, daily final rinse temperature showed less than 180 degrees F, with the exceptions of 11/6/24. In the column corrective action taken and manager weekly review did not show any entry.<br><br>- On 10/2024, daily final rinse temperature showed less than 180 degrees F, with the exceptions of 10/8, 10/9, and 10/16/2024. In the column corrective action taken and manager weekly review did not show any entry.<br><br>- On 9/2024, the final rinse temperature showed less than 180 degrees F on 9/9, 9/11, 9/12, 9/13, 9/15, 9/16, 9/17, 9/27, 9/28, 9/29, and 9/30/2024. In the back of the log showed facility started sanitizing service ware using three compartment sinks until further notice.<br><br>- On 8/2024, the final rinse temperature showed less than 180 degrees F on 8/2, 8/12, 8/14, 8/15, 8/16, 8/21, and 8/26/2024. In the column corrective action taken and manager weekly review did not show any entry.<br><br>Further review of the above logs showed facility was performing daily second checking system Utensils Surface Temperature showed temperature above 160 degrees F. In addition, a note under the above logs showed if the wash temperature was less than 150 degrees F, or final rinse temperature less than 180 or higher than 194, test surface temperature with waterproof thermometer (standard 160 degrees F) and notify the manager, use pot sink, call engineering, and state emergency.<br><br>Review of the facility's document titled Engineering Dept. Work Order summary showed work order was requested on 6/12/24, and 9/10/24, for the dish washing temperature not reaching final rinse temperature 180 degrees F. Under the section solution showed a service was done and final rinse temperature within range of 180-degree F.<br><br>On 1/30/25 at 1400 hours, an interview was conducted with the CDM. The CDM verified the dishwashing machine final rinse temperature was not within range starting August 2024 and submitted only two work order. The CDM stated when the dish washing machine did not reach the final rinse temperature the staff member should start using the manual dish washing machine for sanitizer and call the engineering right away. The CDM stated he sent an email to follow up with the engineering upper management for the same issue on 10/23/25; however, he did not get any response.<br><br>Review of the email addressed to the Plant Operations Director dated 10/23/24, showed an email was sent by the CDM stating the dish washing machine was not reaching the temperature and an outside company assessed and confirmed the broken water system. The email further showed for the outside company to fix the issue they needed the payment.<br><br>On 1/30/25 at 1414 hours, an interview was conducted with the Plant Operations Director. The Plant Operations Director stated the engineering department only received two work orders on 6/12/24, and 9/10/24 for the dish washing machine not reaching the final temperature of 180 degrees and was able to fix the issue at that time. When asked the Plant Operations Director if he received the follow up email from the CDM regarding the same issue he stated yes; however, he was not able to fix the issue with the water system that was identified by the outside company. The Plant Operations Director was not able to show if he followed up when the CDM sent an email on 10/23/24, regarding the concern with dish washing machine not reaching final rinse temperature.<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/31/25 at 1621 hours, the CNO and Director of Quality and Risk was informed and acknowledged the above findings. |