STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555747	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Murrieta Health and Rehabilitation Center	24100 Monroe Avenue Murrieta, CA 92562

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to treat resident with dignity and respect, for one 130 residents (Resident 385), when the resident's urinary bag was not covered with a dignity bag (used to cover a urine collection bag). This failure had the potential to affect Resident 385's psychosocial well being. Findings: On December 9, 2024, at 2:30 p.m., Resident 385's urinary bag was observed hanging at the side of the bed and was not covered with a dignity bag. In a concurrent interview with Resident 385, she stated the urinary bag was not covered when she walked outside of her room and the resident stated she felt embarrassed when people see her urinary bag. On December 9, 2024, at 3:26 p.m., Resident 385 was observed with Licensed Vocational Nurse (LVN) 2. In a concurrent interview, LVN 2 stated the staff did not cover the urinary bag with a dignity bag and was exposed to everyone. LVN 2 further stated, It should have been covered, I would feel embarrassed if that bag was mine and not covered. On December 11, 2024, at 3:20 p.m., during an interview with the Director of Nursing (DON), the DON stated residents should be treated with respect and dignity all the time. The DON further stated leaving the urinary bag uncovered could have psychosocial effects on the resident, and the urinary bag should have been covered with a dignity bag. On December 11, 2024, Resident 385's record was reviewed. Resident 385 was admitted to the facility on [DATE], with diagnoses which included obstructive and reflux uropathy (blockage in urinary tract). A review of Resident 385's Minimum Data Set (MDS - an assessment tool), dated November 29, 2024, indicated Resident 385 had a BIMS (Brief Interview for Mental Status - a tool used to screen and identify cognitive condition of residents) which indicated moderate cognitive impairment. A review of Resident 385's Order Summary, included a physician's order, dated November 22, 2024, indicated an order for indwelling catheter (tube that drains urine) due to neurogenic bladder (blockage in urinary tract), (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Residents Rights, dated February 2023, indicated, . Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be treated with respect, kindness and dignity . A review of the facility's policy and procedure titled, Dignity, dated February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assists resident for example .helping the resident to keep urinary catheter bags covered .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure an assessment for safe self-administration of medication was conducted, for three of 28 residents (Resident 382, 388, and 389) when: 1. One opened box of Allergy Calm (brand of tablet used to treat allergies) tablet medication was found on the over bed table of Resident 382; 2. One opened plastic bottle of 15 ml (milliliters - unit of measurement) Afrin (brand of nasal spray used to treat congestion) nasal spray was found on the over bed table of Resident 388; and 3. One opened 77 g (grams- unit of measurement) tube of Alevex (brand of lotion use for pain) lotion was found on the over bed table of Resident 389. These failures had the potential for Residents 382, 388, and 389 to receive multiple doses of medication without proper monitoring, which could lead to harmful effects. Findings: 1. On December 9, 2024, at 10:44 a.m., during a concurrent observation and interview with Resident 382 in her room, one box of AllergyCalm tablet medication was observed on top of her over bed table. In a concurrent interview with Resident 382, she stated she used the medication AllergyCalm for relief from allergies. Resident 382 further stated, I take it two times a day and if I need more. On December 9, 2024, at 11:15 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3, he stated Resident 382's allergy pills should not be kept at the resident's bedside and should not be administered by the resident. LVN 3 further stated Resident 382 should have been assessed for self-administration of the allergy medication. On December 10, 2024, at 10:16 a.m., the Assistant Director of Nursing (ADON) was interviewed. The ADON stated there was no assessment for self-administration of medication for Resident 382. The ADON stated there was no physician order for Resident 382 to self-administer medications. The ADON further stated if Resident 382 continued to self-medicate, then it would lead to possible adverse effect of the medication. On December 11, 2024, Resident 382's record was reviewed. Resident 382 was admitted on [DATE], with diagnoses which included gastrointestinal hemorrhage (intestinal bleeding). A review of Resident 382's Minimum Data Set (MDS - a resident assessment tool), dated December 3, 2024, indicated Resident 382 had a BIMS (Brief Interview for Mental Status - a tool used to screen and identify cognition) score of 14 (cognitively intact). Further review of Resident 382's medical record indicated there was no documented evidence that a medication self-administration assessment was conducted. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On December 9, 2024, at 10:44 a.m., during a concurrent observation and interview with Resident 388 in her room, one opened plastic bottle of 15 ml nasal spray Afrin medication was observed on top of her over bed table. In a concurrent interview with Resident 388, Resident 388 stated she used the medication for relief from nasal congestion. Resident 388 further stated, I just spray and spray it every now and then. Further review of Resident 388's medical record indicated there was no documented evidence that a self-administration assessment was conducted. On December 9, 2024, at 10:11 a.m., during a concurrent observation and interview with LVN 3, LVN 3 stated the Afrin nasal spray should not be kept at the resident's over bed table and should not let Resident 388 administer the nasal spray to herself without supervision. LVN 3 further stated Resident 388 should have been assessed for self-administration of the medication. On December 10, 2024, at 10:12 a.m., the ADON was interviewed. The ADON stated there was no assessment for self-administration of medications and there was no physician order for Resident 388 to self-administer medications. The ADON further stated if Resident 388 continued to self-medicate, then it would irritate the nasal lining of the resident and the resident could experience adverse effects from the medication. On December 11, 2024, Resident 388's medical record was reviewed. Resident 388 was admitted on [DATE], with diagnoses which included asthma (difficulty in breathing). A review of Resident 388's History and Physical, dated December 1, 2024, indicated Resident 388 was mentally capable of understanding. A review of Resident 388's MDS, dated [DATE], indicated Resident 388 had a BIMS score of 13 (cognitively intact). 3. On December 9, 2024, at 9:16 a.m., during a concurrent observation and interview with Resident 389 in her room, one opened 77-grams tube of pain relieving Alevex lotion was observed on top of her over bed table. Resident 389 stated she used the medication for relief from mild pain. Resident 389 further stated, I applied twice and more to my joints daily. On December 9, 2024, at 10:50 a.m., during a concurrent observation and interview with LVN 3, LVN 3 stated the Alevex pain relieving lotion should not be kept at the over bed table and should not apply herself without supervision. LVN 3 further stated Resident 389 should have been assessed for self-administration of pain-relieving lotion medication. On December 10, 2024, at 10:17 a.m., the ADON was interviewed. The ADON stated there was no assessment for self-administration of medications for pain relieving lotion and there was no physician order for Resident 389 to self-administer medications. The ADON further stated if Resident 389 will continue to self-medicate, then it would irritate the skin for applying more than required, and the resident could experience adverse effects of the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2024, at 3:16 a.m., during an interview with the Director of Nursing (DON), the DON stated she expected licensed nurses to follow the policy and procedure regarding self-administration assessment and administration of medications for all residents. The DON further stated if the policy and procedures were not followed, there was a potential for residents to not receive medications according to the physician's order, and to not be monitored for any adverse effects. On December 12, 2024, Resident 389's medical record was reviewed. Resident 389 was admitted on [DATE], with diagnoses which included spinal stenosis (pressure that cause pain to the spine). A review of Resident 389's History and Physical, dated December 11, 2024, indicated Resident 389 was mentally capable of understanding. Further review of Resident 389's medical record indicated there was no documented evidence that a self-administration assessment was conducted. A review of the facility's policy and procedure titled, Self-Administration of Medications, dated February 2021, indicated, .Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party . A review of the facility's policy and procedure titled, Administering Medications, dated April 2023, indicated, . Medications are administered in a safe and timely manner, and as prescribed .Only person licensed or permitted by this state to prepare, administer and document the administration of medications may do so . Medications are administered in accordance with prescriber orders .Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do safely .

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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** 50204 Based on interview and record review, the facility failed to ensure a copy of the Advance Directive (AD - a written instruction, such as a living will, relating to the provision of treatment and services when the individual becomes unable to decide) was available in the medical record, for one of one residents reviewed for Advance Directives (Resident 68). This failure had the potential to result in Resident 68's wishes related to the provision of medical treatment and services to not be followed if Resident 68 became unable to make decisions for himself. Findings: On December 10, 2024, Resident 68's record was reviewed. Resident 68 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (permanent stage of kidney disease). A review of Resident 68's History and Physical dated December 11, 2024, indicated Resident 68 had the capacity to understand and make decisions. A review Resident 68's Social Service Review, dated November 2, 2024, indicated Resident 68 had an AD and a copy was requested from Resident 68 and his family member (FM). However, further review of Resident 68's record indicated there was no copy of the AD in the record. Further review of Resident 68's record, indicated there was no documented evidence a copy of the AD was obtained from the FM. There was no documented evidence the facility followed up with the FM regarding the AD. On December 11, 2024, at 8:47 a.m., Resident 68 was interviewed. Resident 68 stated he was not sure if an AD was formulated. Resident 68 stated his family member (FM) took care of his documents. On December 11, 2024, at 8:57 a.m., the Social Service Director (SSD) and the Social Services Assistant (SSA) were concurrently interviewed. When asked when the latest follow up was conducted with Resident 68's FM regarding the AD, the SSA stated she did not ask a copy of AD from the FM. The SSD stated there was no follow up from initial review to receive a copy of AD. The SSD further stated the team should have followed up regarding the AD sooner and the AD should have already been in Resident 68's chart. On December 11, 2024, at 4:48 p.m., the Director of Nursing (DON) was interviewed. The DON stated if a resident had an AD, she expected the AD to be readily available in the chart. The DON further stated she expected the social services should have followed up and uploaded the document in the chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Advance Directives, dated September 2022, indicated, . The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy . information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff .If the resident or the resident or the residents representative has executed one or more advance directive(s), or executes upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff .The residents wishes are communicated to the residents direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meeting .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to provide a comfortable homelike environment, for one of 28 residents reviewed (Resident 384), when multiple damaged window blinds were observed. This failure had the potential to disrupt the residents' daily living needs and environment. Findings: On December 9, 2024, at 9:45 a.m., during a concurrent observation and interview with Resident 38 in her room, multiple damaged blinds were observed. In a concurrent interview with Resident 384, she stated it was too bright when light would come on the window when she wakes up in the morning, and she could not get back to sleep. On December 10, 2024, at 9:20 a.m., Resident 384's window was observed to have about two layers of horizontal blinds broken. On December 10, 2024, at 9:27 a.m., a picture of Resident 384's broken blinds were shown to the Assistant Director of Nursing (ADON). The ADON stated Resident 384 had broken blinds and would not feel home-like environment for the residents. The ADON stated, it should be repaired. On December 11, 2024, at 10:20 a.m., Resident 384's window was observed to still have broken blinds. On December 11, 2024, at 11:40 a.m., during an interview with the Maintenance Supervisor (MS), the MS stated he was not aware about the damaged window blinds in Resident 384's room. The MS further stated, the blinds need to be replaced. On December 11, 2024, at 11:35 a.m., during an interview with the Administrator (ADM), the ADM stated he was not aware that the damaged window blinds needed to be repaired. The ADM further stated, the blinds should have been replaced or repaired to provide home like environment for the residents. On December 11, 2024, Resident 384's record was reviewed. Resident 384 was admitted to the facility on [DATE], with diagnoses which included congestive hear failure (a chronic condition that occurs when the heart can not pump enough blood to meet the body's needs). A review of the facility's policy and procedure titled, Homelike Environment, dated February 2021, indicated, . Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent as possible .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .comfortable (minimum glare) yet adequate (suitable to the task) lighting .Comfortable and adequate lighting is provided in all areas of the facility to promote safe, comfortable and homelike environment. The lighting design emphasizes .reduction in glare . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Maintenance Service, dated December 2009, indicated, . Maintenance service shall be provided to all areas of the building, grounds, and equipment .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner of all times .maintaining the building in a good repair and free from hazards .The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the building, grounds and equipment are maintained in a safe and operable manner .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on observation, interview and record review, the facility failed to ensure respiratory tubings were changed according to the facility's policy and procedure, when: 1. For Resident 17, the nebulizer tubing (tubing that turns liquid medication into a mist that can be inhaled) was dated June 23, 2024; 2. For Resident 19, the nebulizer tubing, oxygen tubing (nasal cannula [N/C] - a tube used to deliver oxygen through the nose), and the tubing from the humidifier bottle to the oxygen concentrator (plastic bottle that infuses the normal flow of oxygen with water droplets) were all dated November 21, 2024; and 3. For Resident 80 the oxygen tubing and humidifier bottle (moistens the air) were dated November 24, 2024. This failure had the potential to result in deterioration of the respiratory tubing and humidifier bottle which would allow infectious organisms to grow causing an infection to Residents 17, 19, and 80. Findings: 1. On December 9, 2024, at 10:40 a.m., Resident 17's nebulizer tubing was observed with a label, dated June 23, 2024. On December 9, 2024, at 10:57 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 4. LVN 4 stated the night shift changes the respiratory tubings every Saturday or Sunday night. LVN 4 further stated Resident 17's nebulizer tubing should have been changed a long time ago. On December 10, 2024, Resident 17's record was reviewed. Resident 17 was admitted to the facility on [DATE], with diagnoses of history of transient ischemic attack (a temporary state of reduced blood flow in a portion of the brain) and asthma (a condition that makes it difficult to breath). 2. On December 9, 2024, at 11:42 a.m., Resident 19's oxygen tubing, nebulizer tubing, and tubing to the humidifier bottle were all observed with a label, dated November 21, 2024. On December 9, 2024, at 11:48 a.m., an interview was conducted with LVN 5. LVN 5 stated night shift changes the tubing, but she needs to ask what are the intervals for the tubing to be changed. On December 9, 2024, at 11:54 a.m., a continued interview was conducted with LVN 5. LVN 5 stated all the respiratory tubings should be changed at least once a week. On December 10, 2024, Resident 19's record was reviewed. Resident 19 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure (the lungs can't exchange oxygen and carbon dioxide properly) and chronic obstructive pulmonary disease (lung condition caused by damage to the lungs). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On December 10, 2024, at 3:29 p.m., an observation of Resident 80 was conducted. Resident 80 was observed asleep in her room, with oxygen flowing via NC and an oxygen concentrator (takes in air from the room and filters out the nitrogen providing higher amounts of oxygen) with humidifier attached to it. Both oxygen tubing and humidifier bottle were labeled with the date of November 11, 2024. On December 11, 2024, at 10:10 a.m., an interview with the Director of Nursing (DON) was conducted. The DON stated the staff should monitor the medical equipment used by the residents. The DON stated the practice in the facility was to change oxygen tubing once a week. The DON stated the night shift nurse would change it every Sunday and if the incoming shift staff see the tubing undated or post dated, her expectation was the in-coming staff will change and label the equipment with the current date. The DON stated if the date was November 11, 2024, on the equipment label, this meant the tubing was not changed and it should be changed accordingly. The DON further stated the LVN should replace the oxygen tubing and humidifier regularly and as needed if they were soiled. The DON continued if not changed it could lead to respiratory illness or infection. The DON further stated the staff should follow infection control policy for changing tubings and equipment. On December 12, 2024, at 2:30 p.m., an interview with the Director of Staff Development (DSD) was conducted. The DSD stated oxygen tubing changes are to be done every seven (7) days by the licensed nurse on night shift. The DSD further stated this procedure is being checked off during new hire orientation and reviewed annually. On December 12, 2024, Resident 80's record was reviewed. Resident 80 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). A review of the policy and procedure titled, Departmental (Respiratory Therapy)-Prevention of Infection, revised November 2011, was reviewed. The policy indicated, .change prefilled humidifier when the water level becomes low .change the oxygen cannula and tubing every seven (7) days, or as needed .infection control considerations related to medication nebulizers/continuous aerosol .discard the administration set up every seven (7) days .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46393 Based on observation, interview, and record review, the facility failed to ensure provision of pharmacy services met the needs of the residents when: 1. Residents 88 and 101's discontinued and expired medication were identified stored inside a medication cart along with active/unexpired medications. This had the potential for residents to receive the wrong medication; and 2. Residents 90, 76, and 55's medical record had missing documentation for the administration of controlled substance (CS - those with high potential for abuse and addiction) medications. The CS medications were signed out on the Antibiotic or Controlled Drug Record Medication (count sheet, an inventory sheet that keeps record of the usage of controlled medications), but not documented on the Medication Administration Records (MAR) to indicate they were administered to the residents. This had the potential for misuse or abuse of the CS medications. Findings: 1. On December 9, 2024 at 10:44 a.m., during an inspection of Medication Cart 3 in Nursing Station 3A with Licensed Vocational Nurse (LVN) 6 the following were identified: a. One blister card for Resident 88 containing 26 tablets of meclizine (medication to treat dizziness), with expiration date of December 6, 2024; and b. One blister card for Resident 101 containing 12 tablets of trazodone (medication used to treat depression, anxiety, or insomnia) 50 milligrams (mg, unit of measurement), expiration date November 11, 2024. On December 9, 2024 at 11:04 a.m., during an interview with LVN 6, LVN 6 confirmed the Resident 88's meclizine and Resident 101's trazodone tablets were expired. LVN 6 stated expired medications should have been removed from the medication cart, discarded in the medication room, and should not be available for use. LVN 6 further stated, the expired medications should have been reordered if those medications were still active medication orders. A review of Resident 101's medical record indicated a physician's order, dated May 5, 2024, to start trazodone 50 mg oral tablets, give one tablet by mouth every 24 hours as needed for insomnia at bedtime only. On December 9, 2024, the following records were reviewed: - Resident 101's medical record indicated a physician's order, dated July 9, 2024, to discontinue the trazodone 50 mg order listed above for Resident 101; - Resident 88's medical record indicated a physician's order, dated June 5, 2024, current order for meclizine. (continued on next page)

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	555747	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Murrieta Health and Rehabilitation Center	24100 Monroe Avenue Murrieta, CA 92562

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2024 at 10:52 a.m., during an interview with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to have removed any discontinued or expired medications from the medication cart and to have discarded it in the medication room. The DON stated discontinued or expired medications should not have been stored together with active medications inside the medication cart. A review of the facility's policy and procedure (P&P) titled, Discontinued Medications, dated November 2022, the P&P indicated, Staff shall destroy discontinued medications or return them to the dispensing pharmacy in accordance with facility policy .The nurse receiving the order to discontinue a medication is responsible for recording the information .and notifying the dispensing pharmacy of the discontinuation .Discontinued medication are destroyed or returned to the issuing pharmacy in accordance with facility policy and state regulations . A review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated, .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . A review of the facility's policy and procedure titled, Discontinued Medications, dated November 2022, indicated, .Staff shall destroy discontinued medications or return them to the dispensing pharmacy in accordance with facility policy . 2. On December 10, 2024 at 9:41 a.m., during an interview with LVN 4, LVN 4 stated the facility's process for CS medication administration was as follows: - checking the resident's pain level and the doctor's order; - removing the CS medication from the bubble pack; - logging the CS medication out from the count sheet; and - documenting on the resident's MAR immediately after the resident was administered the CS medication. On December 10, 2024, at 9:54 a.m., during an inspection of the CS medication cart with LVN 4, the following were identified: a. A review of Resident 90's medical record included a physician's order, dated November 1, 2024, for oxycodone-acetaminophen (Percocet - a potent controlled medication for pain) 5/325 mg, 1 tablet by mouth every 4 (four) hours as needed for moderate to severe pain 4-10. A review of the Resident 90's Antibiotic or Controlled Drug Record, and MAR, for November and December 2024, for Percocet 5/325 mg, indicated the nursing staff signed out one tablet but did not document the administration on the MAR on the following dates and times: - November 28, 2024, at 12 p.m.; - December 1, 2024 at 13:59 (1:59 p.m.); (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- December 1, 2024 at 18:00 (6 p.m.); and - December 1, 2024 at 22:00 (10 p.m.) During a concurrent interview and record review with LVN 4, she acknowledged one Percocet 5/325 mg tablet for Resident 90 was unaccounted in November 2024 and three Percocet 5/325 mg tablets were unaccounted in December 2024. 2b. A review of Resident 76's medical record included a physician's order, dated October 30, 2024, for Percocet 10/325 mg, 1 tablet by mouth every 6 (six) hours as needed for severe pain 7-10. On December 10, 2024 at 11:09 a.m., during a concurrent interview and record review with LVN 6, a review of Resident 76's Count Sheet for Percocet 10/325 mg and MAR dated December 2024 indicated the nursing staff signed out one tablet on December 1, 2024 at 17:20 (5:20 p.m.) but did not document the administration on the MAR During this interview and record review, LVN 6 acknowledged one Percocet 10/325 mg tablet for Resident 76 was unaccounted in December 2024. 2c. A review of Resident 55's medical record included a physician's order, dated December 7, 2024, for Norco (hydrocodone-acetaminophen, a potent controlled medication for pain) 10/325 mg tablet, 1 tablet by mouth every 6 (six) hours as needed for severe pain 7/10. On December 10, 2024 at 11:15 a.m., during a concurrent interview and record review with LVN 6, a review of Resident 55's Count Sheet for Norco 10/325 mg and MAR dated December 2024 indicated the nursing staff signed out one tablet but did not document the administration on the MAR on the following dates and times: -December 1, 2024 at 17:30 (5:30 p.m.); -December 6, 2024 at 18:30 (6:30 p.m.); and -December 7, 2024 at 06:50 (6:50 a.m.). During a concurrent interview and record review, LVN 6 acknowledged three Norco 10/325 mg tablets for Resident 55 were unaccounted in December 2024. On December 11, 2024 at 11:20 a.m., during an interview with the DON, the DON stated the expectation during CS medication administration was for nursing staff to have documented on the count sheet and in the MAR at the same time to avoid discrepancies. The DON stated documentation was important for accountability, patient safety, and to prevent diversion. On December 11, 2024 at 11:23 a.m., during a concurrent interview and record review with the DON, she confirmed the discrepancies and acknowledged the missing documentations in the MAR for the dates and times as listed above for Residents 90, 76, and 55. The DON stated the medication administrations should have been documented on the resident's MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Administering Medications, dated April 2023, indicated, .The individual administering the medication initials the resident's MAR on the appropriate line or EMAR after giving each medication and before administering the next ones .the individual administering the medication records in the resident's medical record .the date and time the medication was administered; the dosage; the route of administration .the signature and title of the person administering the drug . During a review of the facility's policy and procedure titled, Controlled Substances, dated November 2022, indicated, .an individual resident controlled substance record is made for each resident who will be receiving a controlled substance .This record contains: name of the resident; name and strength of the medication . number on hand .time of administration; method of administration .signature of nurse administering medication .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46393 Based on interview and record review, the facility failed to ensure, for two of five sampled residents (Residents 34 and 5) were free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications, including quetiapine (brand name Seroquel, an antipsychotic medication for bipolar disorder, depression, and schizophrenia) when: 1. Resident 34 was administered quetiapine without an appropriate indication and/or clinical justification, without an annual GDR (gradual dose reduction) attempt in 2024, and no resident-centered non-pharmacological (any treatment or method used to improve health that doesn't involve taking medication) behavioral interventions were implemented prior to initiation and during use of quetiapine; and 2. Resident 5 was administered quetiapine without resident-centered non-pharmacological behavioral interventions implemented prior to initiation and during the first two months of quetiapine use. These failures resulted in unnecessary medications for Residents 34 and 5, which increased the potential for medication interactions, adverse reactions, and unidentified risks associated with the use of psychotropic medications that included but not limited to sedation, respiratory depression, constipation, anxiety, agitation, and memory loss. Findings: 1. A review of Resident 34's clinical record indicated the resident was initially admitted to the facility on [DATE], and recently readmitted on [DATE] with diagnoses including unspecified psychosis (a collection of symptoms that involve abnormalities in a person's thoughts and perceptions) and dementia (a condition characterized by memory loss) without behavioral, psychotic, or mood disturbances. A review of Resident 34's Minimum Data Set (MDS - a care area assessment and screening tool), dated July 28, 2017 and October 10, 2024, indicated the resident had no exhibition of hallucinations/delusions and no physical/verbal behavioral symptoms directed toward others (hitting, kicking, grabbing, threatening others, screaming at others, cursing at others). A review of Resident 34's medical record indicated she had been receiving quetiapine in various doses since April 2021 and indicated a current physician's order dated October 24, 2023, for Quetiapine 25 milligram (mg, unit of measurement) by mouth at bedtime for psychosis M/B (manifested by) visual hallucination. There was no documented evidence in Resident 34's medical record that non-pharmacological interventions were implemented prior to initiating quetiapine. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 34's Medication Administration Record (MAR), dated September 2024 to December 2024, the MAR indicated, Monitor behaviors(s) of visual hallucination q [every] shift for use of Quetiapine. every shift. On December 12, 2024 at 8:44 a.m., Resident 34 was observed sitting quietly reclined in a wheelchair in the hallway facing Nursing Station 2. Resident 34 was alert, calm, and pleasant. When asked how she was doing, Resident 34 said, My back hurts, and pointed to her lower back. On December 12, 2024 at 8:51 a.m., during an interview with Certified Nursing Assistant (CNA) 4, CNA 4 stated he had been involved with Resident 34's care for one and a half (1.5) years. CNA 4 stated the resident was cooperative with care and sometimes confused (approximately two or three times a week). CNA 4 stated Resident 34 was not combative or dangerous to herself or others. CNA 4 described an example of a behavior or visual hallucination he witnessed: Resident 34 told him she saw her granddaughter outside her room and asked CNA 4 to bring grandchild inside. CNA 4 further added, Resident 34 frequently expressed thoughts about her family, and he said she spoke to her family frequently. On December 12, 2024 at 9:10 a.m., during an interview with the Director of Nursing (DON), regarding Resident 34's behaviors, the DON stated she was not familiar with Resident 34. The DON stated Resident 34 was prescribed quetiapine due to the behavior of visual hallucinations. The DON stated there was no documentation of the nature of the hallucinations or if the behavior was dangerous or harmful. The DON said she would follow-up. During the same interview with the DON, when asked about the Boxed Warning (strongest form of warning required by the Food and Drug Administration [FDA] for prescription drug labeling) for using quetiapine in dementia patients, the DON reviewed the quetiapine manufacturer's Boxed Warning and read out loud verbatim: Increased mortality [death] in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs [medications that treat psychosis] are at an increased risk of death. Seroquel [quetiapine] is not approved for elderly patients with dementia-related psychosis. On December 12, 2024 at 9:35 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated he had participated in monthly behavioral IDT meetings since September 2024 (approximately three months). Regarding Resident 34's behaviors, the ADON said, There are a lot of residents, I don't know [Resident 34] that well. When asked when the last GDR for Resident 34's quetiapine was attempted, the ADON stated he would follow-up. On December 12, 2024 at 9:40 a.m., during a follow-up interview with the DON, the DON confirmed there was no documentation in Resident 34's medical record of non-pharmacological interventions implemented prior to the initiation or during the use of quetiapine and acknowledged there should have been. On December 12, 2024 at 10:04 a.m., during an interview with the Social Services Director (SSD), the SSD stated she had participated in the monthly behavior IDT meetings for the last one and a half (1.5) years. Regarding Resident 34's behaviors, the SSD stated she witnessed Resident 34 having general confusion and said the behavior was nothing out of the ordinary. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 12, 2024 at 10:49 a.m., during a follow-up interview and record review with the DON, she stated Resident 34's IDT Behavior Management, note dated October 24, 2023 was reviewed. The IDT Behavior Management note indicated, .quetiapine 12.5 mg discontinued . The DON stated the resident was previously prescribed quetiapine 12.5 mg one time a day in the mornings and 25 mg at bedtime. The DON confirmed, Resident 34 had been continued on quetiapine 25 mg at bedtime since October 24, 2023 (over one year) without GDR attempt in 2024. On December 12, 2024 at 11:07 a.m., during a telephone interview with the facility's psychiatric Nurse Practitioner (NP), the NP stated Resident 34 was prescribed quetiapine by the facility's primary provider because [Resident 34] was not sleeping and seeing things. The NP stated antipsychotics should not be used long term if avoidable. The NP stated she was unaware Resident 34 had been prescribed quetiapine since October 2023 (over one year). The NP stated she thought quetiapine was started recently in October 2024. The NP stated, there were other treatment options that may help with sleep and said, [quetiapine] should be discontinued. On December 12, 2024 at 1:27 p.m., during a follow-up interview with the DON, the DON stated visual hallucination of grandchildren or family was not harmful and confirmed there was no documentation in Resident 34's medical record of harm resulted from hallucination of seeing grandchildren or family. The DON stated it was important to use antipsychotic medications as indicated to ensure residents were medicated properly and had clinical reason to have continued the medication. The DON confirmed there was no documentation in Resident 34's medical record of non-pharmacological intervention prior to and during administration of quetiapine. The DON stated it was important to try non-pharmacological interventions to avoid antipsychotics when possible due to potential side effects. The DON further added, There are other options for sleep issues. Additionally, the DON confirmed the last time Resident 34's quetiapine had a GDR was on October 24, 2023 (over one year ago) and said there should have been a GDR within the past year in 2024. On December 12, 2024 at 1:38 p.m., during a concurrent interview and record review with the DON, Resident 34's Consultant Pharmacist's [CP] Recommendation To Inter-Disciplinary Team (IDT) dated November 21, 2024, was reviewed. The document indicated, Resident continues from 10/24/23 on Quetiapine .Give 25 mg by mouth at bedtime for psychosis M/B visual hallucination, which was a dose reduction .After the first year a GDR must be attempted annually unless clinically contraindicated .Need to access if clinically appropriate to consider a further gradual dose reduction at this time. Should therapy continue at the current dose, must document rationale describing a dose reduction as clinically contraindicated in the related behavior management notes . Additionally it indicated, IDT evaluation and response: No changes. Stable. The DON stated, there was no documentation in Resident 34's medical record that a GDR was contraindicated or documentation of a clinical rationale for continuing quetiapine. 2. A review of Resident 5's clinical record indicated the resident was initially admitted to the facility on [DATE], and recently readmitted on [DATE] with diagnoses including heart failure (condition that occurs when the heart is unable to pump enough blood and oxygen to the body) and fracture of the left femur (thigh bone). A review of the MDS dated [DATE] and September 5, 2024, indicated the resident had no exhibition of hallucinations/delusions and no physical/verbal behavioral symptoms directed toward others (hitting, kicking, grabbing, threatening others, screaming at others, cursing at others). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 5's Hospice Visit Note, dated August 6, 2024 indicated, Extreme behavior .refusing all meds [medications], kicking everyone out of the room, fighting with staff trying to change her briefs . screaming towards staff .Report given to [doctor] with an order for .Seroquel [quetiapine] 100mg at bedtime . A review of Resident 5's medical record indicated a physician's order, dated August 14, 2024, for quetiapine 100 mg by mouth at bedtime for psychosis M/B hitting staff while receiving care. There was no documented evidence in Resident 5's medical record that non-pharmacological interventions were implemented prior to initiating quetiapine. On December 11, 2024 at 4:20 p.m., during an observation and interview with Resident 5, the resident was observed watching her iPad and stated she had no concerns with the facility. Resident 5 did not show any signs or symptoms of being upset, did not have any outburst, remained calm and polite. On December 12, 2024 at 1:53 p.m., during a concurrent interview and record review with the DON, Resident 5's MARs for August 2024 through December 2024 were reviewed. The DON stated there was no documentation of non-pharmacological interventions implemented for Resident 5 before starting quetiapine. The DON further stated there was no documentation of non-pharmacological interventions implemented until October 14, 2024, after quetiapine was administered to Resident 5 for two months. On December 12, 2024 at 3:24 p.m., during a follow-up interview with the DON, the DON confirmed there was no documentation in Resident 5's medical record of non-pharmacological interventions implemented before quetiapine was started or between August 14, 2024 through October 13, 2024 after quetiapine was started. The DON stated it was important to try non-pharmacological interventions first see if something else could have helped the resident and avoid antipsychotic medications if possible. A review of the facility's policy and procedure titled, Psychotropic Medication Use/Informed Consent, dated March 2024, indicated, .Residents will not receive medications that are not clinically indicated to treat a specific condition .Residents who have not used psychotropics medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record .Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes .Non-pharmacological approaches are used (unless contraindicated) to minimize the need for the medications, permit the lowest possible dose, and allow for discontinuation of medications when possible .Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications .Resident evaluations .when documenting whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether: other causes for symptoms (including symptoms that mimic a psychiatric disorder) have been ruled out; signs and symptoms are clinically significant enough to warrant medication therapy; a particular medication is clinically indicated to manager the symptoms or condition .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46393 Based on observation, interview, and record review, the facility failed to ensure medication were properly stored and labeled when: 1. One (1) expired medication was stored in the medication cart together with unexpired medications; 2. Opened medications were stored without an open date; 3. IV (intravenous - into the vein) Cart 3 contained several expired IV supplies; and 3. The treatment cart contained multiple expired wound care supplies. These failures had a potential for residents to receive medications or medical supplies with unsafe and reduced effectiveness from being used past their discard date; medication errors due to medications not being labeled or removed from active stock; and inadequately monitored medications, which could lead to unsafe and ineffective medications for the residents. Findings: 1. On December 9, 2024 at 10:44 a.m., an inspection of Medication Cart 3 in Nursing Station 3A was conducted with Licensed Vocational Nurse (LVN) 6, one medication blister card for Resident 88 containing 26 tablets of meclizine (medication used to nausea) 12.5 milligrams (mg, unit of measurement), had an expiration date of December 6, 2024; On December 9, 2024 at 11:04 a.m., during an interview with LVN 6, LVN 6 confirmed the meclizine 12.5 mg tablets was expired on December 6, 2024. LVN 6 stated expired medications should have been removed from the medication cart and discarded in the medication room. 2a. On December 9, 2024 at 10:44 a.m., an inspection of Medication Cart 3 in Nursing Station 3A was conducted with Licensed Vocational Nurse (LVN) 6 and the following were identified: - One medication inhaler Advair Diskus (medication for lung disease) 250/50 mcg (micrograms, unit of measurement) for Resident 88, was opened but did not have an open date; - One medication inhaler Symbicort (medication for lung disease) 80/4.5 mcg, for Resident 65, was opened but did not have an open date; and - One medication inhaler Anoro Ellipta (medication for lung disease) 62.5/25 mcg, for Resident 16 was opened but did not have an open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 9, 2024, at 11:08 a.m., during an interview with LVN 6, she stated Residents 88, 65, and 16, were still admitted in the facility. LVN 6 stated there should be a date on the inhalers when it was opened to determine when it would expire. LVN 6 further stated, the inhalers without an opened date should be discarded and reordered from the pharmacy. 2b. On December 9, 2024 at 3:25 p.m., during An inspection of the medication room in Nursing Station 3 with the Assistant Director of Nursing (ADON), two opened refrigerated multi-dose vials (MDV) of Tuberculin PPD (test agent used in the diagnosis of tuberculosis) 5 TU (test unit) per 0.1 ml (milliliter; unit of measurement), did not have an open date. On December 9, 2024 at 3:27 p.m., during an interview with the ADON, the ADON stated the vials needed to be labeled with the opened date. The ADON said, The vials are good for 30 days when opened. The ADON stated it was important for opened vials to be dated to know when the vials would have expired. The ADON further stated if an expired medication was used then the resident might not have received the full effectiveness of the medication. 2c. On December 9, 2024 at 3:55 p.m., during an inspection of Medication Cart 9 in Nursing Station 4A with LVN 2, the following were identified: - One medication inhaler budesonide/formoterol (medication for lung disease) 80/4.5 mcg, was opened but did not have an open date; - One medication inhaler Spiriva Respimat (medication for lung disease), was opened but did not have an open date; and - One medication inhaler Trelegy Ellipta (medication for lung disease) 100/62.5/25 mcg, was opened but did not have an open date. On December 9, 2024 at 4:03 p.m., during an interview with LVN 2, LVN 2 confirmed the three inhalers listed above did not have an opened date. LVN 2 said the opened inhalers should have been labeled with an open date to know the expiration. LVN 2 stated the undated inhalers should have been replaced. On December 11, 2024 at 10:52 a.m., during an interview with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to have removed any discontinued or expired medications from the medication cart and to have discarded it in the medication room. The DON stated discontinued or expired medications should not have been stored together with active medications inside the medication cart. On December 11, 2024 at 10:57 a.m., during an interview with the DON, the DON stated the expectation was for nursing staff to have dated any opened medications, including oral medication inhalers. The DON stated open dates were important because oral inhalers had different expiration dates when opened based on manufacturer. The DON said she expected staff to follow manufacturer instructions and if an oral inhaler was not dated, they would not know when the medication expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2024 at 11:00 a.m., during an interview with the DON, the DON stated the expectation was for any opened or used medication vials to be labeled with the open date and to discard the used vial according to the manufacturer's instructions regarding expiration dates. The DON stated it was important to date the opened vial because if the vial was not dated, then nurses would not know when the vial expired. A review of the facility's policy and procedure titled, Administering Medications, dated April 2023, indicated, . The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container . A review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated, .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .Multi-dose vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial . 41459 3. On December 11, 2024, beginning at 9:30 a.m., an inspection of the Station 3 IV Cart 3 was conducted with the ADON. The following IV supplies were found expired, readily available for use: -Two IV Filter 1.2-micron extension sets (effectively traps particles, and larger fat droplets) were found with an expiration date of June 20, 2024; and - Eight IV Filter 1.2-micron extension sets were found with an expiration date of January 8, 2024. On December 11, 2024, at 9:54 a.m., in a concurrent interview, the ADON stated the expired items should have been removed from the cart, further, they should not be available for resident use. 40988 4. On December 11, 2024, beginning at 9:17 a.m., an inspection of the Station 4 Treatment Cart was conducted with the Treatment Nurse (TN). The following wound care supplies were found expired, readily available for use: - One [NAME] (brand name) Sharp Debridement Tray (kit contains instruments and components used to remove dead, infected, or damaged tissue from a wound) with an expiration of date August 30, 2024. In a concurrent interview, the TN stated this was part of a batch in a box that was still in the Central Supply. After verifying the item in the Central Supply, the TN confirmed the item was expired and should no longer be in the treatment cart; - Five pieces Covident Curity (brand name) 4 (inches) x 4 All Purpose Sponges (used to absorb blood and other fluids as well as clean wounds) with an expiration date of July 1, 2024. The TN confirmed the items were expired and should no longer be in the treatment cart; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 19 pieces Covident Dermacea (brand name) 4 x 4 IV drain sponges with lot number 19H192162. The TN stated same these were the same batch as the Covident Curity sponges and were also expired. The TN further stated these should be taken out of the treatment cart; - One Surgitube (tubular gauze bandage designed to protect and secure primary dressings) in its box with a (name of pharmacy) label identifying the item as house supply, bearing an expiration date of January 15, 2023. The TN stated it was expired based on the pharmacy label, and should not be in the treatment cart; - 16 pieces Silvercell (brand name) Non-Adherent 4.5 x 4.5 antimicrobial alginate dressings (derived from brown algae and are used to treat wounds by absorbing fluid and keeping the wound moist) stuffed in one box, with an expiration date of September 30, 2024; - One piece Gentell (brand name) 5 x 5 Super Absorbent Dressing (consists of a breathable and waterproof non-woven backing, a super absorbent pad layer and a silicone contact layer) with an expiration date of October 10, 2024; and - Five pieces Puracol Plus AG (brand name) Microscaffold Collagen Wound Dressing with Silver (wound dressing with antibacterial silver and a unique three-dimensional dressing material that promotes natural healing), with an expiration date of November 2021. In a concurrent interview, the TN stated the wound care items were expired and should not have been in the cart. The TN further stated the treatment nurses were responsible for checking the wound care items in the treatment cart, and the expectation was that expired treatment supplies should not have been in the cart and should have been discarded. On December 12, 2024, at 1:04 p.m., a concurrent interview was conducted with the DON, ADON, and Nurse Consultant (NC). The DON stated she expected the treatment nurses to check their carts and remove expired supplies from the cart. The DON stated nurses should also inspect for the integrity and expiration of IV kits in the IV cart. The DON further stated the expired supplies should have been removed from the cart. The ADON stated expired supplies should not be in the cart and should not have been in the cart. The NC stated the facility did not have a policy specific to storage of treatment supplies, because the treatment supplies were considered to be under the category of medications and biologicals, so similarly, if there were outdated treatment supplies, these should have been discarded or destroyed. They had highlighted the verbiage in the policy titled Medication Labeling and Storage which they submitted the day before pertaining to the matter. A review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated, .The facility will store all medications and biologicals in locked compartments .If the facility has discontinued, outdated or deteriorated medications or biologicals (this phrase highlighted in bright yellow), the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47374 Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation and storage practices were followed in the kitchen when: 1. Brown-black substance was observed in several areas where the walls and ceiling seams meet in the walk-in refrigerator; 2. Ice formed on the inside doors and seals of the six-door reach-in freezer; 3. Several open packages of food items were observed in the reach-in freezer; and 4. Air vents on the ceiling had brown dust coating. These failures had the potential to cause food-borne illnesses in a highly susceptible resident population. Findings: On December 9, 2024, at 9:10 a.m., an observation of the facility kitchen and concurrent interview with the Registered Dietician (RD) and Dietary Assistant (DA) was conducted. On December 9, 2024, at 9:24 a.m., an observation of the walk-in refrigerator was conducted with the RD. In the back two corners and the front right corner of the walk-in refrigerator, brown-black substance were observed along the seams where metal wall meets the metal ceiling. In a concurrent interview, the RD stated the substance was the color of dirt, the dirt substance should not be in the refrigerator, and could cause cross-contamination of the food causing illness to the residents. On December 9, 2024, at 9:45 a.m., an observation of the six-door reach-in freezer with three (3) doors at the top and three (3) doors at the bottom and a concurrent interview with the RD and the cook was conducted. The cook opened the upper-most right door of the freezer and there was about 1-1 1/2 inches of ice buildup inside by the freezer door. Ice was also observed along the side seals of the door. The cook opened the lower-most right door and a one inch of ice was observed between the seal of the door and the freezer partition. The cook stated the ice should not be there since it could cause damage to the food stored in the freezer. A box of unsealed hamburger patties was observed at the lower-most right compartment of the freezer. The cook removed the box and he stated there were some hamburger patties with freezer burn and all the hamburger patties should be thrown out. The cook further stated there was a chance the hamburger patties would not taste good and could cause illness in the residents. The RD agreed. In the same freezer, a half used box of frozen cookie dough was observed not stored in a sealed container. The cook was observed to remove the box of cookie dough and stated that the box of cookie dough should be thrown out as it was changing color, probably freezer burn. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 9, 2024, at 9:55 a.m., during a concurrent observation of the dry goods store room and interview with the RD, two air vents on the ceiling were observed to have brown and white particles on the vent blades. In a concurrent interview the RD, she stated she agreed the brown dust coating in both vents should not be there and, if the substance dropped onto the food products, this could cause infection or illness if eaten or inhaled by residents. On December 9. 2024, at 3:05 p.m., an observation of the kitchen with Dietary Manager (DM) was conducted. The Administrator (ADM) joined the inspection of the walk-in refrigerator. The DM and the ADM was asked to look at where metal walls meet metal ceiling, in the back two corners of the ceilings and the ceiling corner to the right of the entry door, and describe what he saw. The ADM stated the caulking was peeling off from the joints of the wall and the ceiling. The DM stated the brown substance should not be there as it could peel off and contaminate refrigerated food, possibly cause cross-contamination and illness for the residents. On December 9, 2024, at 3:15 p.m., a concurrent observation and interview with the DM of the six-door reach-in freezer. The DM opened the upper-most right and lower-most right doors and commented the ice should not be in the seals and on the inside metal as it could not allow freezer to maintain a steady temperature, allowing some melting and cross-contamination and resident illness. The facility's policy and procedure titled, Food Receiving and Storage, undated. The policy indicated, .Foods will be .stored in a manner that complies with safe food handling .All foods stored in .freezer will be covered . wrappers on frozen food must stay intact . A review of Federal and Drug Administration (FDA) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces, indicated, .The presence of .dirt on non-food contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage .other pests .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46393 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1a. The nursing staff failed to properly clean and disinfect shared blood pressure (BP- pressure of blood in blood vessels) cuff according to the disposable bleach wipe manufacturer's specified contact time (the time the resident equipment was to be in contact with the bleach disposable wipes to kill micro-organisms). In addition, the facility failed to properly clean and disinfect the shared stethoscope after use according to facility's policy, for Residents 282, 283 and 100; 1b. The nursing staff failed to properly clean and disinfect the resident's prefilled insulin (medication for diabetes) pen before use according to manufacturer's specifications. In addition, the facility failed to disinfect the shared glucometer (blood glucose meter to measure and display the amount of sugar [glucose] in your blood) after use according to the disposable bleach wipe manufacturer's specified contact time, for Resident 282; 2. The oxygen cannula tubing (a plastic device that delivers air through a tube) was observed hanging on top of the oxygen concentrator (medical device that produces filtered air); 3. Certified Nursing Assistant (CNA) did not perform hand hygiene, did not wear proper protective equipment (PPE- equipment use to protect against infection or illness), did not disinfect the blood pressure apparatus before and after providing care to Resident 383, who was on Enhance Barrier Precaution (EBP- an infection control intervention to reduce transmission of germs); 4. One vendor was observed not wearing appropriate PPE while handling Resident 184's low air loss mattress (type of specialty mattress that has small holes and inflatable air tubes to help prevent and treat pressure wounds), who was on EBP. In addition, the staff did not provide education to the vendor regarding the use of PPEs for EBP; 5. The IV (intravenous- into the vein) tubing for Resident 183 was unlabeled; and 6. One Wolf Pak (brand name) Premium Dressing Change Kit was observed in the 3rd drawer of Station 4's IV cart, opened and exposed to air. These failures increased the potential for the spread of infection to an already medically compromised resident population of 130 residents. Findings: 1a. On December 9, 2024, at 9:38 a.m., during a medication pass observation with Licensed Vocational Nurse (LVN) 7, LVN 7 was observed using a shared manual BP cuff and stethoscope to measure Resident 282's BP. LVN 7 was observed wiping the shared manual BP cuff with a bleach disposable wipe and did not disinfect the manual BP cuff according to the manufacturer specified contact time. Additionally, LVN 7 was observed wiping the shared stethoscope with an alcohol pad. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 9, 2024, at 10:27 a.m., during another medication pass observation with LVN 7, LVN 7 was observed using the same shared manual BP cuff and stethoscope as above to measure Resident 283's BP. LVN 7 was observed wiping the same manual BP cuff with a bleach disposable wipe and did not disinfect the manual BP cuff according to the manufacturer specified contact time. Additionally, LVN 7 was observed wiping the same shared stethoscope with an alcohol pad. On December 9, 2024 at 11:25 a.m., during an interview with the Infection Prevention (IP) nurse, the IP stated nursing staff were expected to clean and disinfect all shared resident care equipment after use with bleach disposable wipes in accordance with the manufacturer's contact time. Additionally, the IP stated alcohol pads should not have been used to disinfect any resident care equipment. The IP stated the bleach disposable wipe contact time was three (3) minutes and said nurses were expected to wipe and wait for 3 minutes. The IP read verbatim and out loud from the manufacturer's labeled instructions on the bleach disposable wipe bottle, Disinfection .To clean and disinfect and deodorize hard, nonporous surfaces: Wipe surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for the contact time listed on label . The IP stated nursing staff were not instructed to keep the shared resident care equipment wet to achieve the contact time according to the manufacturer's instructions. The IP acknowledged nursing staff should have been instructed to keep wet for three (3) minutes when they wiped shared resident care equipment. On December 10, 2024, at 8:38 a.m., during another medication pass observation with LVN 8, LVN 8 was observed using a shared manual BP cuff and stethoscope to measure Resident 100's BP. LVN 8 was observed wiping the shared manual BP cuff with a bleach disposable wipe and did not disinfect the manual BP cuff according to the manufacturer specified contact time. Additionally, LVN 8 was not observed to have wiped the shared stethoscope with a bleach disposable wipe after use. On December 10, 2024, at 9:10 a.m., during a follow-up concurrent interview and record review with the IP, the facility's In-Service Meeting Minutes, and Education Program Lesson Plan, dated November 26, 2024 were reviewed. The IP confirmed nursing staff training had not included instructions on how to achieve contact time by keeping the resident care equipment wet for the specified time according to the bleach disposable wipe manufacturer instructions. On December 10, 2024, at 3:08 p.m., during an interview with LVN 8, LVN 8 acknowledged she did not clean or disinfect the shared stethoscope with a bleach disposable wipe after she used it to measure Resident 100's BP. Additionally, LVN 8 acknowledged she did not keep the manual BP cuff wet during disinfection for a contact time of 3 minutes and stated, I did not know about that. 1b. On December 9, 2024, at 9:41 a.m., during a medication pass observation with LVN 7, LVN 7 was observed using a shared glucometer to measure Resident 282's concentration of blood glucose. LVN 7 was observed wiping the glucometer with a bleach disposable wipe and did not disinfect the glucometer according to the manufacturer specified contact time. During the same medication pass observation, LVN 7 was observed preparing eight medications for Resident 282. The medications included a prefilled insulin glargine (brand name: Lantus SoloStar pen, medication for diabetes) 100 units/milliliter (ml, unit of measurement) pen. LVN 7 removed the cap from the prefilled Lantus SoloStar pen and attached the new needle to the pen without wiping the rubber seal on the pen tip with alcohol first. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 9, 2024, at 10:17 a.m., LVN 7 was observed administering 10 units from the prefilled Lantus SoloStar pen as a subcutaneous (under the skin) injection in Resident 282's left upper arm in the rear/back. A review of Resident 282's medical record indicated a physician's order, dated December 2, 2024, for Lantus SoloStar Subcutaneous Solution Pen-Injector 100 units/ml (Insulin Glargine), inject 10 units subcutaneously one time a day. On December 9, 2024, at 3:05 p.m., during an interview with LVN 7, he confirmed he did not wipe the rubber seal on the prefilled Lantus SoloStar pen tip with alcohol before he attached the needle and stated, I thought (wiping rubber seal) was just for vials. On December 10, 2024, at 9:25 a.m., during a follow-up concurrent interview and record review with the IP, the prefilled Lantus SoloStar pen manufacturer's instructions were reviewed. The IP read out loud and verbatim from the manufacturer's instructions, Wipe the pen tip (rubber seal) with an alcohol swab. The IP acknowledged nursing staff should have wiped the Lantus SoloStar pen tip with an alcohol swab before attaching the needle. On December 11, 2024, at 11:02 a.m., during an interview with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to have followed the bleach wipe manufacturer's instructions regarding contact time. The DON stated nursing staff needed to let the device stay wet to achieve the proper kill of microorganisms. Additionally, the DON stated the expectation was for nurses to have used bleach wipes to disinfect all resident care devices/equipment. The DON said, alcohol pads were Only used for skin. When asked if the rubber seal on the Lantus insulin pen was the same as rubber seal of a medication vial, the DON said, Yes same concept. Should be cleaned before use. The DON stated the facility policy's did not mention cleaning rubber seal on medication vials or insulin pens and acknowledged it should have been mentioned. When asked regarding the importance of proper infection control, the DON stated infection control was important for prevention of spreading infections. The DON further added, cleaning the rubber seal of vials or insulin pens before use was important for prevention of contamination. A review of the facility's policy and procedure titled, Subcutaneous Injections, dated March 2011, indicated, . Follow the medication administration guidelines in the policy entitled Administering Medications . A review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2022, indicated, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the current CDC (Centers for Disease Control and Prevention- a nationally recognized disease control and prevention organization) recommendations for disinfection .Non-critical items are those that come in contact with intact skin but not mucous membrane .Reusable items are cleaned and disinfected or sterilized between residents. (e.g., stethoscopes, durable medical equipment) .Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions . A review of the facility's policy and procedure titled, Administering Medications, dated April 2023, indicated, . Staff follows established facility infection control procedures (e.g., .antiseptic technique .) for the administration of medications, as applicable . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the CDC article titled, Disinfection and Sterilization Guideline for Disinfection and Sterilization in Healthcare Facilities, updated May 2019, .non-critical patient-care devices are disinfected when visibly soiled and on a regular basis .such as after use on each patient . 50204 2. On December 9, 2024, at 3:14 p.m., during a concurrent observation and interview with Resident 386 in her room, the oxygen nasal cannula was observed unbagged and was hanging on top of the oxygen concentrator. In a concurrent interview, Resident 386 stated she told the nurse that she would use the oxygen cannula later. Resident 386 further stated The nurse hangs it on top of the machine. On December 11, 2024, Resident 386's medical record was reviewed. Resident 386 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (lung disease). A review of Resident 386's History and Physical, dated November 29, 2024, indicated Resident 386 was mentally capable of understanding. A review of Resident 386's Order Summary, dated November 28, 2024, indicated oxygen at two liters (unit of measurement) per minute via nasal cannula as needed. On December 9, 2024, at 3:17 p.m., during a concurrent observation and interview with LVN 9, LVN 9 stated the oxygen nasal cannula should be placed in a labeled bag and should not be left hanging on top of the oxygen concentrator. LVN 9 further stated if the oxygen nasal cannula was not bagged, it could lead to bacterial (germ) growth, and the resident could inhale the bacteria and cause respiratory illness. On December 11, 2024, at 10:48 a.m., the IP was interviewed. The IP stated staff should place the tubing in a bag and label it with the date and time. The IP further stated if the oxygen tubing was not placed in the proper storage bag, it could contaminate the tubing and lead to infections. On December 11, 2024, at 3:36 p.m., the DON was interviewed. The DON stated she expected the staff members to follow the facility's infection control policy. The DON further stated the oxygen nasal cannula should have been placed in a bag if not in used, to prevent infection. A review of the facility's policy and procedure titled, Departmental (Respiratory Therapy)- Preventions of Infection, dated November 2011, indicated, .The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff . Keep the oxygen cannulae and tubing used PRN (as needed) in a plastic bag when not in use . 3. On December 9, 2024, at 3:48 p.m., Resident 383's room was observed to have a sign by the door indicating instructions to wear appropriate PPE (gown and gloves) before entering the room. CNA 3 was observed entering Resident 383's room and providing care to the resident. In a concurrent interview with CNA 3, CNA 3 stated she did not wash her hands before and after providing care to Resident 383. In addition, she stated she forgot to wear a gown when she was helping Resident 383 to the bathroom, and when she was taking the resident's vital signs. CNA 3 further stated she did not disinfect the blood pressure apparatus before and after she used it on Resident 383. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA 3 stated she should have worn PPE when she provided care to Resident 383, adding I should have washed my hands before and after care to resident. CNA 3 further stated she should have disinfected the blood pressure machine to prevent the spread of germs and protect the residents from infection. On December 12, 2024, Resident 383's medical record was reviewed. Resident 383 was admitted to the facility on [DATE], with diagnoses which included obstructive uropathy (urinary blockage). A review of Resident 383's History and Physical, dated November 19, 2024, indicated Resident 383 was mentally capable of understanding. A review of Resident 383's Order Summary, dated November 28, 2024, indicated, .Resident requires Enhanced Barrier Precautions (EBP) related to indwelling urinary catheter . A review of Resident 383's Care Plan, dated November 28, 2024, indicated, .Resident requires Enhanced Barrier Precaution (EBP) related to indwelling urinary catheter .Use gown and gloves during high contact resident care activities (hygiene, toileting, device care) .Perform hand hygiene upon room entry and exit . On December 11, 2024, at 10:50 a.m., the IP was interviewed. The IP stated CNA 3 should have practiced hand hygiene, proper wearing of PPE, and should have disinfected medical equipment before and after providing care to the resident. The IP further stated if staff did not follow infection control policies and practices, this could cause cross contamination and spread of infection. On December 11, 2024, at 3:20 p.m., an interview was conducted with the DON. The DON stated she expected all staff, nursing and non-nursing, to follow the standard of practice for infection control. The DON further stated if not followed, staff could transmit and spread infection to other staff and residents. A review of the facility's policy and procedure titled, Personal Protective Equipment- Using Gowns, dated September 2010, indicated, .To guide the use of gowns .To prevent the spread of infections .To prevent splashing or spilling blood or body fluids onto clothing or exposed skin .When use of a gown is indicated, all personnel must put on the gown before treating or touching the resident . A review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2022, indicated, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection .Reusable items are cleaned and disinfected or sterilized between residents .Reusable resident care equipment is decontaminated and/or sterilized between residents . A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated October 2023, indicated, .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors .Hand hygiene indicated .immediately before touching a resident .after touching resident .after touching the resident's environment . (continued on next page)

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	555747	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated April 2024, indicated, .Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms(MDROs) to residents .high-contact resident care activities requiring the use of gown and gloves for EBPs include .assisting with toileting .device care or use .EBPs are indicated .for residents with wounds and or indwelling medical devices .EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk . 40988 4. On December 10, 2024, at 2:08 p.m., Resident 184 was observed awake, lying in bed, with an indwelling Foley catheter draining by gravity to a drainage bag covered with a dignity bag, hooked to the side of the bed towards the door. Posted beside the doorframe above the room number and residents' names was a poster indicating the use of EBP. On December, 10, 2024 beginning at 2:14 p.m., two staff were observed putting on gowns, gloves and surgical masks (PPEs) and bringing in a Hoyer lift (a mobility device that uses a sling to hold a person, then lifts and transfers them) into the resident's room. The staff proceeded to use the lift to suspend Resident 184 off and above the bed, then removed Resident 183's regular mattress off the bed, placing it outside the room in a vacant hallway. There was a non-facility representative/visitor waiting outside Resident 184's room. The staff was observed to call out to the representative, stating, We're ready for you. The visitor entered Resident 184's room without wearing any PPEs, proceeded to Resident 184's bed and began to set up the low air loss mattress, picked up the plastic packaging that was on the floor, exited the room, walked towards the hallway leading to the lobby, stopped by the hopper in the middle of the hallway, threw the plastic packaging in one of the hopper compartments, and proceeded to walk through the hallway towards the lobby. The visitor did not perform any handwashing or use of ABHR (alcohol based hand rub) throughout the process. The Registered Nurse (RN), who was in the hallway with the Surveyor while this transpired, stated the visitor must have been from one of the facility's vendors. When asked if there was a break in infection control, the RN said, Yes. The RN further stated, there was a recent in-service regarding infection control, so staff were expected to use PPEs for Resident 184 since he had a Foley catheter, visitors were also expected to use PPEs, and educating visitors regarding the use of PPEs was part of the staff's responsibility in implementing infection control practices. On December 11, 2024, Resident 184's record was reviewed. Resident 184 was admitted to the facility on [DATE], with diagnoses which included benign prostatic hyperplasia (enlarged prostate). A review of Resident 184's physician's order included an order for a Foley catheter to bedside drainage, as well as low air loss mattress for pressure injury prevention. A review of Resident 184's care plan titled, Resident requires Enhanced Barrier Precautions (EBP) related to indwelling urinary catheter, included the interventions, Use gown and gloves during high contact resident care activities(.device care) .Perform hand hygiene upon room entry and exit . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 12, 2024, at 1:04 p.m., a concurrent interview was conducted with the DON, Assistant Director of Nursing (ADON), and Nurse Consultant (NC). The DON stated facility staff should have provided instructions to the vendor regarding the use of PPE prior to entering the room with EBP in place. A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated April 2024, indicated, .Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status .Residents, families and visitors are notified of the implementation of EBPs . 5. On December 10, 2024, at 2:11 p.m., Resident 183 was observed in bed, awake, able to verbalize needs. Hanging on an IV pole beside the bed was an empty 100 ml (milliliter- a unit of measurement) bag of Cefazolin (an IV antibiotic) with the IV tubing attached. The IV tubing was unlabeled. On December 10, 2024, at 2:14 p.m., Resident 183 was observed with LVN 7 inside the room. LVN 7 confirmed the IV tubing was unlabeled. LVN 7 stated IV tubings were changed every 24 hours per facility protocol, but was unable to say when the tubing was last changed since there was no label. LVN 7 further stated the IV tubing should have been labeled. On December 10, 2024, at 2:26 p.m., Resident 183 was observed with the RN inside the room. The RN confirmed Resident 183's IV tubing was unlabeled. The RN stated there should have been a green label bearing the staff initials, stat date, start time, end date, and end time so the nurses would know when to change the IV tubing. On December 11, 2024 , Resident 183's record was reviewed. Resident 183 was admitted to the facility on [DATE], with diagnoses which included arthritis (painful inflammation and stiffness of the joints) due to other bacteria left knee. A review of Resident 183's physician's orders included an order for cefazolin sodium, use two grams intravenously every eight hours for left knee septic (when the body's response to an infection causes organ dysfunction) arthritis. On December 12, 2024, at 1:04 p.m., a concurrent interview was conducted with the DON, ADON, and NC. The DON stated she expected IV tubings to be labeled properly, and the IV tubing for Resident 183 should have been labeled. The ADON stated Resident 183's IV tubing should have been labeled with the date, time, and initialed by the RN. A review of the facility's policy & procedure titled, Administration Set/Tubing Changes, dated February 2023, indicated, .The purpose of this procedure is to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV therapy equipment .Label tubing with date, time, and initials. If facility requires, label may include the date and time that the tubing was initiated and when tubing should be discontinued or changed .Any tubing that is found not labeled must be changed and then labeled accordingly .Primary .administration sets .Change every 24 hours, or if suspected contamination of tubing .has occurred . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41459 6. On December 11, 2024, at 10:00 a.m., an inspection of the Nurses station 4 IV cart was conducted with the ADON. The following IV supplies were found, readily available for use: - One Wolf Pak Premium Dressing Change Kit (a sterile [free from bacteria or living microorganisms/germs] dressing change kit for IV dressings), opened, with contents exposed to air. On December 11, 2024, at 10:07 a.m., in a concurrent interview with the ADON, the ADON stated the opened IV dressing change kit should not be in the drawer, readily available for resident use. On December 12, 2024, at 1:04 p.m., a concurrent interview was conducted with the DON, ADON, and NC. The DON stated nurses should also inspect the integrity of the IV kits in the IV cart, in addition to the expiration dates. The DON further stated non-intact supplies should have been removed from the cart. A review of the facility's policy and procedure titled, Dressings, Sterile, revised September 2013, indicated, . Using sterile technique .open sterile dressing , touching only exterior surface . A review of the facility's policy and procedure titled, Peripheral and Midline IV Dressing Changes, revised 2022, indicated, .Maintain sterile dressing .change the dressing immediately if the dressing is compromised . Visually inspect the entire infusion system .

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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** 50204 Based on interview and record review, the facility failed to follow the facility's policy and procedure on antibiotic stewardship (a set of coordinated efforts aimed at promoting the appropriate use of antibiotics to optimize patient outcomes while minimizing the risk of antibiotic resistance and adverse effects), for one of five sampled residents reviewed (Resident 390) when there was a delay in obtaining the urinalysis specimen and was not evaluated for antibiotic time out (a healthcare practice where a review of antibiotic therapy occurs within a predetermined time frame after the initial prescription) within 72 hours. These deficient practices had the potential to result in the development of antibiotic-resistant organisms (organisms not affected by antibiotics). Findings: On December 11, 2024, Resident 390's record was reviewed. Resident 390 was admitted to the facility on [DATE], with diagnoses which included dysuria (difficulty in urination). A review of Resident 390's Progress Notes, dated December 3, 2024, at 12:59 p.m., .wbc 14.19 DX (diagnosis) leukocytosis (elevated white blood cells) . start antibiotic Keflex for 10 days and to repeat urinalysis with culture and sensitivity, may perform straight cathetherization and lab specimen was contaminated . A review of the facility document titled, Infection Surveillance Monthly Report, for the month of December 2024, indicated Resident 390 was prescribed for Keflex .elevated WBC (white blood count). Awaiting UA C/S . (urine cuture and sensitivity) . A review of Resident 390's Order Summary Report, included a physician's order which indicated: - December 3, 2024, at 4:36 p.m., .Urinalysis SENT Uncollected 12/3/2024 . - December 3, 2024, at 9:02 p.m., .Keflex Oral Capsule 500 MG (Cephalexin) (brand of antibiotic) Give 1 capsule by mouth every 8 hours for Leukocytosis for 10 days . - December 5, 2024, at 3:38 p.m., .Urinalysis SENT Uncollected 12/5/2024 . Further record review indicated, the urine specimen was not collected until December 8, 2024 (five days after onset of antibiotic use) There was no documented evidence of other symptoms of infection related to leukocytosis. A review of Resident 390's urinalysis result, dated December 8, 2024, indicated no presence of bacteria, and no growth of organism. A review of Resident 390's Progress Notes, dated December 9, 2024, at 12:16 a.m., .Urinalysis report collected 12/8/2024 (December 8, 2024) received and placed on MD folder as no critical findings . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 390's Medication Administration Record (MAR), for December 2024, indicated, Keflex was administered on December 3, 2024 until December 11, 2024 (date of survey). On December 11, 2024, at 10:33 a.m., a concurrent interview and record review was conducted with the Infection Preventionist (IP). The IP stated she would check the dashboard to check which resident was ordered for antibiotic and would assess if resident meets the McGeers criteria (a set of specific definitions to identify true infections in long term nursing facilities). The IP stated if the criteria of an infection were not met, she would notify the physician. The IP stated the facility implemented a 3-day antibiotic time out where the resident was monitored for side effects while the resident continued to get the antibiotic. The IP stated Resident 390's used of Keflex should have been reevaluated and the physician should have been notified when there was no C/S performed for the resident's urinalysis. The IP further stated she should have initiated the antibiotic timeout and followed up regarding specimen collection. The IP stated resident could develop antibiotic resistance if not appropriately used for a certain microorganism. On December 11, 2024, at 3:40 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated she expected all licensed nurses to use the antibiotic stewardship using Mcgeers criteria for Long Term Care to determine the appropriate use of antibiotics. The DON further stated the IP should have been performed the antibiotic time out and notified the physician about the specimen delay in collecting the resident's urine specimen. The DON stated residents could develop antibiotic resistance due to misuse of antibiotic. A review of the facility's policy and procedure titled, Specimen Collection, dated April 2007, indicated, .Our facility will collect specimens in accordance with established nursing service procedures .All specimens . ordered for testing shall obtained in accordance with established nursing service procedures . A review of the facility's policy and procedure titled, Antibiotic Stewardship-Orders for Antibiotics, dated December 2016, indicated, .Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program and in conjunction with the facility's general policy for medication utilization and prescribing .Appropriate indications for use of antibiotics include: pathogen susceptibility, based on culture and sensitivity .when antibiotics are prescribed .the primary care practitioner will assess the resident within 72 hours .when a culture and sensitivity (C&S) is ordered, it will be completed, and lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued . According to McGeer's Criteria for Long Term Care Surveillance Definitions for Infections, updated 2012, indicated, .Urinary Tract Infections (UTI's) .New Criteria for UTI without a Catheter: (Both criteria 1 and 2 must be present) .Criteria 1 .At least one of the following signs or symptoms criteria: a. Acute dysuria or acute pain .Criteria 2 .a. At least 10 x5 cfu/ml (colony-forming units per milliliter) of no more than 2 species of microorganisms in a voided urine sample .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (vaccines against the bacterium Streptococcus pneumoniae [bacteria that can cause pneumonia]) was offered, for one of five residents reviewed for immunizations (Resident 31) . This failure had the potential for Resident 31 not fully be protected against pneumonia (infection of lungs). Findings: On December 11, 2024, Resident 31's medical records were reviewed. Resident 31 was admitted to the facility on [DATE], with diagnoses which included muscle weakness and Alzheimer's disease with late onset (memory loss). On December 11, 2024, at 10:30 a.m., during a concurrent interview and record review of Resident 31's immunization record, with the Infection Preventionist (IP), the IP stated Resident 31 received one dose of pneumococcal (PCV13- prevnar13) vaccine on June 15, 2015. The IP stated residents who received one dose of Pneumococcal (PCV13) should be offered a dose of pneumococcal (PCV20) after one year. The IP stated the facility follows current CDC (Centers for Disease Control and Prevention - responsible for protecting public health and safety) guidelines. The IP stated there was no documentation that Resident 31 was offered the dose of the pneumococcal vaccine after one year after the initial dose. The IP further stated Resident 31 should have been offered and administered vaccine to protect against pneumonia. On December 11, 2024, at 3:50 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated she expected all licensed nurses to follow the facility's policy and procedure guidelines for pneumococcal immunization. The DON further stated the IP should have been offered and administered pneumococcal vaccine to protect the resident against pneumonia. A review of the facility's policy and procedure titled, Vaccination of Residents, dated October 2019, indicated, .All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated .All new residents shall be assessed for current vaccination status upon admission . A review of the facility's policy and procedure titled, Pneumococcal Vaccine, dated October 2023, indicated, . All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections . Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission .Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission .