STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555763	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Juan Hills Healthcare Center	31741 Rancho Viejo Road San Juan Capistrano, CA 92675

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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 - Potential for minimal harm Residents Affected - Some	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** 35346 Based on observation, medical record review, and interview, the facility failed to provide an equal access to nutritional services for one nonsampled resident (Resident 25). This failure posed the risk of the resident's rights not being honored. Findings: On 11/12/24, medical record review for Resident 25 was initiated. Resident 25 was admitted on [DATE]. Resident 25's admitting diagnoses included dementia and chronic kidney disease. During a lunch meal observation on 11/12/24 at 1215 hours, Resident 25 was observed asking multiple staff on multiple times about getting her lunch meal tray. All residents in the dining room were observed being served their meals at 1215 hours. Resident 25 was observed waiting 40 minutes for her lunch meal tray to be delivered and served while other residents were observed already eating their meals. Review of a posted sign for meal times showed the lunch was to be served to all residents at 1215 hours. Review of the facility's PCC list of diets for the residents failed to show Resident 25's name on the list. On 11/12/24 at 1240 hours, during an interview, when asked about Resident 25's lunch meal tray, the staff including the DON were unable to explain.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, and medical record review, the facility failed to ensure the self-administration of medications was safe for one of 14 final sampled resident (Resident 132) and one nonsampled resident (Resident 14). This failure had the potential to negatively impact the residents' physiological well-being and administer the medications inaccurately. Findings: 1. During an initial tour of the facility on 11/12/24 at 0814 hours, a concurrent observation and interview with Resident 132. Resident 132 was observed lying in bed. Resident 132 was noted with one bottle of Biotin (supplement) 10,000 mcg, one bottle of coconut oil extra virgin oil 1000 mg, one bottle of hair growth medication on the TV (television) stand drawer. Resident 132 stated she had been taking the medications since she was admitted in the facility. On 11/12/24 at 0823 hours, an observation and concurrent interview with the MDS Coordinator was conducted. The MDS Coordinator was asked about the process of self-administering medication and leaving medication at bedside. The MDS Coordinator stated no medication should be left at the resident's TV stand drawer, and the facility needed to assess the resident if it was safe to self-administer medication, have an order from the MD and care plan. The MDS Coordinator confirmed and verified Resident 132 had one bottle of Biotin 10,000 mcg, one bottle of coconut oil extra virgin oil 1000 mg, and one bottle of hair growth medication at the TV stand drawer. Medical Record Review for Resident 132 was initiated on 11/12/24. Resident 132 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 132's H&P examination dated 10/30/24, showed the resident had a fluctuating capacity to understand and make decisions. Review of Residents 132's MDS dated [DATE], showed a BIMS score of 9 (meaning moderately cognitive impaired). Further review of the medical record showed no documented evidence Resident 132 was assessed for self-administration of medications. There were no physician's orders for the about medication found at the resident's bedside. On 11/12/24 at 0842 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 was no able to show documented evidence Resident 132 was assessed for self-administration of the medication. On 11/13/24 at 1334 hours, a concurrent interview and medical record review with the MDS Coordinator. The MDS coordinator verified Resident 132's Order Summary Report did not show the orders for the above medication. On 11/15/24 at 1801 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44175 2. On 11/12/24 at 1046 hours, a concurrent observation and interview was conducted with Resident 14. Resident 14 was observed in the wheelchair. An eye drops medication was observed on top of the bed inside a plastic bag. Resident 14 stated she had been using the eye drops medication for about six weeks and kept it at the bedside. Medical record review for Resident 14 was initiated on 11/12/24. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's Admission assessment dated [DATE], showed Resident 14 did not request for self-administration of the medication. Review of Resident 14's physician's order dated 10/9/24, showed to instill artificial tears ophthalmic medication solution (Artificial Tears Solution) one drop on both eyes as needed and twice a day as needed. However, further review of the medical record failed to show documented evidence of the physician's order for Resident 14 to self-administer eye drop medication. On 11/12/24 at 1048 hours, a concurrent observation, interview, and medical record review for Resident 14 was conducted with LVN 3. LVN 3 verified the eye drop medication was observed at Resident 14's bedside and stated the medication should not have been kept at the bedside. LVN 3 reviewed Resident 14's medical record and verified there were no assessment and physician's order for self-administration of medication. On 11/14/24 at 1011 hours, an interview was conducted with the DON. The DON was informed and verified the findings.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 29461 Based on interview, facility document review, and facility P&P review, the facility failed to address the concerns brought forth in the resident council meetings (a group of residents gathered to discuss interest and issues noted in the facility) and failed to notify two nonsampled residents (Residents 12 and 137) who filed the grievances regarding the outcomes of investigation. These failures had the potential for the residents' identified issues to go uncorrected. Findings: Review of the facility's P&P titled Resident Council revised 4/2017 showed a Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. Review of the facility's Resident Council Departmental Feedback Form showed the Department to return the response to the Activity Director within two to three days of the meeting date. a. Review of the facility's document titled Resident Council Meeting Agenda & Notes dated 8/9/24, showed the following concerns: - The staff were loud in the hallways after hours, and to use English only in the vicinity or in front of the residents. - Resident 137 would like more light next to couch on the left side of the room. - Resident 137 would like an explanation on a bill she received she thought insurance should pay. Review of the Resident Council Minutes-Review of Old Business dated 9/13/24, showed from the Nursing Department: the residents were satisfied with nurses conversing in English; the concern was resolved. However, there was no documentation on how the concern was resolved. In addition, there was no documentation Resident 137's concerns were followed through. There was no Resident Council Departmental Feedback form filled out by the facility. b. Review of the facility's document titled Resident Council Meeting Agenda & Notes dated 9/13/24, showed the following concerns: - Resident 12 was not getting what she was requesting on meals. Most of the time, it was hot, and needed more assistance with menus. - Slow on call buttons usually at night. Further review of the documents failed to show documentation the concerns were followed through. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 1441 hours, an interview and concurrent facility document review was conducted with the Activity Director. When asked regarding the facility's process with concerns identified during the Resident Council Meeting, the Activity Director stated the Administrator was notified immediately after the concerns were identified and the concerns were also discussed in the stand-up meeting with the Department Heads to take care of the concerns. The Activity Director further stated she was responsible to make sure all concerns were addressed. The Activity Director verified there was no follow-through on the concerns brought forth in the resident council meetings. On 11/13/24 at 1530 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified the concerns identified on 8/9 and 9/13/24, from the resident council meetings. The DON also verified there was no documentation on how the concerns were investigated and resolution, and no documentation the residents were notified of the outcome of the investigation. The DON further stated all concerns needed to be investigated within 72 hours from when the facility was notified of the concerns.

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 29461 Based on interview and facility document review, the facility failed to ensure two final sampled residents (Residents 132 and 285) and four nonsampled residents (Residents 2, 26, 135, and 436) who attended the resident council meeting were informed of their rights and given information on how to formally complain to the State Agency about the care they received. This failure posed the risk of the residents and/or their legal representatives to not receive the necessary services. Findings: On 11/13/24 at 1016 hours, a resident council meeting was conducted with six residents, Residents 2, 26, 132, 135, 285, and 436. They stated they did not know the contact information for the State Licensing and Certification Office and were not provided with the information on how to formally complain to the State Agency about the care they received. The residents stated if they wanted to file a grievance or complaint, they just talked to the nurses. On 11/13/24 at 1441 hours, an interview was conducted with the Activity Director. The Activity Director verified she had not provided the residents on how to contact the State Agency. On 11/13/24 at 1545 hours, an interview was conducted with the Admissions Director. The Admissions Director showed a listed of Health Care Agencies and Resources which included the State Agency's contact information posted in the facility's consumer board; however, the Admissions Director verified the information on how to contact the State Agency was not part of the admission packet and stated she also verified with the SSD the information on how to formally file a complaint to the State Agency was not mentioned to the residents. The Admissions Director further stated if a resident asked, they would provide the contact information then. The Admissions Director provided a copy of the list of documents included in the admissions packet. The information on how to formally complain to the State about the care received in the facility was not included on the list.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 16) who had a mental disorder was referred to state PASARR representative for Level II evaluation and determination screening process. This failure pose risk for the resident not to receive adequate level of services, comprehensive assessment, intervention, and evaluation for conditions related to mental disorder. Findings: Review of the facility's P&P titled Preadmission Screening & Resident Review (PASRR) dated 11/30/23, showed the facility will confirm the PASARR process was completed by the hospital by accepting and reviewing the PASRR documentation submitted. If the facility determines that the hospital did not initiate the PASARR, the facility will contact the hospital and request to initiate the file exchange prior to discharge. Medical record review for Resident 16 was initiated on 11/12/24. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's PASARR Level 1 Screening Form dated 5/9/24, showed Resident 16 did not have mental disorder or intellectual disability diagnosis and had no prescribed psychotropic medications for mental illness. However, review of Resident 16's Admission Record dated 11/13/24, showed Resident 16 had diagnosis of major depressive disorder, psychosis, and anxiety. In addition, the Order Summary Report dated 11/14/24, showed Resident 16 had the physician's orders to administer sertraline (antidepressant medication) 100 mg via PEG tube at bedtime for depression. On 11/13/24 at 1043 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator verified there was an error in completing the PASARR assessment. The MDS Coordinator further stated if the PASARR Level 1 was not accurately completed, the facility must do screening again and refer accordingly. The MDS Coordinator verified Resident 16 had a diagnosis of depression and had been receiving antidepressant medication. The MDS Coordinator Resident 16's PASARR Level 1 was not completed accurately. On 11/14/24 at 1007 hours, an interview for Resident 16 was conducted with the DON. The DON was informed of the findings and verified the findings.

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F 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29461 Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure one of 14 final sampled residents (Resident 132) attained and maintained their highest practicable physical well-being. * The facility failed to ensure Resident 132's physician's order to discontinue the use of sling for the right shoulder was carried out. This failure created the risk of not providing appropriate and consistent care to the resident. Findings: Medical record review for Resident 132 was initiated on 11/12/24. Resident 132 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 132's Internal Medicine H&P/Progress Notes dated 10/30/24, showed the resident had fluctuating capacity. Review of Resident 132's medical record showed a physician's order dated 10/29/24, may use sling on the RUE. On 11/12/24 at 0814 hours, during the initial tour of the facility, Resident 132 was observed wearing a sling on her right arm. On 11/15/24 at 1547 hours, an interview and concurrent medical record review for Resident 132 was conducted with the DON. Resident 132's medical record showed on 11/12/24, an order was written by the physician to discontinue the sling on the right shoulder. The order was noted on 11/12/24, untimed, and without signature from the licensed staff who noted the order. The DON verified the written physician's order did not include the time and the signature of the licensed nurse who noted the order. On 11/15/24 at 1553 hours, an interview and medical record review for Resident 132 was conducted with the DSD. The DSD verified the order dated 11/12/24, to discontinue the sling on the RUE was not carried out and should have been carried out.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility's P&P review, and facility document review, the facility failed to provide the safe environment free from potentially serious accident hazards for two of two final sampled residents (Residents 383 and 432) who smoked in the facility. - Resident 383 was not accurately and thoroughly assessed to determine if they required supervision or any adaptive equipment while smoking, nor if they could safely store their own cigarettes or lighters. - Resident 432's smoking paraphernalia was left unsupervised. The residents who were assessed as requiring supervision or those with a history of non-compliance with the facility's smoking P&P were permitted to keep the cigarettes, lighters, and other smoking materials in their possession. - The facility failed to ensure the designated area for smoking outside the facility have readily available and accessible portable fire extinguishers and fire-retardant smoking aprons as per the facility's smoking P&P. These failures posed the risk of fire and serious injuries to the residents who smoked and to the other residents who resided in the facility. Findings: Review of the facility's P&P titled Safe Smoking - Resident dated 8/24/22, showed the facility shall establish and maintain safe resident smoking practices. The residents will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include their ability to smoke safely with or without supervision. The staff shall consult with the attending physician and the DON to determine if safety restrictions need to be placed on a resident's smoking privileges. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Only residents who have independent smoking privileges are permitted to keep cigarettes and other smoking articles in their possession. Residents without independent smoking privileges may not have or keep any smoking articles. Residents are allowed to smoke outside the facility in designated area with safety measures readily available and accessible such as ashtrays, portable fire extinguishers and fire-retardant smoking aprons. 1.a. On 11/12/24 at 0932 hours, during the initial tour of the facility, an observation and concurrent interview with Resident 383 was conducted. Resident 383 was in bed and the smoking materials (green disposable lighter and a pack of cigarettes) were observed on top of the bedside drawer. Resident 383 verified he smoked and the smoking materials on top of the bedside drawer were his. Resident 383 added the facility staff were not aware that he smoked, and he kept his smoking secret and hid well. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 1013 hours, an interview and concurrent facility's document review was conducted with the Administrator and DON. The Administrator submitted the list of the residents who currently smoked. Review of the smoking list and showed Resident 383 was not on the list. The DON verified Resident 383 was not included in the smoking list and was not aware if Resident 383 was a smoker. The DON was asked to go to Resident 383's room and the DON verified the smoking materials on top of the bedside drawer. The DON stated she would talk to Resident 383 about the smoking paraphernalia. Medical record review for Resident 383 was initiated on 11/13/24. Resident 383 was admitted to the facility on [DATE], with the diagnosis of tobacco use per admission record. Review of Resident 383's MDS dated [DATE], showed under section J, current tobacco use was coded as no. Review of the Admission/Readmission Screen and Baseline Care Plan dated 10/25/24, showed Resident 383 did not wish to smoke. Further review of Resident 383's medical record failed to show documented evidence a smoking assessment was conducted; a physician's order was obtained, and a plan of care was developed for smoking were documented. On 11/13/24 at 1005 hours, an interview for Resident 383 was conducted with LVN 1. LVN 1 verified he was not aware and had not seen Resident 383 smoking. LVN 1 stated Resident 383 did not inform the facility staff about his smoking. On 11/14/24 at 1451 hours, an interview for Resident 383 was conducted with the DON. The DON was informed of the findings and verified the above findings. 35346 2.a. On 11/12/24 at 1030 hours, Resident 432's lighter and pack of cigarettes were observed on Resident 432's overbed table. Resident 432 was not in her room. On 11/13/24 0819 hours, an interview was conducted with Resident 432. When asked about her smoking habits, Resident 432 verbalized she would go to the facility's patio to smoke at 2200 hours. Resident 432 stated sometimes she would smoke without staff present. On 11/13/24, 1538 hours, a telephone interview was conducted with LVN 5. When asked about Resident 432's smoking paraphernalia, LVN 5 verbalized he did not provide Resident 432 her smoking paraphernalia. LVN 5 stated Resident 432 was an independent smoker who would go out and smoke alone in the facility's front patio area. On 11/12/24, medical record review was initiated for Resident 432. Resident 432 was admitted to the facility on [DATE]. Review of Resident 432's H&P examination dated 10/30/24, showed with diagnoses including anxiety, insomnia, with tobacco use. The H&P examination also showed Resident 432 had capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 432's care plans addressing the resident's smoking showed interventions including Resident 432 was to be observed for unsafe smoking practices. b. On 11/13/24 at 1105 hours, an observation and concurrent interview was conducted with the Activity Director. The Activity Director was observed with Resident 432 in the smoking patio area. Resident 432 was on a wheelchair and observed lighting up her cigarette with a disposable lighter. The Activity Director was observed sitting near the resident. The Activity Director was asked about the smoking protector devices such as the smoking apron and fire extinguisher were available and accessible in the smoking area. The Activity Director verified there was no available smoking apron and did not know where the fire extinguisher was located at. On 11/14/24 at 0830 hours, the above findings were verified with the DON.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of 14 final sampled residents (Resident 285) and one nonsampled resident (Resident 436) to maintain or restore their bladder functions. * The facility failed to provide a bladder retraining for Resident 285 as identified in the care plan and facility's P&P. * The facility failed to ensure Resident 436 was placed on toileting program and a care plan to address Resident 436's toileting needs was developed. These failures posed the risk for these residents to lose their bladder control. Findings: Review of the facility's P&P titled Bowel and Bladder Program dated 6/2021 showed on admission of the resident, the admission nurse will initiate an elimination schedule every two hours regardless if the resident is continent or incontinent. The Admission Nurse will communicate to the CNAs and licensed nurse. The CNAs will document the result of their visit with the resident. 1. On 11/12/24 at 1120 hours, an interview was conducted with Resident 285. Resident 285 stated he liked to go to the bathroom and the facility staff helped him to use the bathroom during daytime; however, they let him wore a disposable brief at night. Resident 285 stated he did not feel good about not going to the bathroom and using a disposable brief. Resident 285 informed the facility staff that he would like to go to the restroom, but the staff told him that he could not go the restroom and was high risk for fall, and was instructed to urinate in the disposable brief. Medical record review for Resident 285 was initiated on 11/12/24. Resident 285 was admitted to the facility on [DATE]. Review of Resident 285's MDS dated [DATE], showed Resident 285 was cognitively intact. Review of Resident 285's Order Summary Report dated 11/13/24, showed a physician's order dated 11/7/24, for bladder retraining program every shift for 14 days. Review of Resident 285's plan of care showed a care plan problem dated 11/7/24, addressing the episodes of incontinence of bladder. Interventions included to retrain Resident 285's bladder to follow the toileting schedule every two hours and as needed. On 11/13/24 at 1458 hours, an interview for Resident 285 was conducted with CNA 1. CNA 1 stated Resident 285 was incontinent at nighttime. CNA 1 was asked if Resident 285 was on bladder training program, CNA 1 stated she did not know. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 0939 hours, an interview and concurrent medical record review for Resident 285 was conducted with LVN 2. LVN 2 stated the CNAs were to check and offer the residents to use the rest room or urinal every two hours. LVN 2 stated the staff did not have to document the amount unless specified in the order. LVN 2 verified there was no documented evidence from 11/7/24 to 11/14/24, for Resident 285's bladder training was offered every two hours by the CNA's. On 11/1/424/ at 1004 hours, an interview for Resident 285 was conducted with the DON. The DON was informed and verified the findings. The DON stated the resident should have received the bladder training program. 35346 2. On 11/13/24, at 1055 hours, during a resident council meeting, Resident 436 verbalized she did not want staff putting a diaper on her. On 11/13/24 at 1525 hours, a concurrent observation and interview was conducted with Resident 436 inside her room. Resident 436 stated she was allergic to all the plastic on the diaper, was wearing diapers now, and did not want to wear a diaper. On 11/14/24, medical record review for Resident 436 was initiated. Review of Resident 436's admission baseline screening showed Resident 436 was continent for her bladder needs. On 11/15/24 at 0741 hours, an interview was conducted with CNA 8. When asked about Resident 436's toileting needs, CNA 8 stated Resident 436 was able to verbalize when she needed to use the toilet. CNA 8 stated he also checked Resident 436's disposable brief every hour. CNA 8 further stated Resident 436 did not verbalize any concerns. On 11/15/24 at 1522 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated Resident 436 was admitted to the facility on [DATE], for rehabilitation post status right hip fracture and with MASD to the sacrococcyx area. The DON stated even if a resident wore diapers, they could still be taken to the toilet. The DON verified a care plan problem to address Resident 436's specific toileting needs was not included in Resident 436's baseline care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of two final sampled residents (Residents 132 and 282) reviewed for respiratory care were provided with the appropriate respiratory care. * The facility failed to ensure Residents 132 and 282's physician's order for administration of oxygen was clarified with the physician for continuous or PRN use. This failure had the potential to effect the respiratory health and well-being of the residents. Findings: Review of the facility's P&P titled Oxygen Administration revised October 2010 showed to verify there is a physician's order for this procedure and review the physician's order or facility protocol for the oxygen administration. 1. On 11/13/24 at 1441 hours, Resident 132 was observed in bed with oxygen via nasal cannula at 2 liters per minute. Medical record review for Resident 132 was initiated on 11/13/24. Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's Order Summary Report dated 11/13/24, showed a physician's order dated 10/29/24, to administer oxygen at 2 liters per nasal cannula every shift. However, further review of the physician's order failed to show if the oxygen was to be administered continuously or as necessary. On 11/15/24 at 0813 hours, an interview and concurrent medical record review for Resident 132 was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 132's use of the oxygen therapy. The MDS Coordinator verified the physician's order for the use of oxygen for Resident 132 was not clear if it was to be administered continously or as needed. 2. On 11/12/24 at 0832 hours, Resident 282 was observed in bed with oxygen at 2 liters per minute via nasal cannula. Medical record review for Resident 282 was initiated on 11/14/24. Resident 282 was admitted to the facility on [DATE]. On 11/14/24 at 0828 hours, Resident 282 was observed in bed receiving oxygen at 3 liters per minute via nasal cannula. Review of Resident 282's Order Summary Report dated 11/13/24, showed a physician's order dated 11/8/24, to administer oxygen at 3 liters per nasal cannula every shift. Further review of the physician's order for oxygen did not show if the oxygen was to be administered continuously. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 0757 hours, an interview and concurrent medical record review for Resident 282 was conducted with MDS Coordinator. The MDS Coordinator verified Resident 282's use of oxygen. The MDS Coordinator verified the physician's order for the use of oxygen did not show if it was continuous or as needed. The MDS Coordinator stated the physician's order was not clear and needed to be clarified with the physician. On 11/15/24 at 1616 hours, an interview and concurrent medical record review for Residents 132 and 282 was conducted with the DON. The DON was informed and verified the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 29461 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided when: * The facility failed to ensure all controlled medications were accurately accounted for and documented for one of 14 final sampled residents (Resident 432). * The medications received from pharmacy were accounted and signed for by the licensed staff who received the medications at the facility. * The facility failed to ensure the proper disposal of medications was followed. These failures posed the risk of drug diversion. Findings: 1. Review of the facility's P&P titled Medication Storage in the Facility ID3: Controlled Medication Storage dated 8/2014 showed the medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handing, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. Further review of the facility's P&P showed at each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record. In addition, the P&P showed any discrepancy in controlled substance medication counts is reported to the Director of Nursing immediately. The Director of Nursing or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The Director of Nursing documents irreconcilable discrepancies in a report to the Administrator. On 11/14/24 at 0837 hours, Medication Room A inspection and concurrent interview was conducted with the DON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 0926 hours, during Medication Room A inspection, a medication bottle with Resident 432's name was observed inside the locked cabinet in the medication room which held all the narcotics for disposal. The medication container was labeled showing buprenorphine-naloxone (medication to treat narcotic dependence) 8-2 mg place one tablet sublingual (under the tongue) three times a day. The form titled Antibiotic or Controlled Drug Record for Resident 432 showed the bottle of medication was from family supply. The controlled sheet showed there were 59 tablets to begin with, and the remaining count was a total of 22 tablets. The form showed a date written on the middle of the page dated 11/12/24, with two licensed nurses' signatures. When the DON counted the tablets from the medication bottle, the DON counted 23 tablets which did not tally with the number of tablets remaining on the controlled sheet. The DON stated she was one of the licensed nurses who counted the medications. The DON verified the total tablets left in the bottle did not match the controlled count sheet. When asked what did the facility do when the discrepancy with the count was identified, the DON did not provide a response. On 11/15/24 at 1326 hours, a follow-up interview was conducted with the DON. When asked regarding the facility's process when a discrepancy was identified with the narcotic count, the DON stated the facility needed to investigate and check the MAR and administration dates and times. The DON further stated she called the facility's pharmacy consultant; however, they did not initiate an investigation when the discrepancy was identified on 11/12/24. 2. Review of the facility's P&P titled Medication Ordering and Receiving From Pharmacy revised 1/2022 showed when receiving the medications from the pharmacy, a licensed nurse: a. Receives the medications delivered to the facility and documents that the delivery was received and secure on the medication delivery receipts. b. Verifies the medications received and directions for use with the medication order form and/or physician's orders. On 11/14/24 at 0837 hours, a Medication Room A inspection and concurrent interview was conducted with the DON. During the inspection, the following was observed: - a pharmacy delivery slip dated 11/13/24, for Emergency PO E-kit without a signature from the receiving nurse. - a pharmacy delivery slip dated 11/13/34, for 30 tablets of hydrocodone/APAP 5-325 mg (controlled pain medication) 30 tablets for Resident 436 without a signature from the receiving nurse. - a pharmacy delivery slip dated 11/13/24, for 30 tablets of oxycodone HCL 5 mg tab (controlled pain medication) 30 tablets for Resident 282 without a signature from the receiving nurse - a pharmacy delivery slip dated 11/13/24, for 30 tablets of hydrocodone/APAP 10-325 mg 30 tablets for Resident 434 without a signature from the receiving nurse. The DON acknowledged and verified the findings and stated the pharmacy delivery slips should have been signed by the licensed nurse who received the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 11/14/24 at 0837 hours, a Medication Room A inspection and concurrent interview was conducted with the DON. During the inspection, a brown box containing multiple bottles with a label showing Ready to Use Drug Disposal was observed on a wood pallet on the floor. Review of the Drug Disposition Binder inside Medication Room A was reviewed and observed with multiple pages of drug disposition records. Two pages of Medication Disposition Record/Pass Log were observed with labels specific to different residents and name of medications for disposal. The forms were signed by two licensed nurses for drug disposal/waste management; however, there was no documentation when the drug disposal occurred. The DON acknowledged and verified the findings and stated the forms should have been dated when the medications were disposed of.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the orthostatic blood pressure monitoring was accurately performed as ordered by the physician related to the use of antipsychotic medication for one of one final resident (Resident 132) reviewed for antipsychotic medications. This failure had the potential for the resident to have adverse complications from the medication and the potential of not providing the correct data to the prescriber to adjust the dose of the psychotropic medication for the resident. Findings: Review of the facility's P&P titled Measuring Blood Pressure dated 9/2010 showed the orthostatic (postural) hypotension is defined as a 20 mm/hg (or greater) decline in systolic blood pressure (top number) or a 10 mm/hg (or greater) decline in diastolic blood pressure (bottom number) upon standing. Note the changes in both systolic and diastolic measurements compare to the reading taken while the resident was in a seated position. Medical record review for Resident 132 was initiated on 11/14/24. Resident 132 was admitted to the facility on [DATE]. Review of the Order Summary Report dated 11/14/24, showed the following physician's orders: - dated 10/29/24, to administer Abilify (antipsychotic medication) 5 mg two tablets by mouth one time a day for psychosis manifested by angry outburst. - dated 10/29/24, to check for orthostatic hypotension by checking the blood pressure in three positions (lying, sitting, and standing) once a day every Wednesday. Review of the MAR for November 2024 showed the orthostatic blood pressure (lying, sitting, and standing) were scheduled to be monitored every Wednesday. However, the blood pressure readings for all three positions were the same as follows: - On 11/6/24, the blood pressure readings were 121/63 mm/Hg for the lying position, 121/63 mm/Hg for the sitting position, and 121/63 mm/Hg for the standing position. - On 11/13/24, the blood pressure readings were 125/75 mm/Hg for the lying position, 125/75 mm/Hg for the sitting position, and 125/75 mm/Hg for the standing position. On 11/14/24 at 1442 hours, an interview and concurrent medical record review for Resident 132 was conducted with the DON. The DON was informed of the orthostatic blood pressure monitoring for Resident 132. The DON reviewed the medical record and verified the licensed nurses were not monitoring the orthostatic hypotension accurately because of the same blood pressure readings for all three positions (lying, sitting, and standing). The DON stated there should be a variation on each position on the reading results of the orthostatic hypotension blood pressure readings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29461 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.14% One licensed nurse (LVN 4) was found to have made error during the medication administration. * Resident 134 had a physician's order for Calcium Carbonate Tablet Chewable 500 mg one tablet by mouth one time a day for indigestion, chew and swallow. LVN 4 did not administer the medication as ordered by the physician. * Resident 4 had a physician's order for Effexor XR (medication to treat depression) Oral Capsule Extended Release 24 hour 75 mg one capsule by mouth one time a day for depression m/b persistent expression of hopelessness, give with food. LVN 4 did not administer the medication with food as ordered by the physician. These failures resulted in the residents not receiving the medications as ordered by the physicians, posed the risk of adverse effects, and had the potential to negatively affect the residents' health. Findings: Review of the facility's P&P titled Administering Medications revised 12/2012 showed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. 1. On 11/13/24 at 0805 hours, a medication administration observation for Resident 134 was conducted with LVN 4. LVN 4 was observed preparing and administering the following medications: - bupropion XL 150 mg one tablet - gabapentin (medication to treat pain or seizure activity) 300 mg two capsules - oxybutynin ER (medication to treat over active bladder) 15 mg one tablet - calcium carbonate 500 mg one tablet, chewable - ferrous sulfate (iron supplement) one tablet - minocycline (antibiotic to treat infection) 100 mg one capsule - multivitamin with minerals one tablet - Megace (medication to improve appetite) 40 mg/10 ml - maxitrol eye ointment one ribbon to the right eye (medication to treat eye redness) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 134 requested the medications be prepared separately in two medication cups and Resident 134 was observed to have taken the medications. However, LVN 4 did not provide instructions to Resident 134 to chew the calcium carbonate tablet and the calcium carbonate 500 mg was not chewed prior to swallowing. Medical record review for Resident 134 was initiated on 11/13/24. Resident 134 was admitted to the facility on [DATE]. Review of Resident 134's Order Summary Report dated 11/13/24, showed a physician's order dated 11/5/24, for calcium carbonate tablet chewable 500 mg one tablet by mouth one time a day for indigeston, chew and swallow. 2. On 11/13/24 at 0840 hours, a medication administration observation for Resident 4 was conducted with LVN 4. LVN 4 was observed preparing and administering the following medications: - acidophilus 500 milliion active cell one capsule (supplement) - aspirin (medication to treat pain, fever, inflammation, or reduce the risk of heart attack) 81 mg enteric coated (serves as barrier to prevent the gastric acids in the stomach from dissolving the medication after being swallowed) one tablet - vitamin D 3 (supplement) 50 mcg (2000 iu) one tablet - multivitamins with minerals one tablet - gabapentin 100 mg two capsules - losartan (medication to treat high blood pressure) 25 mg one tablet - metoprolol succinate ER (medication to treat high blood pressure) 50 mg one tablet - venlafaxine ER (medication to treat depression) one capsule - senna plus 8.6 mg two tablets - heparin sodium 5000 unit/ml 1 ml (medication to prevent blood clot) Resident 4, post administration of medications, verified the breakfast tray had not been served yet and she had not eaten breakfast prior to receiving the medications from LVN 4. Medical record review for Resident 4 was initiated on 11/13/24. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's Order Summary Report dated 11/13/24, showed a physician's order dated 10/28/24, for Effexor XR Oral Capsule Extended RElease 24 Hour 75 mg (same as venlafaxine HCL) one capsule by mouth one time a day for depression m/b persisten expression of hopelessness, give with food. However, the medication was not administered with food as ordered by the physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 1338 hours, an interview and concurrent record review for Residents 4 and 134 was conducted with LVN 4. LVN 4 was informed and verified the findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper medication storage. * The facility failed to ensure the expired treatment medications were removed from the medication cart. * The facility failed to ensure to separate the externally and internally medications from the medication cart and Medication Room A. * The facility failed to ensure proper storage of feeding formula and temperature monitoring. These failures had the potential to negatively impact the residents' well-being, and medication errors. Findings Review of the facility's P&P titled Medication Storage in the Facility dated ,d+[DATE] showed orally administered medications are kept separate from externally used medication, such as suppositories, liquids and lotion. 1.a. On [DATE] at 1046 hours, a medication cart inspection for Medication Cart A was conducted with RN 1. During the inspection of Medication Cart A, the following was observed: - seven individual packs of povidone-iodine prep pad, with an expiration date ,d+[DATE]. On [DATE] 1103 hours, an interview was cvonducted with DON. The DON verified the above findings. b. On [DATE] at 1424 hours, a medication cart inspection for Medication Cart B was conducted with LVN 4. During the inspection of Medication Cart B, the following was observed: -zofran (antiemetic) medication together with acetaminophen (analgesic) suppositories and bisacodyl (laxative) suppository. On [DATE] at 1445 hours, an interview was conducted with LVN 4. LVN 4 verified and confirmed the findings. 2. On [DATE] at 1001 hours, an inspection of Medication Room B and concurrent interview was conducted with LVN 7. During the inspection of Medication Room B, the following was observed: - eye drop medication and oral medication were observed in the same cabinet, and - nasal spray and oral medication were observed in the same cabinet. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 7 stated those medications needed to be separated and not stored in the same cabinet. On [DATE] at 1801 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 51423 3. On [DATE] at 1045 hours, an interview and observation was conducted with the Central Supply Designee. The Central Supply Designee reviewed and verified the enteral feeding formulas and oral supplements were all stored in the Storage Room. The temperature of the room was at 75 degrees F verified by the Central Supply Designee. The Central Supply Designee verified the temperature log had not been filled out since , d+[DATE]. The Central Supply Designee stated she was not aware the Storage Room temperature needed to be monitored and logged. On [DATE] at 1026 hours, an interview and observation was conducted with the Central Supply Designee. The Central Supply Designee reviewed and verified that over the counter medications were stored in the Health Equipment room. The Central Supply Designee verified that there was no thermometer and no temperature log.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Juan Hills Healthcare Center	31741 Rancho Viejo Road San Juan Capistrano, CA 92675

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 35346 Based on observation, interview, and facility P&P review, the facility failed to ensure the dietary staff were competent in the skills needed to carry out the functions of the food and nutrition services. This failure posed the risk of the residents not receiving appropriate food and nutrition services. Findings: Review of the Residents' Order Summary Report dated 11/12/24, showed 41 of 42 residents received food prepared from the kitchen. 1.a. On 11/12/24 at 0750 hours, a kitchen inspection of the facility's satellite kitchen was initiated with CDM 1. CDM 1 was asked about checking the dishwasher located inside the facility's kitchen. The dishwasher was observed to have a label with the words prewash temperature 120 degrees F. CDM 1 pointed to the label on the dishwasher and stated that was the cycle to check the temperature for the dishwasher. The temperature was a low temperature dishwasher and supposed to be checked during the wash cycle to ensure it was working properly. Review of the Temperature Log Dish Machine Low temp showed the wash cycle temperature was to be checked. The CDM was asked about the range for the sanitizing pails in the satellite kitchen. The CDM kept pointing to the dishwashing log. The dishwashing log showed a target ppm for chlorine sanitizer to be 50 ppm with another note showing the target ppm was to be at 50-100 ppm. Review of the Sani Pail Test Log for November 2024 showed the target ppm was greater than or equal to 200 ppm. Further review showed a note stating the sanitizer solution was to be maintained at levels 200-400 ppm. The log showed the ppm was documented as 200 ppm. When asked to demonstrate a check for the proper range for the sanitzing solution pails, CDM 1 filled a sanitizing pail with soap and water and kept testing this solution. CDM 1 failed to check the sanitizing solution and failed to verbalize the correct range for the sanitizing solutions. Review of the posting for checking sanitizing solutions showed the sanitizer solutions were to be kept at a range of 150-250 ppm. b. On 11/12/24 at 1000 hours, a kitchen inspection of the facility's main kitchen was initiated with CDM 2. Unsanitary conditions were observed inside the kitchen and verified with CDM 2. On 11/15/24, review of CDM 2's personnel file was conducted with the Administrator. Review of CDM 2's file showed discussions with CDM 2 related to improving unsanitary conditions in the kitchen was conducted on 8/14/24. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 11/13/24 at 1000 hours, during a walk through of satellite kitchen, the new Sani Pail Test Log was observed on wall with new PPMs listed for all days and times in November. CDM 1 confirmed the new log had different ppms that were now in correct range for the month. Review of the new log for the month of November 2024 showed 300 ppm was documented for the month of November 2024. On 11/13/24 at 1353 hours, the written duties and responsibilities for the RD, and CDMs 1 and 2 were reviewed. The RD's competency showed the RD shall have oversight of the Food service department. Review of CDM 1's written duties and responsibilities showed CDM 1 would assume the administrative authority, responsibility and accountability of directing the Food Services Department. Review of CDM 2's written duties and responsibilities showed CDM 2 would assume the administrative authority, responsibility and accountability of directing the Food Services Department. d. On 11/14/24 at 1130 hours, during observation of lunch trayline in satellite kitchen and concurrent interview with CDM 1 and the RD. The following item was observed: - Cottage cheese container on cart for trayline left outside of the refrigeration On 11/14/24 at 1130 hours, during observation of lunch trayline in the satellite kitchen, CDM 1 confirmed the temperature of the cottage cheese had not been taken as part of trayline temperature log. After a request was made to check the temperature, CDM 1 checked the temperature and confirmed the temperature was 53 degrees and out of the appropriate range. CDM 1 did not dispose of the cottage cheese and continued to serve lunch. At 1145 hours, the RD confirmed the temperature was 53 degrees and out of the acceptable range. At this time, CDM 1 disposed of the cottage cheese. Cross reference to F812.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and facility document review, the facility failed to ensure the menu and diet orders were followed as evidenced by: * Chicken salad was not documented on the cool down log. * The kitchen staff did not use the correct serving size scoop. * The temperatures for milk and cottage cheese were not taken at the tray line. Cottage cheese was not maintained at the acceptable temperature. * Plates of dessert were near the dirty sink. * Tray ticket was inaccurate for one of 14 final sampled resident (Resident 383) * Food item was not served as per the tray ticket for one nonsampled resident (Resident A). * The lunch tray included a food item not appropriate for the resident's prescribed diet order for one nonsampled resident (Resident 136). * The facility failed to ensure the menu and diet order were followed for one of 14 final sampled residents (Resident 9). These findings posed the risk of the residents not receiving nutritional adequacy. Findings: Review of the Residents' Order Summary Report dated 11/12/24, showed 41 of 42 residents received food prepared from the kitchen. 1.a. On 11/13/24 at 1100 hours, a concurrent interview and facility's documents review was conducted with [NAME] 1, the RD, CDM 2, and the Regional RD. When asked why the chicken salad listed as lunch meal for 11/11/24 lunch menu was not documented on the cool down log, [NAME] 1 verified chicken salad was not on the cool down log. b. On 11/14/24 at 1130 hours, a concurrent observation and interview of the trayline service in satellite kitchen was conducted with CDM 1. The following findings were observed and verified: - Appropriate scoop size was not being used. The Spreadsheet showed for noodles, to use #8 scoop, but the staff used a 3 oz slotted spoon. Noodles and peas were in the water. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The temperatures for milk and cottage cheese were not taken. Cottage cheese was stored on the counter, not in ice bath. When asked to take milk temperature, CDM 1 stated, I don't have to it comes from the refrigerator. CDM 1 verified there was a space on the trayline temperature log where the milk temperature should be documented. The Cottage cheese temperature was 53 degrees Fahrenheit, in the danger zone for food items. Dietary Aide 2 verified the cottage cheese had been on the counter for at least 10 minutes. CDM 1 confirmed the temperature to dispose of cottage cheese. However, CDM 1 allowed the cottage cheese to sit on the counter for another 15 minutes. The RD was asked to confirm the temperature and determine proper course of action for the cottage cheese. The RD instructed CDM 1 to dispose of the cottage cheese. CDM 1 asked the RD How long can I leave it/cottage cheese out? - Meal tray for Resident 383 was a CCHO NAS (Consistent Carbohydrate Diet No Added Salt) diet but was changed to a regular and CCHO NAS was crossed out; however, CCHO dessert was still listed on tray ticket as Omit Icing. Tray included a regular dessert. CDM 1 verified the regular dessert was on the tray but omit icing was listed on the ticket. - Meal tray for Resident A showed liberal house renal CCHO diet, and on the tray ticket listed as supplements was apple slices. CDM 1 confirmed the apple slices was listed on the ticket but not on the meal tray. CDM 1 stated, We must not have apple slices in the kitchen. c. On 11/15/24 at 1230 hours, Resident 136's diet order and meal ticket showed liberal renal diet, mechanical soft texture, and thin liquids consistency. Resident 136 was served gravy on his lunch tray, which was not listed on his meal ticket. Also yogurt was added. Review of Resident 136's meal ticket showed Resident 136 was not to be on a diet with high phosphorus. The Diet Manual showed, only 4 oz of dairy on tray High sodium foods to be avoided. The Fresh fruit was listed on the meal ticket but canned fruit was provided. All the findings were verified with Dietary Aide 1. 44175 2. On 11/12/24 at 1243 hours, an observation and concurrent interview was conducted with Resident 9. Resident 9 was observed in her room with the lunch food tray. The food tray plate had pork meat with gravy, rice and cauliflower; and there was no bread roll included in the food plate. Resident 9 stated she did not like the food provided to her so she requested a turkey sandwich and milk. Resident 9 stated she had the butter on her meal tray but there was no bread roll to put it on and added she like the bread roll. On 11/12/24 at 1300 hours, CNA 7 was observed bringing the sandwich to Resident 9. CNA 7 verified the food tray of Resident 9 did not include the bread roll. Medical record review for Resident 9 was initiated on 11/13/24. Resident 9 was admitted to the facility on [DATE]. Review of the Internal Medicine History & Physical/Progress note for Resident 9 dated 9/13/24, showed Resident 9 had the capacity to make a medical decisions. On 11/13/24 at 1358 hours, an interview and concurrent facility document review was conducted with CDM 1. CDM 1 was informed of the observation on Resident 9's food tray of not including the bread roll upon serving. CDM 1 verified and stated the food tray should have included the bread roll. CDM 1 acknowledged the findings. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1004 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35346 Based on observation and interview, the facility failed to follow the puree recipe for seven residents on puree diet. This failure posed the risk of the residents not receiving foods prepared by methods that conserve nutritive value. Findings: Review of the Residents' Order Summary Report dated 11/12/24, showed seven residents received puree food prepared from the kitchen. On 11/14/24 at 1000 hours, an observation of puree meals preparation was conducted with [NAME] 1. Cook 1 stated she was preparing puree the foods for a total of seven residents and would prepare the foods for 10 servings. During the puree preparation for peas, [NAME] 1 was observed adding chicken broth to the cooked peas while the recipe showed to add liquid used to cook peas. [NAME] 1 was then observed to keep adding thickener to obtain the right consistency for the peas and manually mixing the food item with a whisk. The recipe showed to use one and one half tablespoons of thickener. [NAME] 1 was then observed to puree other main entree items and continue to add multiple tablespoons of thickener to the food items, not following the recipes located in front of her. These findings were verified with the RD.

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 35346 Based on observation and interview, the facility failed to ensure the therapeutic diets were served as prescribed by the residents' physicians for one of 14 final sampled resident (Resident 16) and one nonsampled resident (Resident 284). * Resident 284 was not served the prescribed diet. * Resident 16 was served Magic cup (supplement) but not listed on the physician's orders. These failures had the potential for the residents not meeting the therapeutic needs. Findings: Review of the Residents' Order Summary Report dated 11/12/24, showed 41 of 42 residents received food prepared from the kitchen. 1. On 11/12/14 at 1120 hours, during a dining room observation, LVN 2 was observed checking the residents' meal trays against the residents' meal tickets. When asked about verifying diets against the physician's orders, LVN 2 verbalized she had most of the residents' diets memorized. When asked to check the meal served, meal ticket, and list of the physician's orders for Resident 284, LVN 2 stated the meal served was no added salt, regular diet while the physician's diet order showed no added salt, mechanical soft diet. LVN 2 acknowledged she should have checked the list of physician's orders against the meal served and meal ticket for all the residents. 2. On 11/15/24 at 1230 hours, a concurrent observation and interview of the lunch trayline in the facility's satellite kitchen was conducted with Dietary Aide 1, CDM 1, the Regional RD, and RD. Two meal trays were pulled to check for accuracy, comparing the tray ticket to items on the tray and the following was observed: - Tray #1 for Resident 16 showed Resident 16 was on a puree nectar thick liquid. Under the tray note was listed a mechanical soft meat. The Magic cup was listed on the tray ticket and observed on tray but was not on the physician's order. The finding was verified with the Regional RD.

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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. 35346 Based on observation and interview, the facility failed to ensure the sanitary conditions in the satellite and main kitchens. This failure posed the risk of food services not meeting professional standards Findings: Review of the Residents' Order Summary Report dated 11/12/24, showed 41 of 42 residents received meals prepared in the facility's kitchen. 1. On 11/12/24 at 0750 hours, an inspection of the facility's satellite kitchen was initiated. The following findings were observed: - a plastic see through container of juice was observed defrosting under running water in the hand wash sink of the satellite kitchen. The sink was observed with yellow and black stains, and a piece of wet paper towel in it. When asked about this finding, Dietary Aide 1 verified the findings. - a gnat was observed flying inside the satellite kitchen. - the portable plate lowerator was observed with rust. CDM 1 verified the finding and verified there was no cleaning log for the lowerator. - the drain near the dishwasher was dirty and with food particles in it. CDM 1 verified the finding. b. On 11/12/24 at 0804 hours, an inspection of the facility's main kitchen was initiated. The following findings were observed and verified with CDM 2: - Dietary Aide 3 was observed without a hair net. - Dishwasher 1 was observed without a beard restraint. - Dietary Aide 2 was observed without a restraint for his moustache. - Three cutting boards were observed marred. - Four cutting boards were observed wet and stored next to each other, atop a pan with stains on it, atop a counter with stains on it - Food items were stored close to the sprinkler system inside the walk-in refrigerator. No marking to designate the highest storage area was observed. - The two vent hoods above the stove area were soiled with stains and grease. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The drains on the floor were dirty and with food particles in them. - The Safe Knife Kitchen used to store knives had stains and dust on it. - Three pans were soiled. One of the three pans had black residue on it. - An 18 inch skillet had a white residue on it. - A small frying pan was soiled with grease. - Two oven racks were stored on the floor. A posting showed the approved hair and facial hair restraints was observed at the main kitchen entrance. c. On 11/12/14 at 1115 hours, an unlabeled food item was stored inside the residents' refrigerator used to store food brought from the outside for the residents. LVN 6 verified the findings and verified there was no date to show when the food item was placed inside the refrigerator. When asked about the employee's food items also being stored inside the residents' refrigerator, CDM 1 stated she had a 2nd refrigerator. CDM 1 did not do a follow up to remove the food items from the refrigerator. d. On 11/12/24 at 1120 hours, LVN 2 was observed touching her surgical mask, then touching the dining room meal carts containing the residents' lunch trays inside, without performing hand hygiene in between. LVN 2 verified the findings. On 11/13/24 at 1050 hours, during a follow-up inspection of the satellite kitchen, the following was observed and verified with CDM 1: - CDM 1 was observed without a hair restraint. - CDM 1 then put a hair restraint on; however, CDM 1 was observed with hair strands coming out of the hair restraint she put on. e. On 11/13/24 at 1109 hours, during a follow-up inspection of the main kitchen, the following was observed and verified with CDM 2: - Dishwasher 2 was observed using a knife to pry open the door of a cart containing dirty dishes. Dishwasher 2 stated he had informed the staff about this findings eight months prior to this date. - A male staff was observed putting a pitcher filled with ice and half covered with plastic wrapping into the ice machine bin - a staff's purse was observed stored on a rack bottom shelf next to the food items. f. On 11/14/24 at 0757 and 0905 hours, during a follow-up kitchen inspection of the main kitchen, the following was observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- food items were stored close to the sprinkler system inside the walk-in refrigerator. No marking to designate the highest storage area was observed. - The Activities Director for the independent living was observed cutting lemons without a beard restraint. The finding was verified with CDM 2. - A staff working for the independent living area was observed resting a hotel pan on top of the ice inside the ice machine. The finding was verified with CDM 2. On 11/14/24 at 1125 hours, during a follow-up kitchen inspection of the satellite kitchen, the following was observed and verified with CDM 1: - a gnat was observed flying around the satellite kitchen. CDM 1 was observed moving her hand side to side to move the flying gnat out of her face. - a ripped rag was in the sanitizer bucket. - Plates of dessert were stored on top of drainboard next to dirty dish sink. 2. According to the USDA Food Code 2022, Section 3-501.14 Cooling, (A) Cooked time/ temperature control for safety food shall be cooled: (1) within two hours from 135 degrees Fahrenheit (F) to 70 degrees F; and (2) within a total of six hours from 135 degrees F to 41 degrees F or less. On 11/13/24 at 1100 hours, an observation and interview was conducted with [NAME] 1, RD, CDM 2, and the Regional RD. [NAME] 1 verified the chicken salad on the menu from Monday was not included on the Cool Down Log. The Cool Down Log was observed posted in the kitchen. After reviewing the log the RD, CDM 2, and Regional RD also verified the chicken salad was not on the Cool Down Log and should be. CDM 2 stated sometimes precooked chicken was used as an ingredient. CDM 2 did not provide a recipe or an invoice that included the purchase of precooked chicken 3. On 11/13/24 at 1355 hours, a concurrent observation and interview about the main kitchen ice machine was conducted with the Maintenance Director. The Maintenance Director was observed placing his personal cell phone inside the main kitchen ice machine while the cubed ice fell on to the Maintenance Director's cell phone, then bounced from the cell phone onto the bottom of the ice machine bin. 4. According to USDA Food Code 2022, Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (Centigrade) (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 degrees C (130 degrees F) or above; or (2) At 5 degrees C (41 degrees F) or less. On 11/14/24 at 1130 hours, during an observation of the lunch trayline in the satellite kitchen and concurrent interview with CDM 1 and the RD, the following was observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cottage cheese container on the cart for the trayline was left outside of the refrigeration On 11/14/24 at 1130 hours, during an observation of lunch trayline in satellite kitchen, CDM 1 confirmed that the temperature of the cottage cheese had not been taken as part of trayline temperature log. After a request was made to check the temperature, CDM 2 checked the temperature and confirmed the temperature was 53 degrees F and out of appropriate range. CDM 2 did not dispose of the cottage cheese and continued to serve lunch. At 1145 hours, the RD confirmed the temperature was 53 degrees F and out of acceptable range. CDM 2 then disposed of the cottage cheese.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, and medical record review, the facility failed to ensure the medical record was accurately documented for one of 14 final sampled resident (Resident 132). This failure had the potential for the residents' care needs not being met as their medical information was inaccurate. Findings: Medical record review for Resident 132 was initiated on 11/12/24. Resident 132 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 132's H&P examination dated 10/30/24, showed the resident had a fluctuating capacity to understand and make decisions. Resident 132 has a diagnosis of right humerus (long bone in the upper arm that runs from the shoulder to the elbow) fracture. Review of Residents 132's MDS dated [DATE], showed a BIMS score of 9 (meaning moderately cognitive impaired). During an initial tour of the facility on 11/12/24 at 0814 hours, a concurrent observation and interview with Resident 132 was conducted. Resident 132 was observed lying in his bed with a sling on the right upper arm. Resident 132 stated she had a fracture on the right arm from a fall. Resident 132 was using the right sling since admission to the facility. Review of Resident 132's Weights and Vitals Summary from 10/29 to 11/30/24, showed a documentation the BP reading was obtained from the resident's right arm. For example, -On 10/30/24 at 0906 hours, a BP reading of 138/88 mmHg on the right arm. -On 10/31/24 at 1039 hours, a BP reading of 128/70 mmHg on the right arm. -On 10/31/24 at 1055 hours, a BP reading of 124/70 mmHg on the right arm. -On 11/1/24 at 0520 hours, a BP reading of 145/75 mmHg on the right arm. -On 11/1/24 at 0849 hours, a BP reading of 141/71 mmHg on the right arm. -On 11/1/24 at 1830 hours, a BP reading of 132/67 mmHg on the right arm. -On 11/3/24 at 0953 hours, a BP reading of 132/66 mmHg on the right arm. -On 11/5/24 at 0947 hours, a BP reading of 123/76 mmHg on the right arm. -On 11/6/24 at 0932 hours, a BP reading of 121/63 mmHg on the right arm. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	-On 11/7/24 at 0937 hours, a BP reading of 128/74 mmHg on the right arm. -On 11/7/24 at 2010 hours, a BP reading of 122/70 mmHg on the right arm. -On 11/8/24 at 1133 hours, a BP reading of 125/67 mmHg on the right arm. -On 11/9/24 at 0936 hours, a BP reading of 126/68 mmHg on the right arm. -On 11/10/24 at 1025 hours, a BP reading of 124/65 mmHg on the right arm. -On 11/11/24 at 1003 hours, a BP reading of 127/71 mmHg on the right arm. On 11/13/24 at 0915 hours, during the medication administration observation with LVN 1, LVN 1 attempted to take the blood pressure of Resident 132 on the right arm. Resident 132 refused to have the blood pressure taken on the right arm. On 11/15/24 at 0928 hours, concurrent interview, and medical record review with LVN 1 was conducted. LVN 1 verified the findings and stated the resident's blood pressure should not be taking on the right upper arm. Resident 132 had the right humerus fracture. On 11/15/24 0931 hours, an interview was conducted with the DON. The DON was informed of the licensed nurses's blood pressure recording for the right arm, and Resident 132 had a fracture on the right humerus. The DON stated the licensed nurses should not take the blood pressure from the right arm because it would be painful and worsen the fracture.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Juan Hills Healthcare Center	31741 Rancho Viejo Road San Juan Capistrano, CA 92675

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50953 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were followed for two of 14 final sampled residents (Resident 132 and 435) and one nonsampled resident (Resident 134); in the laundry area; hand washing; and preventing Legionella. * The facility failed to perform handwashing before and after assisting Resident 435 with meals * The facility failed to perform handwashing before and after medication administration for Residents 132 and 134. * The facility failed to ensure infection control practices was maintained in the facility's laundry room when a facility staff personal clothing was stored with the rack of clean pillows. * The facility failed to ensure the water management program was established and implemented to include the implementation of measures to prevent the growth of Legionella and other opportunistic pathogens; and a way to monitor the measures they had in place These failures posed the risk for transmission of disease-causing microorganisms and infections. Findings: Review of the facility's P&P titled Administering Medication dated 12/2012 showed the staff follow establish facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medication, as applicable. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 6/2021 showed this facility considers hand hygiene the primary means to prevent the spread of infection. * Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial on non-antimicrobial) and water for the following situation: - before and after direct contacts with resident; - before preparing or handling medication; - before donning sterile gloves; - after contact with resident's intact skin; - after removing gloves; - before and after assisting a resident with meals. * Hand hygiene is the final step after removing and disposing of personal protective equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 11/12/24 at 1209 hours, during the dining room observation for Resident 435, Resident 435 was observed sitting in a wheelchair, and the OT staff gave the resident a tray and put gloves on without washing hand, then started feeding Resident 435. The OT staff left Resident 435 and opened the dining room door for another resident to go out to the patio, removed gloves, and without washing hand, put a new pair of gloves and started feeding Resident 435. On 11/12/24 at 1242 hours, an observation and concurrent interview was conducted with the OT staff. The OT staff confirmed and verified she did not wash her hand before and after removing the gloves when she opened the door for one of the residents. The OT was asked if the resident needed assistance in feeding and stated Resident 435's wrist was hurting and she was helping with the feeding. 2.a. On 11/13/24 at 0805 hours, a medication administration observation for Resident 134 was conducted with LVN 4. LVN 4 did not perform handwashing before and after medication administration. On 11/13/24 at 1338 hours, an interview was conducted with LVN 4. LVN 4 stated if the hands were not visible soiled, just needed to hand sanitize. On 11/13/24 at 1347 hours, an interview was conducted with the DON. The DON stated the licensed nurses needed to perform handwashing if passing the medication from one resident to another resident. b. On 11/13/24 at 0928 hours, a medication administration observation for Resident 132 was conducted with LVN 1. LVN 1 did not perform handwashing before and after medication administration to the resident. On 11/13/24 at 1355 hours, an interview was conducted with LVN 1. LVN 1 verified the above findings and stated the staff needed to wash hands before and after medication administration. On 11/15/24 at 1801 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 44175 3. Review of the facility's P&P titled Departmental (Environmental Services)- Laundry and Linen revised January 2014 showed the facility will provide a process for a safe and aseptic handling, washing and storage of linen. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness), through measures designed to protect it from environmental contamination, such as covering clean linen carts. On 11/14/24 at 1425 hours, an observation of the laundry area and concurrent interview was conducted with the Maintenance Director. An employee clothing was observed stored in the rack with clean pillows. The Maintenance Director verified the observation and stated the employee should not have stored personal clothing in the rack with the clean pillows. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the facility's P&P titled Legionella Water Management Program dated 6/12/24, showed the purpose of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The facility has considered the ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) industry standard and the CDC (Center and Disease Control) toolkit to evaluate the current facility control measures and determine awareness protocols. Example of systems: resident bathrooms (faucet- hot and cold shower), decorative fountains, evaporative cooling water, ice machine water, hot water storage tanks (domestic and laundry), emergency water storage container, water filters, showerheads and hoses, eye wash station. According to the CDC's guidelines for Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings dated 6/26/15, control measures and limits should be established for each control point. You will need to monitor to ensure your control measures are performing as designed. Control limits, in which a chemical or physical parameter must be maintained, should include a minimum and a maximum value. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: Water quality should be measured throughout the system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring, Water heaters should be maintained at appropriate temperatures, Decorative fountains should be kept free of debris and visible biofilm, Disinfectant and other chemical levels in cooling towers and hot tubs should be continuously maintained and regularly monitored. Surfaces with any visible biofilm (i.e., slime) should be cleaned. Under section Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program is being implemented as designed. This step is called verification. Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called validation. On 11/15/24 at 0847 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director verified the facility did not test for legionella in regular basis. The Maintenance Director was not able to provide a documentation showing the risk assessment to identify the areas in the water system where legionella bacetria could grow. The Maintenance Director was not able to show specific control measures that the facility was using to prevent the growth of legionella bacteria in the facility. On 11/15/24 at 0930 hours, an interview was conducted with the DSD/IP. The DSD/IP stated the facility tested the legionella infection; however, he was not sure how often. On 11/15/24 at 1021 hours, an interview and concurrent facility document review with the Administrator. The Administrator was informed and verified the above findings.

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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** 44175 Based on interview, facility document review, and facility P&P review, the facility failed to monitor and address the use of antibiotics when the resident's condition did not meet McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) for two residents (one discharged resident, Resident 10; and one nonsampled resident, Resident 7) on the surveillance log. This failure had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria. Findings: Review of the facility's P&P titled Antibiotic Stewardship Program dated 6/2021 showed appropriate use of antibiotic included criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). The IP will track, collect and review data whether McGeer criteria was met to consider prescribing antibiotics. Review of the Survillance Log for October 2024 showed Resident 7 was admitted on [DATE], and onset of cough showed 10/16/24; and the resident was prescribed antibiotic, Z-pak (azythromiacin). Further review of the log showed the resident had healthcare associated infection. Review of the Infection Surveillance data collection form showed the date of admission did not show if the resident did meet the McGeer criteria. Review of the Surveillance Log for October 2024 showed Resident 10 received Bactrim DS (double strengt) antibiotic for recurrent pneumonia. Further review of the surveillance log showed it was ordered for prophylaxis, recurrent pneumonia. Review of the Survillance Data Collection form dated 10/5/24, did not show if the resident's infection met the McGeer criteria. Further review of the records did not show if the infection was a true infection. On 11/15/24 at 1006 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP verified the above findings. The DSD/IP was asked about the facility's antibiotic stewardship program. The DSD/IP stated the facility used McGeer's criteria. The DSD/IP stated if a resident did not meet the criteria for an infection using the McGeer's criteria, the physician would be notified. On 11/15/24 at 1616 hours, an interview and concurrent facility document review for Residents 7 and 10 was conducted with the DON. The DON was informed and verified the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 29461 Based on observation, interview, and facility document review, the facility failed to ensure the freezer compartment inside the medication refrigerator inside Medication Room A was free of ice buildup. In addition, the facility failed to ensure the freezer temperature was monitored and recorded in the temperature log. These failure had the potential for not maintaining the acceptable temperature for medication storage in the refrigerator. Findings: Review of the facility's document titled Medication Room, Refrigerator, Temperature Log dated 11/2024 showed to verify and document refrigerator, freezer, and room temperatures twice per day (AM/PM). If any temperature is outside of the range(s) below, notify the Nurse Leader or Health Care Administrator. On 11/14/24 at 0837 hours, an inspection of Medication Room A and concurrent interview was conducted with the DON. On 11/14/24 at 0956 hours, during Medication Room A inspection, the medication refrigerator was observed to have ice build up in the freezer compartment. There were ice packs stored in the freezer compartment and there was no thermometer inside the freezer. Review of the temperature log for Medication Room A dated 11/2024, failed to show documentation the freezer temperature was being monitored twice a day as per the facility's P&P. The column for freezer temperature showed written horizontal lines from 11/1 through 11/14/24. The DON verified the findings and stated the freezer temperature should have been monitored twice a day and recorded in the temperature log, and the ice build up in the freezer should have been cleaned.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate and complete, and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of bed rails for one of 14 final sampled residents (Resident 132). This failure had the potential to negatively impact the resident resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety dated 12/2007 showed for the purpose of this policy, bed rails include side rails, safety rails, and grab or assist bars. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail, and mattresses will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA. Maintenance staff routinely inspects all bed and related equipment to identify risks and problems including potential entrapment risks. The maintenance department provides a copy of inspection to the administrator and report results to the QAPI committee for appropriate actions. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation, medical record review, and facility document review for Residents 132 showed the resident's bed entrapment assessments were not accurate, completed, or the bed inspection gap measurements were recorded from the bed to side rail or bed headboard to side rail. The facility failed to ensure the entrapment zones were measured for the use of the side rails. On 11/13/24 at 1441 hours, and 11/14/24 at 0848 hours, Resident 132 was observed lying in bed with bilateral grab rails elevated. Medical record review for Resident 132 was initiated on 11/13/24. Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's Bed System Measurement Device test result Worksheet dated 11/3/24, showed the entrapment zones (1, 2, 3, and 4) for the right side rail were not measured. Further review of the document did not show if entrapment Zones 6 (Between the end of the rail and the side edge of the headboard or footboard) and 7 (Between the headboard or footboard and the end of the mattress) were measured. On 11/15/24 at 0813 hours, an observation and concurrent interview for Resident 132 was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 132's use of the grab rails. The MDS Coordinator stated the maintenance staff was responsible for the entrapment assessment and in charge of the measuring the entrapment zones. On 11/15/24 at 0834 hours, an interview and concurrent facility document review for Resident 132 was conducted with the Maintenance Director. The Maintenance Director stated he used a bed measuring device to measure the entrapment zones every year and when the resident was admitted to the facility. The Maintenance Director verified the above findings, and stated he should have measured entrapment zones (1, 2, 3, and 4,) for the right side rail and Zones 6 and 7 for both side rails were measured. The Maintenance Director stated he was not aware that Resident 132 had bilateral grab rails, so she did not measure for the right side rail entrapment assessment for Resident 132. The Maintenance Director verified he did not measure Zone 6 for the bilateral side rails and Zone 7 of the entrapment assessment for Resident 132 . On 11/15/24 at 1616 hours, an interview for Resident 132 was conducted with the DON. The DON was informed and verified the above findings.