STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555790	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crest Nursing and Rehabilitation Center	797 E Fremont Avenue Sunnyvale, CA 94087

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on observation, interview, and facility document review, the facility failed to treat one of 22 sampled residents (Resident 390) with respect and dignity when Certified Nurse Assistant E (CNA E) was standing while feeding the resident. This failure had the potential to negatively affect residents' emotional and psychosocial well-being. Findings: Review of Resident 390's clinical records indicated he was admitted on [DATE] and had diagnoses including dysphagia (difficulty swallowing). During an observation and interview on 3/26/24 at 8:32 a.m. with CNA E, CNA E was observed standing over Resident 390 while feeding the resident. Licensed Vocational Nurse J (LVN J) was observed in the room for medication administration. CNA E confirmed the observation. CNA E stated she should have sit down while feeding residents but she did not sit down on a chair. During an interview on 3/26/24 at 8:35 a.m. with Licensed Vocational Nurse J, she confirmed the above observation. LVN J stated CNA E should have sit down to the resident's eye level while feeding residents. During a review of the facility's undated policy and procedure (P&P) titled Dignity, the P&P indicated, Each resident shall be cared in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. During a review of the facility's undated policy and procedure (P&P) titled Assistance with Meals, the P&P indicated, Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on interview and record review, the facility failed to document the status of the resident's advance directive (AD, a written set of instructions, such as a living will or durable power of attorney, which is a document that authorizes to act on behalf of the resident for health care when the individual is incapacitated) for one of seven residents investigated (Resident 2). This failure had the potential for the resident's wishes to not be fulfilled, and not address. Findings: Review of Resident 2's face sheet (a document that gives residents' information at a quick glance) indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including angioneurotic edema (which usually presents with episodic and unpredictable swellings of the head and neck, especially of the tongue and oropharynx), subsequent encounter, unspecified heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and unspecified hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Review of Resident 2's clinical records indicated, there was no documentation that the facility verified or obtained an advance directive for Resident 2. There was also no care plan regarding the advance directive of Resident 2. Review of Resident 2's physician orders for life-sustaining treatment (POLST, a document that specifies the medical treatments, the resident wants to receive during serious illness) form, dated 3/29/19, indicated, all options in section D, for advance directive, were left blank. During a concurrent record review of Resident 2's clinical records and interview with the social service director K (SSD K) on 3/27/24 at 1:39 p.m., SSD K verified, section D, for advance directive of Resident 2's POLST, was left blank. SSD K further verified, there was no documentation or care plan regarding her advance directive. During a concurrent record review of Resident 2's clinical records and interview with the registered nurse supervisor (RNS) on 3/28/24 at 9:45 a.m., RNS verified, section D, for advance directive of Resident 2's POLST, was left blank. RNS further verified, there was no documentation or care plan regarding her advance directive. Review of the undated facility's policy and procedures titled Advance Directives indicated, Advance directives will be respected in accordance with state law and facility policy. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives .Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on interview and record review, the facility failed to accurately complete the discharge Minimum Data Set (MDS, an assessment tool) for one of three residents (Resident 79). Failure to accurately assess had the potential to compromise the facility's ability to provide resident-centered discharge care planning and interventions for the resident. Findings: Review of Resident 79's face sheet (a document that gives resident's information at a quick glance) indicated, Resident 79 was admitted to the facility on [DATE] with diagnoses including displaced (the ends of the bone have come out of alignment) intertrochanteric (located between the greater and lesser trochanters and is composed of dense trabecular bone) fracture (broken bone) of left femur (thigh bone), subsequent encounter for closed fracture (a break in the continuity of the bone which does not communicate with the outside of the body) with routine healing, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and essential primary hypertension (high blood pressure that doesn't have a known secondary cause). Review of Resident 79's interdisciplinary team (IDT, a group of dedicated healthcare professionals who work together to provide the care needed and when it is needed) planned discharge summary report indicated, Resident 79 was discharged to home with home health services (medical care delivered in the resident's home) on 12/30/23. Review of Resident 79's section A of the MDS on 3/27/24 at 1:16 p.m., Resident 79's MDS, section A2105, regarding discharge status indicated, Resident 79 was discharged to the short-term general hospital. During a concurrent record review of Resident 79's discharge MDS and interview with the social service director K (SSD K) on 3/27/24 at 2:19 p.m., SSD K confirmed, the coding for Resident 79's discharge MDS was incorrect. SSD K verified, Resident 79 was discharged to home with home health services and not to the short-term general hospital. During a concurrent record review of Resident 79's discharge MDS and interview with the Minimum Data Set Coordinator (MDSC) on 3/27/24 at 2:27 p.m., the MDSC also verified that Resident 79's discharge MDS was incorrectly coded. The MDSC stated, Resident 79 was not discharged to a short-term general hospital but to her home with home health services, and she will update the discharge MDS to correctly code her discharge. During a concurrent record review of Resident 79's discharge MDS and interview with the registered nurse supervisor (RNS) on 3/28/24 at 9:42 a.m., RNS verified, the coding for Resident 79's discharge MDS was incorrect. RNS further verified, Resident 79 was discharged to home with home health services and not to the short-term general hospital. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers for Medicare and Medicaid Services (CMS), October 2023 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions) indicated, for section A2105, Discharge Status, Code 12, Home under care of organized home health service organization.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive, resident-centered care plans for six out of twenty-two sampled residents (Residents 37, 1, 53, 71, 41, and 2), when the activity care plans of Residents 37, 1, 53, 71, 41, and 2 were not comprehensive and resident-centered. These failures had the potential to result in the residents not receiving the interventions necessary to maintain their highest level of well-being. Findings: 1. Review of Resident 37's face sheet (a document that gives the resident's information at a quick glance) indicated, Resident 37 was admitted to the facility on [DATE] with diagnoses including unspecified nondisplaced fracture (the bone typically stays aligned in an acceptable position for healing) of surgical neck of left humerus (a bony constriction at the proximal end of shaft of the upper arm bone), subsequent encounter for fracture (broken bone) with routine healing, history of falling, and other abnormalities of gait (a person's manner of walking) and mobility. During an observation of Resident 37 on 3/25/24 at 10:42 a.m., Resident 37 was sitting in his wheelchair, alert, calm, comfortable, and verbally responsive. He's able to answer the questions asked. Review of Resident 37's active physician orders as of 3/27/24 indicated, Resident 37 may participate in activities, not in conflict with treatment plan ordered on 2/27/24. During the interview with the activity director (AD), on 3/27/24 at 8:51 a.m., AD stated that Resident 37 liked to be alone, wanted the blinds closed, liked his privacy, and also wanted to watch television. AD further stated that they do room visits daily, asking for Resident 37's concerns and desires for his activities. Review of Resident 37's care plans indicated, Resident 37 did not have the specific activities that would be provided to him in his activity care plan. The interventions in the care plan did not mention that he had daily room visits, and there was no mention of the activities that would be provided to him or the activities in which Resident 37 would be participating. Resident 37's activity care plan was not comprehensive and resident-centered, it included measurable objectives and timetables to meet the resident's physical, psychosocia,l and functional needs. During a concurrent record review of Resident 37's activity care plan and interview with the registered nurse supervisor (RNS), on 3/29/24 at 10:08 a.m., RNS verified Resident 37 did not have specific activities to be provided to him in his care plan. RNS further verified, Resident 37's activity care plan was not comprehensive and resident-centered, which includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. RNS then stated that Resident 37 should have a comprehensive, person-centered activity care plan, and the activity care plan of Resident 37 needed to be updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with AD on 3/29/24 at 10:33 a.m., AD verified, Resident 37 did not have specific activities to be provided to him in his care plan. AD further verified, Resident 37's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. AD then stated that Resident 37 should have a comprehensive, resident-centered activity care plan, and she would update Resident 37's activity care plan. 2. Review of Resident 1's face sheet indicated, Resident 1 was readmitted to the facility on [DATE] with diagnoses including unspecified chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), unspecified schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and unspecified hyperlipidemia (a condition in which there are high levels of fat particles in the blood). During an observation of Resident 1 on 3/25/24 at 10:52 a.m., Resident 1 was laying in his bed, alert, oriented, calm, and comfortable. Review of Resident 1's active physician orders as of 3/27/24 indicated, Resident 1 may participate in activities, not in conflict with treatment plan. During the interview with AD on 3/27/24 at 8:43 a.m., AD stated that Resident 1 liked watching television, going outside daily, and smoking outside. AD further stated that they do daily room visits, asking for Resident 1's concerns and desires for his activities. Review of Resident 1's care plans indicated, Resident 1 did not have the specific activities that would be provided to him in his activity care plan. The interventions in the care plan did not mention that he had daily room visits, and there was no mention of the activities that would be provided to him or the activities that Resident 1 would be participating. Resident 1's activity care plan was not comprehensive and resident-centered, that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. During a concurrent record review of Resident 1's activity care plan and interview with RNS, on 3/29/24 at 9:53 a.m., RNS verified, Resident 1 did not have specific activities to be provided to him in his care plan. RNS further verified, Resident 1's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. RNS then stated that Resident 1 should have a comprehensive, person-centered activity care plan, and the activity care plan of Resident 1 needed to be updated. During an interview with AD on 3/29/24 at 10:25 a.m., AD verified, Resident 1 did not have specific activities to be provided to him in his care plan. AD further verified, Resident 1's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. AD then stated that Resident 1 should have a comprehensive, resident-centered activity care plan, and she would update Resident 1's activity care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident 53's face sheet indicated, Resident 53 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), unspecified severity (seriousness of the condition), with other behavioral disturbance, hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the vessels that supply it) affecting right dominant side, and essential primary hypertension (high blood pressure that doesn't have a known secondary cause). During an observation of Resident 53 on 3/25/24 at 10:58 a.m., Resident 53 was laying in his bed, appeared calm, confused, and comfortable. Review of Resident 53's active physician orders as of 3/27/24 indicated, Resident 53 may participate in activities, not in conflict with treatment plan ordered on 6/25/21. During the interview with AD on 3/27/24 at 8:31 a.m., AD stated that Resident 53 had room visits daily, aroma therapy, blessings, and prayers for his activities. Review of Resident 53's care plans indicated, Resident 53 did not have the specific activities that would be provided to him in his activity care plan. The interventions in the care plan did not mention that he had daily room visits, and there was no mention of the activities that would be provided to him or the activities that Resident 53 would be participating. Resident 53's activity care plan was not comprehensive and resident-centered, that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. During a concurrent record review of Resident 53's activity care plan and interview with RNS on 3/29/24 at 9:35 a.m., RNS verified, Resident 53 did not have specific activities to be provided to him in his care plan. RNS further verified, Resident 53's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. RNS then stated that Resident 53 should have a comprehensive, person-centered activity care plan, and the activity care plan of Resident 53 needed to be updated. During an interview with AD on 3/29/24 at 10:18 a.m., AD verified, Resident 53 did not have specific activities to be provided to him in his care plan. AD further verified, Resident 53's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. AD then stated that Resident 53 should have a comprehensive, resident-centered activity care plan, and she will update Resident 53's activity care plan. 4. Review of Resident 71's face sheet indicated, Resident 71 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction, type 2 diabetes mellitus (adult-onset high blood sugar) without complications, and essential primary hypertension. During an observation of Resident 71 on 3/25/24 at 12:10 p.m., Resident 71 was sitting in her wheelchair, alert, calm, comfortable, and verbally responsive. Review of Resident 71's active physician orders as of 3/27/24 indicated, Resident 71 may participate in activities, not in conflict with treatment plan ordered on 12/29/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview with AD on 3/27/24 at 8:49 a.m., AD stated that Resident 71 liked watching television and had room visits daily. Review of Resident 71's care plans indicated, Resident 71 did not have the specific activities that would be provided to her in her activity care plan. The interventions in the care plan did not mention that she had daily room visits, and there was no mention of the activities that would be provided to her or the activities that Resident 71 would be participating. Resident 71's activity care plan was not comprehensive and resident-centered, that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. During a concurrent record review of Resident 71's activity care plan and interview with the RNS on 3/29/24 at 10:05 a.m., the RNS verified, Resident 71 did not have specific activities to be provided to her in her care plan. The RNS further verified, Resident 71's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. The RNS then stated that Resident 71 should have a comprehensive, person-centered activity care plan, and the activity care plan of Resident 71 needed to be updated. During an interview with AD, on 3/29/24 at 10:29 a.m., AD verified, Resident 71 did not have specific activities to be provided to her in her care plan. AD further verified, Resident 71's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. AD then stated that Resident 71 should have a comprehensive, resident-centered activity care plan, and she will update Resident 71's activity care plan. 5. Review of Resident 41's face sheet indicated, Resident 41 was admitted to the facility on [DATE] with diagnoses including unspecified Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertensive heart disease (constellation of changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation) with heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and unspecified insomnia (sleep disorder where people have trouble sleeping). During an observation of Resident 41 on 3/25/24 at 1:50 p.m., Resident 41 was laying in her bed, alert, calm, comfortable, and verbally responsive. Review of Resident 41's active physician orders as of 3/27/24 indicated, Resident 41 may participate in activities, not in conflict with treatment plan ordered on 3/11/20. During the interview with AD on 3/27/24 at 8:45 a.m., AD stated that Resident 41 liked talking to staff, socialization, stuffed toys, comedy shows, old movies, and religious movies. Resident 41 also had daily room visits. Review of Resident 41's care plans indicated, Resident 41 did not have the specific activities that would be provided to her in her activity care plan. The interventions in the care plan did not mention that she had daily room visits, and there was no mention of the activities that would be provided to her or the activities that Resident 41 would be participating. Resident 41's activity care plan was not comprehensive and resident-centered, that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 41's activity care plan and interview with the RNS on 3/29/24 at 10:00 a.m., the RNS verified, Resident 41 did not have specific activities to be provided to her in her care plan. The RNS further verified, Resident 41's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. The RNS then stated that Resident 41 should have a comprehensive, person-centered activity care plan, and the activity care plan of Resident 41 needed to be updated. During an interview with AD on 3/29/24 at 10:27 a.m., AD verified, Resident 41 did not have specific activities to be provided to her in her care plan. AD further verified, Resident 41's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. AD then stated that Resident 41 should have a comprehensive, resident-centered activity care plan, and she will update Resident 41's activity care plan. 6. Review of Resident 2's face sheet indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including angioneurotic edema (usually presents with episodic and unpredictable swellings of the head and neck, especially of the tongue and oropharynx), subsequent encounter, unspecified heart failure, and unspecified hyperlipidemia. During an observation of Resident 2 on 3/25/24 at 1:53 p.m., Resident 2 was laying in her bed, alert, calm, comfortable, and verbally responsive. Review of Resident 2's active physician orders as of 3/27/24 indicated, Resident 2 may participate in an approved activity plan, if not in conflict with resident's treatment plan, ordered on 1/25/19. During the interview with AD on 3/27/24 at 8:39 a.m., AD stated that Resident 2 liked current events, watching television, and using the iPad (brand name of a touchscreen tablet computer). Resident 2 had daily room visits. Review of Resident 2's care plans indicated, Resident 2 did not have the specific activities that would be provided to her in her activity care plan. The interventions in the care plan did not mention that she had daily room visits, and there was no mention of the activities that would be provided to her or the activities that Resident 2 would be participating. Resident 2's activity care plan, was not comprehensive and resident-centered, that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. During a concurrent record review of Resident 2's activity care plan and interview with the RNS on 3/29/24 at 9:49 a.m., the RNS verified, Resident 2 did not have specific activities to be provided to her in her care plan. The RNS further verified, Resident 2's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. The RNS then stated that Resident 2 should have a comprehensive, person-centered activity care plan, and the activity care plan of Resident 2 needed to be updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with AD on 3/29/24 at 10:21 a.m., AD verified, Resident 2 did not have specific activities to be provided to her in her care plan. AD further verified, Resident 2's activity care plan was not comprehensive and resident-centered, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. AD then stated that Resident 2 should have a comprehensive, resident-centered activity care plan, and she will update Resident 2's activity care plan. Review of the undated facility's policy and procedures titled, Care Plan, indicated, Our facility develops a resident-centered comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and psychological needs. An Interdisciplinary Assessment team (provides care in which several disciplines coordinates assessment and treatment, so that problems can be dealt with consistently and comprehensively) in coordination with the resident and his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident. Care plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly.

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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** 44733 Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with professional standards of practice for one of 22 sampled residents (Resident 390) when staff failed to ensure oxygen was administered as specified in the physician's order. This failure had the potential to compromise the residents' health and safety. Findings: Review of Resident 390's clinical records indicated he was admitted on [DATE] and had diagnoses including chronic respiratory failure (inability to keep oxygen and carbon dioxide at normal levels). Review of Resident 390's physician's order, dated 3/21/24, indicated he was to receive oxygen (O2) at 2 liters per minute (LPM, rate of oxygen administration) via a nasal cannula (flexible tubing placed into the nostrils and connected to an oxygen source) every shift. Review of Resident 390's care plan for admitted on oxygen therapy indicated, Administer oxygen as ordered by physician. During an observation on 3/27/24 at 8:08 a.m., Resident 390's oxygen concentrator (the machine used to deliver oxygen) was set at 4 LPM. During an observation on 3/27/24 at 12:17 p.m., Resident 390's oxygen concentrator was set at 4 LPM. During an interview and record review on 3/27/24 at 12:19 p.m. with Licensed Vocational Nurse J (LVN J), she reviewed Resident 390's oxygen order and confirmed he was to receive oxygen at 2 LPM via nasal cannula. During an observation and interview on 3/27/24 at 12:21 p.m. with LVN J, Resident 390's oxygen concentrator was set at 4 LPM. LVN J confirmed the observation. LVN J stated the oxygen concentrator for Resident 390 should have been set at 2 LPM and not on 4 LPM. LVN J confirmed staff should have administer oxygen as ordered by the physician. During an interview on 3/27/24 at 12:57 p.m. with the Registered Nurse Supervisor (RNS), she acknowledged staff should ensure the oxygen was administered at the prescribed rate. During a review of the facility's undated policy and procedure (P&P) titled Physician Orders, the P&P indicated, 4. A physician's order is needed for diets, therapies, and other treatments as required under State and Federal regulations. During a review of the facility's undated policy and procedure (P&P) titled Oxygen Administration, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview and record review, the facility failed to consistently complete the dialysis (the clinical purification of blood as a substitute for the normal function of the kidney) communication form after dialysis for one of five residents (Resident 381) who received dialysis services. This failure had the potential to compromise the facility's ability to identify and address potential complications after dialysis. Findings: Review of Resident 381's clinical record indicated she was admitted on [DATE] and had diagnoses including end stage renal disease (kidneys are no longer able to work as they should to meet the body's needs). The clinical record further indicated Resident 381 received dialysis on Tuesdays, Thursdays, and Saturdays. Review of Resident 381's dialysis communication forms indicated that To be filled up by licensed nurse receiving patient from dialysis on the dialysis communication form was not completed consistently. The dialysis communication form was to be completed by the facility nurses upon Resident 381's return from dialysis. The To be filled up by licensed nurse receiving patient from dialysis on the dialysis communication form was to be completed with information including his vital signs: temperature; heart rate; respirator rate; blood pressure; oxygen saturation; blood sugar; and pain upon returning to the facility. There was no documentation of vital signs on 3/24/24, which was signed by Registered Nurse G (RN G), and no documentation of blood sugar on 3/26/24, which was signed by Licensed Vocational Nurse C (LVN C). During an interview and concurrent record review on 3/27/24 at 9:45 a.m. with RN G, she stated the nurse should have filled up the dialysis form To be filled up by licensed nurse receiving patient from dialysis on the dialysis communication form upon the resident's return from dialysis. RN G reviewed Resident 381's dialysis communication forms and confirmed the above record review. RN G stated she did not check Resident 381's vital signs, but LVN C might have checked the resident's vital signs when the resident returned from dialysis on 3/24/24. RN G acknowledged she should have completed the To be filled up by licensed nurse receiving patient from dialysis on the dialysis communication form when Resident 381 returned from dialysis on 3/24/24. During an interview on 3/27/24 at 9:50 a.m. with LVN C, he stated there was no documentation indicating he checked Resident 381's vital signs when the resident returned from dialysis on 3/24/24. During an interview and concurrent record review on 3/27/24 at 9:51 a.m. with LVN C, he reviewed Resident 381's dialysis communication forms and confirmed the above record review. LVN C acknowledged he should have completed the To be filled up by licensed nurse receiving patient from dialysis on the dialysis communication form when Resident 381 returned from dialysis on 3/27/24. During a review of the facility's undated policy and procedure (P&P) titled Care of Dialysis Resident, the P&P indicated, It is the policy of this facility to provide nursing care that maintains the patency of arteriovenous shunts, prevents complications, and identifies specific measures to be followed if complications occur. Post Dialysis: 1. Take vital signs upon return from dialysis.

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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. 26917 Based on observations, interviews, and a review of records, it was found that the facility failed to maintain a medication error rate of less than 5%. During the medication pass, four medication errors were observed out of thirty opportunities for three of seven residents, resulting in an error rate of 13%. Findings: A review on 3/26/24 of Resident 19's clinical record revealed a physician's order for Flonase (Fluticasone) 50 microgram, with the following instructions: *Administration: One spray in each nostril *Frequency: Once daily *Indication: Treatment of allergies During an observation on 03/26/24 at 8:02 AM, a Licensed Vocational Nurse A (LVN A) administered Flonase to Resident 19. LVN A sprayed two sprays in each nostril instead of the prescribed one spray in each nostril as indicated in the physician's orders. This discrepancy between the prescribed dosage and the actual administration could potentially result in an excessive dose, which may lead to adverse effects or reduced treatment efficacy. During an interview conducted on 03/26/24 at 2:45 PM, LVN A confirmed administering two sprays of Flonase in each nostril to Resident 19. LVN A acknowledged the discrepancy between the administered dosage and the physician's orders, attributing it to initial confusion about how the orders were written. After clarifying the intended dosage, the LVN A stated that they now understand the prescription requires only one spray in each nostril and committed to adhering to the correct dosage for future administrations. A review on 3/26/24 of the manufacturer's guidelines for the proper administration of Flonase 50 microgram nasal spray are as follows: Firstly, blow your nose gently to clear your nostrils. Then, close one nostril by pressing your finger against the side of your nose. Tilt your head forward slightly and keep the bottle upright. Carefully insert the nasal applicator into the open nostril. While breathing in through your nose, press firmly and quickly down one time on the applicator to release the spray and ensure a full dose is delivered. Use your index finger and middle finger to activate the spray while supporting the base of the bottle with your thumb. After administration, breathe out through your mouth. Finally, wipe the nasal applicator with a clean tissue and replace the dust cap and safety clip. Adhering to these guidelines will help maximize the effectiveness of the medication and maintain resident safety during administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/26/24 at 8:02 AM, a Licensed Vocational Nurse A (LVN A) administered physician prescribed Flonase 50 microgram nasal spray 1 spray in each nostril to Resident 19. However, LVN A did not adhere to the recommended administration guidelines as follows: *Failed to instruct the resident to blow their nose before administering the nasal spray. *Did not close the opposite nostril during administration, which may reduce the medication's efficacy. *Neglected to follow the general manufacturer's instructions while administering Flonase nasal spray including not wiping the nasal applicator with a clean tissue. During an interview on 3/26/24 at 8:12 AM LVN A said he did not follow the manufacturer guidelines for the administration of Flonase nasal spray. LVN A admitted that he had forgotten at the time of the administration. LVN A expressed his commitment to ensuring proper administration in the future and stated that they would strive for improvement. A review on 3/26/24 of the manufacturer's insert for Brimonidine (Alphagan) 0.1% ophthalmic solution provides crucial instructions to prevent contamination and ensure proper administration. These are as follows: Firstly, avoid touching the tip of the bottle with eyelashes or any other surface to minimize the risk of contamination. Secondly, wash your hands before using eye drops to maintain proper hygiene. Thirdly, tilt your head back and gently pull down the lower eyelid to create a small pocket. Then, position the dropper above the eye and gently squeeze the bottle to release one drop into the affected eye(s). Finally, close your eye(s) for 1 to 2 minutes after administering the drop and press your index finger gently against the inner corner of the eye to prevent the medication from draining. During an observation on 3/26/24 at 8:02 AM, LVN A administered physician prescribed Alphagan ophthalmic solution one drop to both eyes for Resident 19. However, LVN A did not adhere to the manufacturer's recommended guidelines, as observed through the following actions: *Allowed the tip of the eye drop bottle to contact the eyelashes of both eyes, increasing the risk of contamination. *Failed to follow the manufacturer's instructions for proper administration technique, which may affect the medication's effectiveness and resident safety. LVN A failed to instruct Resident 19 to keep their eye(s) closed for 1 to 2 minutes after administering the eye drop, and to gently press their index finger against the inner corner of the eye. This step is crucial to prevent the medication from draining away. During an interview on 3/26/24 at 8:12 AM LVN A said he did not follow the manufacturer guidelines for the administration of Alphagan ophthalmic solution. LVN A admitted that he had forgotten at the time of the administration. LVN A expressed his commitment to ensuring proper administration in the future and stated that they would strive for improvement. A review conducted on 3/26/24, using Lexicomp Online, a nationally recognized drug information resource, revealed that for MiraLAX (Polyethylene Glycol) to stir powder in 120 to 240 ml (4 to 8 ounces) of water, juice, soda, coffee, or tea .until dissolved and administer immediately. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/26/24 at 8:24 AM, LVN B administered physician prescribed Polyethylene Glycol (MiraLAX) 17 g to Resident 61. However, the administration process did not follow optimal guidelines, as observed in the following steps: * The LVN mixed MiraLAX with approximately 8 ounces (about 236.59 ml) of water, but the mixing was not thorough enough to ensure proper dissolution. This was evident as the solute could still be seen at the bottom of the glass. *After the mixture was handed over, Resident 61 drank less than half of the mixture. However, the MiraLAX that had settled at the bottom of the glass remained there even after Resident 61 placed the glass back on the table. This suggests that most of the MiraLAX was not consumed. *Resident 61 consumed less than half of the mixture, leaving a substantial amount of undissolved MiraLAX powder in the glass. As a result, Resident 61 did not receive the full prescribed dose of MiraLAX due to inadequate mixing and incomplete consumption. To ensure proper administration of MiraLAX and other medications requiring reconstitution, healthcare providers should follow recommended guidelines and thoroughly mix the solution before administering it to the resident. During an interview on 3/26/24 at 8:35 AM LVN B admitted to not adhering to the manufacturer's guidelines for the preparation of the MiraLAX solution. He acknowledged his awareness of the need for thorough mixing. LVN B confessed that he had overlooked the necessity to fully mix the solution and instruct Resident 61 to consume the entire glass immediately. Despite this, LVN B expressed a firm commitment to ensure proper administration in the future and pledged to strive for improvement. During an observation on 3/26/24 at 8:58 AM, LVN C administered physician prescribed MiraLAX 17 g to Resident 75. During the medication administration process, several actions were observed. LVN C provided Resident 75 with a glass containing an 8-ounce mixture of MiraLAX. However, Resident 75 only took a small sip of the mixture, leaving most of it in the glass (approximately 95% of the mixture was still present). Resident 75 then set the glass on her bedside table. Notably, LVN C departed without ensuring that the medication was fully consumed. As a result, Resident 75 did not receive the full prescribed dose of MiraLAX. During an interview on 3/26/24 at 9:10 AM LVN C confessed to leaving before confirming that Resident 75 had completely consumed her MiraLAX. He recognized that if MiraLAX is not consumed promptly, it could thicken and potentially choke the resident. He attributed this oversight to an error in judgement and pledged to improve his practices in the future.

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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. 44185 Based on observation, interview, and record review, the facility failed to ensure kitchen utensils and equipment were maintained in good condition and stored in accordance with professional standards for safety when baking pans and magnetic knife holder were not kept in good working conditions. These failures had the potential to cause the growth of microorganisms, which could cause foodborne illness (illness caused by food or water contaminated with bacteria, viruses, parasites, or toxins) and cross contamination of food that could affect the 81 residents residing and consuming food at the facility. Findings: During the initial kitchen tour observation on 3/25/2024 at 9:21 a.m. with the dietary supervisor (DS), observed ten baking pans with brownish to dark colored spots that looked dirty and rusty and one magnetic knife holder with kitchen knives attached to it with brownish discolorations that looked dirty and rusty as well. During an interview with the DS on 3/25/24 at 9:30 a.m., the DS verified the ten baking pans that looked dirty and rusty and removed them right away. The DS also verified the magnetic knife holder with kitchen knives attached that also looked dirty and rusty, and stated that he would clean it. During an interview with the registered dietitian (RD) on 3/28/24 at 1:25 p.m., the RD verified baking pans and the magnetic knife holder should be kept clean and free of rust and would remind the DS about them. Review of the facility's undated policy and procedures titled Sanitation, indicated, The food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, and cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 26917 Based on observation and interview it was found that the hospital's Quality Assessment Performance Improvement (QAPI) program was ineffective. Despite its purpose to proactively identify and prevent medication administration errors, it fell short. This was evident during a medication pass observation conducted during the survey, which revealed a concerning 13% medication error rate (See F759). Findings: On 3/26/24, a review of Resident 19's clinical record revealed a physician's order for Flonase (Fluticasone) 50 micrograms. The instructions were to administer one spray in each nostril once daily for the treatment of allergies. However, during an observation at 8:02 AM on the same day, a Licensed Vocational Nurse A (LVN A) administered Flonase to Resident 19 but did not follow the prescribed instructions. Instead of one spray in each nostril, LVN A sprayed two sprays in each nostril. This discrepancy between the prescribed dosage and the actual administration could potentially result in an excessive dose, leading to adverse effects or reduced treatment efficacy. Later that day, at 2:45 PM, during an interview, LVN A confirmed administering two sprays of Flonase in each nostril to Resident 19. LVN A acknowledged the discrepancy between the administered dosage and the physician's orders, attributing it to initial confusion about how the orders were written. After clarifying the intended dosage, LVN A stated that they now understand the prescription requires only one spray in each nostril and committed to adhering to the correct dosage for future administrations. On the morning of 3/26/24, at 8:02 AM, an observation was conducted where a Licensed Vocational Nurse A (LVN A) was seen administering a physician-prescribed Flonase 50 microgram nasal spray to Resident 19. The prescribed dosage was one spray in each nostril. However, LVN A deviated from the recommended administration guidelines in several ways. Firstly, LVN A failed to instruct the resident to blow their nose before administering the nasal spray. Secondly, LVN A did not close the opposite nostril during administration, which could potentially reduce the medication's efficacy. Lastly, LVN A neglected to follow the general manufacturer's instructions while administering Flonase nasal spray, including not wiping the nasal applicator with a clean tissue. Later that day, at 8:12 AM, LVN A was interviewed and admitted to not following the manufacturer guidelines for the administration of Flonase nasal spray. LVN A acknowledged being aware of the proper administration guidelines for Flonase nasal spray but admitted to having forgotten them at the time of administration. LVN A expressed a commitment to ensuring proper administration in the future and stated a desire to strive for improvement. This incident underscores the importance of adhering to manufacturer guidelines to ensure the safety and efficacy of medication administration. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the morning of 3/26/24, at 8:02 AM, an observation was made where a Licensed Vocational Nurse A (LVN A) was seen administering a physician prescribed Alphagan ophthalmic solution, one drop to both eyes, to Resident 19. However, LVN A did not adhere to the manufacturer's recommended guidelines. Specifically, LVN A allowed the tip of the eye drop bottle to contact the eyelashes of both eyes, which increases the risk of contamination. Furthermore, LVN A failed to follow the manufacturer's instructions for proper administration techniques, which could affect the medication's effectiveness and resident safety. LVN A did not instruct Resident 19 to keep their eyes closed for 1 to 2 minutes after administering the eye drop, nor did they instruct the resident to gently press their index finger against the inner corner of the eye, a crucial step to prevent the medication from draining away. Later that day, at 8:12 AM, LVN A was interviewed and admitted to not following the manufacturer guidelines for the administration of Alphagan ophthalmic solution. LVN A expressed a commitment to ensuring proper administration in the future and stated a desire to strive for improvement. This incident underscores the importance of adhering to manufacturer guidelines to ensure the safety and efficacy of medication administration. On 3/26/24, at 8:24 AM, an observation was made where a Licensed Vocational Nurse B (LVN B) administered a physician prescribed dose of Polyethylene Glycol (MiraLAX) 17 g to Resident 61. However, the administration process did not adhere to optimal guidelines. Specifically, LVN B mixed MiraLAX with approximately 8 ounces (about 236.59 ml) of water, but the mixing was not thorough enough to ensure proper dissolution. This was evident as the solute could still be seen at the bottom of the glass. After the mixture was handed over, Resident 61 drank less than half of the mixture. However, the MiraLAX that had settled at the bottom of the glass remained there even after Resident 61 placed the glass back on the table. This suggests that most of the MiraLAX was not consumed. As a result, Resident 61 did not receive the full prescribed dose of MiraLAX due to inadequate mixing and incomplete consumption. To ensure proper administration of MiraLAX and other medications requiring reconstitution, healthcare providers should follow recommended guidelines and thoroughly mix the solution before administering it to the resident. On 3/26/24, at 8:58 AM, an observation was made where a Licensed Vocational Nurse C (LVN C) administered a physician-prescribed dose of MiraLAX 17 g to Resident 75. During the medication administration process, LVN C provided Resident 75 with a glass containing an 8-ounce mixture of MiraLAX. However, Resident 75 only took a small sip of the mixture, leaving most of it in the glass. Resident 75 then set the glass on her bedside table. Notably, LVN C departed without ensuring that the medication was fully consumed. As a result, Resident 75 did not receive the full prescribed dose of MiraLAX. Later that day, at 9:10 AM, LVN C was interviewed and confessed to leaving before confirming that Resident 75 had completely consumed her MiraLAX. He recognized that if MiraLAX is not consumed promptly, it could thicken and potentially choke the resident. He attributed this oversight to an error in judgement and pledged to improve his practices in the future. This incident underscores the importance of adhering to manufacturer guidelines to ensure the safety and efficacy of medication administration. During an interview conducted on 3/27/24 at 9:09 AM, The Assistant Administrator stated that she was involved with the QAPI program, and she expressed her unawareness of any medication administration issues within the facility. She further stated that the Quality Assessment Performance Improvement (QAPI) program had neither identified nor addressed any medication administration issues. Additionally, there were no ongoing performance improvement projects aimed at enhancing the medication administration process. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It is important for healthcare organizations to continuously assess and monitor medication administration processes, identify areas for improvement, and implement appropriate interventions to reduce the risk of medication errors. The apparent lack of awareness regarding medication administration issues and the QAPI program's failure to address such concerns indicated a gap in the facility's quality assurance practices. The facility failed to provide any documented proof that medication administration errors were being reviewed or that any performance improvement projects were in place to address these errors. This lack of evidence raises concerns about the facility's commitment to quality assurance and resident safety. It's crucial for healthcare facilities to have robust systems in place to monitor, review, and rectify medication administration errors to ensure optimal resident care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42819 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. One laundry staff did not perform hand hygiene before handling clean linens and residents' personal clothings; and 2. For Resident 381, staff did not perform hand hygiene during her treatment. These failures had the potential to spread infections, and compromise resident's health and safety in the facility. Findings: 1. During an observation and concurrent interview with the maintenance director (MD) on 3/28/24, at 11:00 a.m., in the laundry room, the MD stated that the clean area was located on the right side of the room, designated for linens (such as sheets, blankets, and pillows), towels, bibs, and residents' personal clothing. It was noted that laundry staff H (LS H) entered the laundry room and began folding linens in the designated clean area. Subsequently, LS I entered the laundry room and performed hand hygiene before handling clean linens and residents' personal clothing, while LS H did not. The MD was informed of the observation, the MD stated that LS H had just started her shift, and the MD stated that all laundry staff should have washed their hands before handling clean linens and residents' personal clothing in the designated area. During an interview with the Infection Preventionist (IP) on 3/29/24, at 12:30 p.m., the IP was informed of the above observation. The IP stated the importance of LS H washing her hands before handling clean linens, bedding, and residents' personal clothing, emphasizing the need for sanitary handling of residents' clean belongings. Review of the facility's undated policy and procedure titled Handwashing/Hand Hygiene, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty . 44733 2. Review of Resident 381's clinical record indicated she was admitted on [DATE] and had diagnoses including acquired absence (removed or amputated) of left leg below knee and pressure ulcer (injury to the skin and underlying tissue from prolonged pressure) of sacral region (the portion of the spine between the lower back and tailbone). During a wound treatment observation on 3/28/24 at 7:38 a.m., Certified Nurse Assistant D (CNA D) with gloves removed pillows under Resident 381's leg and turned Resident 381 to her right side. Licensed Vocational Nurse F (LVN F) provided wound treatment for Resident 381's coccyx area. Then CNA D applied a diaper without performing hand hygiene or changing his gloves. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/28/24 at 7:55 a.m., CNA D, with the same gloves, turned Resident 381 to her back and held her left leg above the knee. LVN F provided wound treatment on Resident 381's surgical wound on the left leg amputation area. LVN F's gloved hands were observed touching CNA D's gloved hands multiple times during the treatment. During an observation on 3/28/24 at 8:09 a.m., CNA D, with the same gloves, placed pillows under Resident 381's leg and put the blanket over for the resident without performing hand hygiene or changing his gloves. During an interview on 3/28/24 at 8:13 a.m. with CNA D, he confirmed the above observation. CNA D stated he should have performed hand hygiene and changed his gloves after the wound treatment for Resident 381 on the coccyx area and also after the wound treatment on the leg, but he forgot to do it. During an interview on 3/28/24 at 8:16 a.m. with LVN F, she confirmed the above observation. LVN F stated CNA D should have performed hand hygiene and changed his gloves during the wound treatment procedure, as well as before starting another wound treatment for infection control. During a review of the facility's undated policy and procedure (P&P) titled Handwashing/Hand Hygiene, the P&P indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: Before and after direct contact with residents; Before handling clean or soiled dressings, gauze pads, etc.; Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident's intact skin.