

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Veterans Home of California - Chula Vista		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Naples Court Chula Vista, CA 91911	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>39119</p> <p>Based on interview and record review, the facility failed to ensure a copy of a notice of transfer/discharge was sent to the Ombudsman (an advocate for residents of nursing homes) for three of 44 sampled residents (Residents 19, 47, and 99) when:</p> <ol style="list-style-type: none"> <li>1. Resident 19 was transferred to the hospital on 1/22/2025.</li> <li>2. Resident 47 was transferred to the hospital on 8/27/2024.</li> <li>3. Resident 99 was transferred to the hospital on 1/8/2025.</li> </ol> <p>This failure had the potential for residents to be inappropriately transferred or discharged which could result in violating their rights.</p> <p>Findings:</p> <p>1. During a review of Resident 19's Physician's Progress Note, dated 12/4/2024, the Physician's Progress Note indicated Resident 19 had diagnoses of diabetes mellitus (a disorder that results in too much sugar in the blood) and sacral (buttocks) moisture associated skin damage (MASD, skin irritation caused by prolonged exposure to moisture usually from incontinence).</p> <p>During a review of Resident 19's Physician's Orders, dated 1/22/2025, the Physician's Orders indicated, for Resident 19 to be Send to [hospital's name] for further evaluation and treatment related to left and right buttocks wound.</p> <p>Further review of Resident 19's medical record indicated there was no documented evidence that the ombudsman was notified of Resident 19's transfer to the hospital on 1/22/2025.</p> <p>During an interview on 1/29/2025 at 4:05 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility does not notify an ombudsman when a resident is transferred to the hospital or discharged from the facility.</p> <p>During an interview on 1/30/2025 at 11:56 a.m. with the ADON, the ADON stated he was not aware the ombudsman had to be notified of resident transfers or discharges.</p> <p>(continued on next page)</p>

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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Transfer/Discharge, dated 9/27/2022, the P&amp;P did not address notifying the ombudsman of resident transfers/discharges.</p> <p>2. During a review of Resident 47's Physician's Progress Note, dated 12/9/2024, the Physician's Progress Note indicated Resident 47 was readmitted to the facility from the hospital on 12/7/2024 with a diagnosis of status post right above knee amputation. The Physician's Progress Note further indicated Resident 47 was hospitalized from 8/27/2024 - 12/6/2024.</p> <p>During a review of Resident 47's Nursing Notes, dated 8/27/2024 at 10:46 p.m., the Nursing Notes indicated the facility placed a call to [hospital's name] and was informed that Resident 47 will be admitted .</p> <p>Further review of Resident 47's medical record indicated there was no documented evidence that the ombudsman was notified of Resident 47's transfer to the hospital on 8/27/2024.</p> <p>During an interview on 1/29/2025 at 4:05 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility does not notify an ombudsman when a resident is transferred to the hospital or discharged from the facility.</p> <p>During an interview on 1/30/2025 at 11:56 a.m. with the ADON, the ADON stated he was not aware the ombudsman had to be notified of resident transfers or discharges.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Transfer/Discharge, dated 9/27/2022, the P&amp;P did not address notifying the ombudsman of transfers/discharges.</p> <p>50148</p> <p>3. During a review of Resident 99's Admission Face Sheet Record (demographics), [undated], the Face Sheet indicated Resident 99 had a diagnosis of osteomyelitis (a chronic bone infection).</p> <p>During a review of Resident 99's Physician Order, the Physician Order indicated, send Resident 99 to [hospital's name] on 1/8/2025 for further evaluation and treatment related to the bone infection.</p> <p>Further review of Resident 99's medical record indicated there was no documented evidence that the ombudsman was notified of Resident 99's transfer to the hospital on 1/8/2025.</p> <p>During an interview on 1/29/2025 at 4:05 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility does not notify the ombudsman when a resident is transferred to the hospital or discharged from the facility. The ADON confirmed that the ombudsman was not notified when Resident 99 was transferred out.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Transfer/Discharge, dated 9/27/2022, the P&amp;P did not address notifying the ombudsman of transfers/discharges.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>39119</p> <p>Based on interview and record review, the facility failed to provide a written bed hold policy notification to one of 44 sampled residents (Resident 47) and/or his representative upon Resident 47's transfer to an acute care hospital on 8/27/2024.</p> <p>This failure had the potential for Resident 44 and/or his representative to not be informed of his rights to return to the facility following hospitalization .</p> <p>Findings:</p> <p>During a review of Resident 47's Physician's Progress Note, dated 12/9/2024, the Physician's Progress Note indicated Resident 47 was readmitted to the facility from the hospital on 12/7/2024 with a diagnosis of status post right above knee amputation. The Physician's Progress Note further indicated Resident 47 was hospitalized from 8/27/2024 - 12/6/2024.</p> <p>During a review of Resident 47's Nursing Notes, dated 8/27/2024 at 10:46 p.m., the Nursing Notes indicated the facility placed a call to [hospital's name] and was informed that Resident 47 will be admitted .</p> <p>Further review of Resident 47's medical record indicated there was no documented evidence of a bed hold notification to Resident 47 and/or his representative.</p> <p>During an interview on 1/29/2025 at 3:27 p.m., with Registered Nurse 5 (RN 5), RN 5 stated a bed hold notification was not completed for Resident 47 when he transferred to the hospital on 8/27/2024.</p> <p>During an interview on 1/30/2025 at 12:01 p.m., with RN 6, RN 6 stated the facility should have completed a bed hold notification form for Resident 47 when he transferred to the hospital on 8/27/2024.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Bed Hold Policy, dated 1/29/2025, the P&amp;P indicated, If a Resident is transferred to a general acute hospital, the facility will afford the Resident a bed hold of seven (7) days, which may be exercised by the Resident or the Resident's representative . II. Transfer/Discharge To Acute A. When a Resident is transferred to an acute hospital the licensed nurse will: 1. Notify the Resident, family or legal representative of the reason for the transfer in a language and manner they understand. 2. If a Resident is alert, discuss bed hold notification/election form and provide a copy and file the original form in the medical record. 3. If the Resident has a responsible party, notify and discuss the bed hold notification/election form. Explain that the form will be mailed to him/her by the Veterans Home designated department for his/her signature and must be mailed back as soon as possible.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38924</p> <p>50674</p> <p>Based on observation, interview, and record review, the facility failed to ensure a person-centered care plan for weight loss was updated for one of 44 sampled residents (Resident 20).</p> <p>This failure had the potential for Resident 20 not to receive nutrition interventions and treatments according to evaluation of his needs and contributing to continued weight loss.</p> <p>Cross reference F692 and F801</p> <p>Findings:</p> <p>During a review of Resident 20's Admission Face Sheet Record (demographics), [undated], the Face Sheet indicated Resident 20 was admitted on [DATE] with diagnoses of Hypertension (HTN, high blood pressure), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 12/5/2024, the MDS indicated the Resident 20 had a BIMS (brief interview of mental status) score of 10 (moderate impairment) and experienced a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, but was not on a physician-prescribed weight-loss regimen.</p> <p>During a review of Resident 20's Monthly Weights, from 6/20/2024 - 1/18/2025 indicated:</p> <p>6/20/2024 -136.1 lbs. (pounds)</p> <p>7/20/2024 -132.8 lbs.</p> <p>8/17/2024 -128.4 lbs.</p> <p>9/21/2024 -129.8 lbs.</p> <p>10/19/2024 -128 lbs.</p> <p>11/6/2024 - 126 lbs.</p> <p>12/21/2024 - 121.8 lbs.</p> <p>1/18/2025 - 118.4 lbs.</p> <p>Resident 20 experienced an unintentional weight loss of 7.79% from August 2024 through January 2025.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 1/29/2025 at 9:30 a.m., with Resident 20 in the resident's room, Resident 20 was sitting in his wheelchair next to his bed watching television. Resident 20 stated that he ate breakfast, but he was not a heavy eater. Resident 20 stated he preferred eating vegetables and fruits, and he liked grilled cheese and tuna sandwiches. Resident 20 stated he was aware that he had lost weight because he remembered he was 160 pounds in 2023 and has lost 40 pounds, but did not know how. Resident 20 further stated the Dietitian was aware of his food preferences.</p> <p>During a review of Resident 20's ADL (Activities of Daily Living) Supplemental Flow Sheet, indicated the following:</p> <p>For the Month of December 2024:</p> <p>Average Breakfast Consumed was 55%</p> <p>Average Lunch Consumed was 51%</p> <p>Average Dinner Consumed was 48%</p> <p>For the Month of January 2025:</p> <p>Average Breakfast Consumed was 49%</p> <p>Average Lunch Consumed was 51%</p> <p>Average Dinner Consumed was 44%</p> <p>During an interview on 1/30/2025 at 10:11 a.m., with Registered Nurse 3 (RN 3), RN 3 stated Resident 20 had an order for Prostat (a concentrated liquid protein drink). RN 3 further stated she would offer Resident 20 substitutions for his food but she did not give it to Resident 20 for breakfast.</p> <p>During a review of the Resident 20's Physician Orders, dated 1/17/2025, indicated Prostat supplement 30 ml (milliliters), PO (by mouth), BID (twice a day).</p> <p>During a review of Resident 20's Medication Administration Record (MAR), dated 1/1/2025- 1/31/2025, the MAR indicated, 30 milliliters of Prostat supplement was given to Resident 20 at 9:00 AM and at 5:00 PM on 1/18/2025 through 1/29/2025. Resident 20 did not receive Prostat on 1/30/25 at 9:00 AM.</p> <p>During a review of Resident 20's Nutrition Care plan created 1-5-22 and updated 1-27-25 indicated Problems/Conclusions .9/9/24-WT LOSS OF 17.2#/6MOS AT 11% IS SIGNIFICANT, RESIDENT IS SURPRISED BY Loss .9/9/24 &amp; 12/6/24: Referred resident to MD d/t (due to) ongoing weight loss . Measurable Goals .Weight, No significant variances: Resident will maintain wt greater than 121 pounds (+/- 5 pounds) every week x 3 months .Interventions .Diet, Document % consumed: Regular .Chop Meat .</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/30/2025 at 2:47 p.m. with Registered Dietitian (RD) and the Director of Dietetics (DD), Resident 20's care plan titled, Risk of Alteration in Nutrition, was reviewed. The RD stated she was responsible for entering information and updating the nutrition care plans for residents. The RD confirmed Resident 20's nutrition care plan was updated on 6/19/2022, 3/14/2024, 9/9/2024, and 12/6/2024 and was not sure when she last updated the goal for Resident 20. The RD stated she notified Resident 20's physician of the weight loss and she sees Resident 20 quarterly or as needed but, the care plan did not reflect those dates. The DD confirmed, the care plan was not updated to reflect the additional food or other items Resident 20 received which was recommended by the RD. The DD stated Resident 20's interventions should have been updated in the care plan.</p> <p>During an interview on 1/30/2025 at 4:15 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the RD was responsible for updating the care plan of the residents after dietary meetings and should be followed up every month. The ADON stated dietary notes were separated from nursing notes and the nursing staff did not have access to the dietary notes. The ADON stated his expectation for the RD was to document their goals clearly to communicate to the rest of the staff. The ADON further stated the documented goals were important so nursing staff can carry out interventions correctly.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Care Planning, dated 8/12/2024, the P&amp;P indicated, Resident care plans will be reviewed, evaluated and updated as necessary by professional personnel involved in the care of the resident at least quarterly. Implementation: Delivery of actual resident care, IDT [interdisciplinary] activities, putting approaches or solutions to work. Services provided must meet professional standards of quality and be provided by qualified persons. Evaluation: Consists of reassessment and comparing the observed resident goals/outcomes of the interventions with the expected outcomes established during the planning phase; this is an on-going process.</p> <p>During a review of the facility's policy &amp; procedure (P&amp;P) titled, Food &amp; Nutrition Services- Assessments and Care/ Treatment Plans, dated 1/2/2025, the P&amp;P indicated, The home will ensure the resident maintains acceptable parameters of nutritional status (such as usual body weight range, protein). D. Significant Change of Status Assessment (SCSA): 1. The dietitian will complete a comprehensive reassessment. 2. Within fourteen (14) days of change of condition. 3. Examples of significant changes are not limited to: a. Unplanned weight loss of 5% change in 30 days, 7.5% change in 90 days, or 10% change in 180 days. b. Chronic unplanned weight loss. E. Quarterly Nutrition Assessment: 2. Review and revision of the resident's care plan to ensure the continued accuracy of the resident's assessment. G. Care Plan: A comprehensive person-centered care plan including measurable objectives and time frames to meet resident's needs, preferences and goals that are identified in the comprehensive assessment.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38924</p> <p>Based on observation, interview, and record review, the facility failed to ensure a comprehensive systematic approach for monitoring nutrition interventions was implemented for one of 44 sampled residents, (Resident 20), who experienced an unplanned unintentional weight loss of 7.79% in six months, according to facility policy.</p> <p>This failure had the potential for Resident 20 to experience additional unintentional weight loss, which could lead to further decline in the resident's health and nutrition status.</p> <p>Cross reference F657 and F801</p> <p>Findings:</p> <p>During a review of an article titled, 2002 American Academy of Family Physicians Journal, indicated, Involuntary weight loss can lead to muscle wasting, decreased immunocompetence, (the ability for the body to develop an immune response) depression and an increased rate of disease complications. Research has shown institutionalized elderly patients who lost 5 percent of their body weight in one month were found to be four times more likely to die within one year. (www.aafp.org/afp)</p> <p>During a review of the professional reference titled, The Academy of Nutrition and Dietetics Evidence Analysis Library, regarding Unintended Weight Loss for Older Adults Evidence-Based Nutrition Practice Guidelines, dated 2007-2009, indicated, The Registered Dietitian should monitor and evaluate weekly body weights of older adults with unintended weight loss, until body weight has stabilized, to determine effectiveness of medical nutrition therapy (MNT).</p> <p>During a review of Resident 20's Admission Face Sheet Record (demographics), [undated], the Face Sheet indicated Resident 20 was admitted on [DATE] with diagnoses of hypertension (HTN, high blood pressure), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 12/5/2024, the MDS indicated Resident 20 had a BIMS (brief interview of mental status) score of 10 (moderate cognitive impairment) in section C, indicating he was cognitively intact. The MDS further indicated Resident 20 experienced a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months but was not on a physician-prescribed weight-loss regimen.</p> <p>During a review of Resident 20's Monthly Weights, from 6/20/2024 -1/18/2025 indicated:</p> <p>6/20/2024 -136.1 lbs. (pounds)</p> <p>7/20/2024 -132.8 lbs.</p> <p>8/17/2024 -128.4 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9/21/2024 -129.8 lbs.</p> <p>10/19/2024 -128 lbs.</p> <p>11/6/2024 - 126 lbs.</p> <p>12/21/2024 - 121.8 lbs.</p> <p>1/18/2025 - 118.4 lbs.</p> <p>Resident 20 experienced a 10.84% significant weight loss from July 2024 and January 2025, and a 7.79 % significant weight loss from August 2024 through January 2025.</p> <p>During a review of Resident 20's Physician Diet Order, dated 12/6/2024, indicated, Change Diet to: Regular/thin liquids per ST (Speech Therapy)/resident; nursing to help out PRN (as needed).</p> <p>During a review of Resident 20's Physician Orders, dated 1/17/2025, indicated, Prostat (a concentrated liquid protein drink supplement), 30 ml (milliliters), PO (by mouth), BID (twice a day).</p> <p>During a review of Resident 20's Medication Administration Record (MAR), from 1/1/2025- 1/31/2025, indicated 30 ml of Prostat supplement was given to Resident 20 at 9:00 a.m. and 5:00 p.m. on 1/18/2025 through 1/29/2025. Further review of the MAR indicated Resident 20 did not receive Prostat on 1/30/2025.</p> <p>During a review of the Facility's List of Resident's and Diets, dated 1/25/2025, indicated Resident 20's diet as Regular, No Yogurt at breakfast, lunch, and dinner.</p> <p>During a review of Resident 20's ADL (Activities of Daily Living) Supplemental Flow Sheet, indicated the following:</p> <p>For the Month of November 2024:</p> <p>Average Breakfast consumed: 62.5%</p> <p>Average Lunch consumed: 75%</p> <p>Average Dinner consumed: 50%</p> <p>For the Month of December 2024:</p> <p>Average Breakfast Consumed: 55%</p> <p>Average Lunch Consumed: 51%</p> <p>Average Dinner Consumed: 48%</p> <p>For the Month of January 2025:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Average Breakfast Consumed: 49%</p> <p>Average Lunch Consumed: 51%</p> <p>Average Dinner Consumed: 44%</p> <p>During a concurrent observation and interview on 1/29/2025 at 9:42 a.m., Resident 20 was sitting in his wheelchair next to his bed in his room with a 1/2 cup of coffee on his bedside table in front of him. Resident 20 stated he ate most of his breakfast and liked the banana, sausage links, and some cereal along with fruit. Resident 20 further stated he's lost 40 pounds in two years and has not spoken with his doctor about his weight loss. Resident 20 stated some of his food preferences were sausages, pears, bananas, grilled cheese sandwiches, tuna sandwiches, and chicken meals. Resident 20 stated he did not like oatmeal or yogurt.</p> <p>During a concurrent observation and interview on 1/30/2025 at 10:00 a.m. with Resident 20, Resident 20 stated he did not like some foods and meals served at the facility. Resident 20 stated he does not receive any sandwiches at lunch or dinner, or other foods with meals but would like to have a grilled cheese sandwich sometimes. Resident 20 stated he also received a supplement shake three times a day.</p> <p>During an interview on 1/30/2025 at 10:11 a.m., with Registered Nurse 3 (RN 3), RN 3 stated Resident 20 had an order for Prostat. RN 3 further stated she would offer Resident 20 substitutions for his food but did not give it to Resident 20 for breakfast.</p> <p>During an interview on 1/30/2025 at 11:34 a.m., with the Resident 20's Physician (PHYS), the PHYS stated Resident 20 had a stroke a few years ago and received chemotherapy ten years ago for prostate cancer. The PHYS further stated he was aware of Resident 20's weight loss a month ago and believed the Registered Dietitian (RD) was giving the resident supplements to address it. The PHYS stated he wasn't aware Resident 20's weight loss was severe for six or seven months. The PHYS further stated severe weight loss was a priority and could potentially be treated with interventions.</p> <p>During a review of Resident 20's Nutrition Care Plan, created 1/5/2022 and updated 1/27/2025, indicated, Problems/Conclusions .9/9/2024-WT. (weight) LOSS OF 17.2#/6MOS AT 11% IS SIGNIFICANT, RESIDENT 20 IS SURPRISED BY Loss .9/9/2024 &amp; 12/6/2024: Referred Resident 20 to MD (medical doctor) d/t (due to) ongoing weight loss . Measurable Goals .Weight, No significant variances: Resident 20 will maintain wt. greater than 121 pounds (+/- 5 pounds) every week x 3 months .Interventions .Diet, Document % consumed: Regular .Chop Meat.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/29/2025 at 2:47 p.m. with Registered Dietitian (RD) and the Director of Dietetics (DD), Resident 20's care plan titled, Risk of Alteration in Nutrition, was reviewed. The RD stated she was responsible for entering information and updating the nutrition care plans for residents. The RD confirmed Resident 20's nutrition care plan was updated on 6/19/2022, 3/14/2024, 9/9/2024, and 12/6/2024 and was not sure when she last updated the nutrition and weight goals for Resident 20. The RD stated the Resident 20's weight loss was unintentional, and Resident 20's physician was notified of the weight loss in November 2024. The RD stated she assessed Resident 20 quarterly or as needed but the interventions were not always updated. The DD acknowledged the care plan was not updated to reflect the additional food or other items Resident 20 received which was recommended by the RD. The DD stated Resident 20's interventions should have been updated in the care plan. The DD acknowledged the care plans did not have a weight loss goal.</p> <p>During a review of Resident 20's Nutritional Assessment, dated 3/15/2024, completed by the RD indicated, Resident 20's current body weight 145.6 pounds, ideal body weight (IBW) 148 pounds, usual body weight (UBW) was 160 pounds; Estimated caloric needs: 1600 calories per day, 65 grams of protein; .Plan and Goals: Resident 20 reports good appetite and is aware of weight loss .Continue supplement at HS (evening) . no further changes at this time.</p> <p>During a review of Resident 20's Nutritional Assessment, dated 6/11/2024 completed by the RD indicated, Resident 20's current body weight 140 pounds, ideal body weight was 148 pounds; Estimated caloric needs: 1600 calories per day, 65 grams of protein; .Nutrition Diagnosis: Resident 20 with inadequate intake as evidenced by ongoing weight loss . Plan and Goals: Resident 20 reports good appetite and is aware of weight loss but surprised of total weight loss . Resident 20 indicates prefers weight of 160 pounds as his goal .Continue supplement TID (three times a day) and sandwich at 10 AM to increase calories.</p> <p>During a review of Resident 20's Nutritional Assessment, dated 11/27/2024 completed by the RD indicated, Resident 20's current weight was 126 pounds, IBW: 148 pounds, IBW: 86%; Oral supplementation/additional foods: Chocolate house supplement TID; .Nutrition Requirements: Total kcals (kilocalorie): 1800 per day .; protein: 68 grams/day; Plan: .Resident 20 Goals: weight &gt; 126 pounds +/- 5 pounds as desired by resident . Comments: .Wt. loss of 14 pounds/6 months @ 10% change .RD recommend appetite stimulant High nutrition risk .Monitor changes and f/up prn (as needed)</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/30/2025 at 2:54 p.m., with Registered Dietitian (RD) and the Director of Dietetics (DD), the DD stated the RD was responsible for attending the Nutritional At Risk (NAR) monthly meetings and reporting to the interdisciplinary NAR committee the resident's nutrition interventions. The August 2024 through December 2024 NAR meeting minutes indicated added Super Suds to L/D (lunch/dinner). The RD stated she mentioned fortified food items to Resident 20 like super suds (buttered mashed potatoes), and per Resident 20 he told her he would try them. The RD stated she did not recommend Resident 20 be placed on a fortified diet, which could have provided up to 300 to 500 additional calories per day at every meal. The RD stated she was unsure if Resident 20 was regularly receiving the super suds (mashed potatoes) at lunch and dinner after she informed the kitchen in August. The RD further stated Resident 20 could have benefitted from the extra calories and acknowledged she could have followed up with Resident 20 on the different interventions. The RD stated she should have updated Resident 20's nutrition calorie goals in the assessment to reflect the resident's continuous weight loss. The RD further stated Resident 20's food preferences were taken a while ago, but she did not know where they were in the medical record system because the facility had a new system last year. The DD acknowledged Resident 20's nutrition assessment did not have the additional foods recommended by the RD for Resident 20. The DD stated Resident 20's interventions should have been updated and included.</p> <p>During an interview on 1/30/2025 at 4:15 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the RD was responsible for updating the care plan of the residents after dietary meetings and should be followed up every month. The ADON stated dietary notes were separated from nursing notes and the nursing staff did not have access to the dietary notes. The ADON stated his expectation for the RD was to document their goals clearly to communicate to the rest of the staff. The ADON further stated the documented goals were important so the nursing staff can carry out interventions correctly.</p> <p>During a review of the facility's job description titled, Registered Dietitian, dated 2/23/2018 indicated, Complete nutrition assessments for assigned residents within specified time frames. Identify risk factors and nutrition-related problems; coordinate MNT for residents; communicate recommendations to appropriate health care team members and monitor response to plan of care. Provide follow-up care and documentation as needed according to nutritional risk, nutrition care plan (NCP), and IDT meetings. Provide nutrition counseling, diet intervention, and resident education regarding disease/disability management, food medication interactions, weight management, health promotion, wellness, and other education as needed. Monitor quality control as assigned to evaluate effectiveness of resident nutritional care and food service. Communicate with appropriate staff any problems, changes, or recommendations found through meal observations; .Provider will complete documentation in a thorough and timely manner.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy &amp; procedure (P&amp;P) titled, Food &amp; Nutrition Services- Assessments and Care/ Treatment Plans, dated 1/2/2025, the P&amp;P indicated, The [name of the facility] will ensure the resident maintains acceptable parameters of nutritional status (such as usual body weight range, protein) .D. Significant Change of Status Assessment (SCSA): 1. The dietitian will complete a comprehensive reassessment. 2. Within fourteen (14) days of change of condition. 3. Examples of significant changes are not limited to: a. Unplanned weight loss of 5% change in 30 days, 7.5% change in 90 days, or 10% change in 180 days. b. Chronic unplanned weight loss. E. Quarterly Nutrition Assessment: 2. Review and revision of the resident's care plan to ensure the continued accuracy of the resident's assessment. G. Care Plan: A comprehensive person-centered care plan including measurable objectives and time frames to meet resident's needs, preferences and goals that are identified in the comprehensive assessment.</p> <p>During a review of the facility's policy &amp; procedure (P&amp;P) titled, Food &amp; Nutrition Services- Weight Policy SNF/ICF, dated 6/12/2024, the P&amp;P indicated, Body weight and laboratory results can often be stabilized with time. I. Monitoring Weights and Weight Variances .A. The Registered Dietitian (RD) will monitor weights and significant weight changes. C. The RD will assess each Resident with a monthly significant weight change and determine if weight loss was planned or unplanned. II. Systemic approach. C. Developing and consistently implementing pertinent approaches. D. Monitoring the effectiveness of interventions and revising them, as necessary. V. Significant Weight Change is defined as: B. decrease of 5% or more body weight in 30 days. C. decrease of 7.5% or more body weight in 90 days. D. decrease of 10% or more of body weight in 180 days. VII. Nutrition Care Planning. C. On-going monitoring of care planned interventions is necessary for all residents.</p> <p>50674</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35335</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services for a universe of 103 residents when:</p> <ol style="list-style-type: none"> <li>1. During an inspection of one of two medication rooms, outdated Procrit (drug to treat low red blood cell count), Mantoux (diagnostic test to detect tuberculosis infection which is a lung infection) vial, and insulin (drug to manage blood sugar levels) pen were observed stored and available for resident use.</li> </ol> <p>This failure had the potential for residents to receive outdated and/or ineffective medications which could result in adverse clinical outcomes.</p> <ol style="list-style-type: none"> <li>2. During an inspection of one of two medication carts, one expired nitroglycerin (drug to manage chest pain) vial was observed stored and available for resident use.</li> </ol> <p>This failure had the potential for residents to receive outdated and/or ineffective medications which could result in adverse clinical outcomes.</p> <ol style="list-style-type: none"> <li>3. For Resident 5, the facility could not demonstrate controlled drug (narcotics with potential for physical and psychological dependence) records were maintained in an organized and orderly manner to show the receipt to disposition (Chain of custody) of each dose was readily traced in sufficient detail.</li> </ol> <p>This failure had the potential for inadequate narcotic accountability and/or drug diversion (illegal use of medication unauthorized individuals), abuse, or misuse.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on [DATE] at 10:55 a.m., an inspection of the Unit 300 Medication Room was conducted with Pharmacist 1 (RPH 1).</li> </ol> <ol style="list-style-type: none"> <li>1A. During a concurrent observation and interview on [DATE], at 10:59 a.m., one vial of Procrit 10,000 units/mL (milliliter - a unit of measurement) was observed stored in the medication refrigerator with a manufacturer expiration date of ,d+[DATE] [[DATE]]. RPH 1 acknowledged the Procrit vial observed stored in the Unit 300 medication refrigerator expired in [DATE].</li> <li>1B. During a concurrent observation and interview on [DATE], at 10:59 a.m., one opened vial of Mantoux was observed stored in the medication refrigerator with O.D (Open Date): [DATE] and Exp. (expiration date) [DATE] handwritten in black ink. The manufacturer's product labeling on the vial indicated Discard opened product after 30 days. RPH 1 acknowledged the opened Mantoux vial with the manufacturer's product labeling observed stored in the Unit 300 medication refrigerator was labeled outdated on [DATE].</li> </ol> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the Mantoux package insert (information on how to safely use a drug) dated [DATE], indicated A vial of TUBERSOL (also known as Mantoux) which has been entered and in use for 30 days should be discarded.</p> <p>1C. During a concurrent observation and interview on [DATE] at 2:48 p.m., an inspection of the Unit 700 Medication Room was conducted with RPH 1.</p> <p>During a concurrent observation and interview on [DATE] at 2:48 p.m., one insulin pen labeled with a yellow sticker was observed stored in the medication refrigerator with a Date Opened ,d+[DATE] [[DATE]] and Exp Date ,d+[DATE] [[DATE]]. RPH 1 acknowledged the insulin pen was labeled outdated on [DATE].</p> <p>During a concurrent interview and record review on [DATE] at 2:23 p.m., the facility's policy and procedure (P&amp;P) titled Drug Storage dated [DATE] was reviewed with the Director of Pharmacy (DOP). The DOP acknowledged the policy indicated Drugs will not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs will be available for use. The DOP stated the outdated Procrit vial and insulin pen should have been removed from the medication refrigerator when the resident's medication was discontinued.</p> <p>During a concurrent interview and record review on [DATE] at 2:38 p.m., the facility's P&amp;P titled Drug Storage dated [DATE] was reviewed with the DOP. The DOP acknowledged the policy indicated Drugs will not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs will be available for use. The DOP stated the outdated Mantoux vial should have been removed from the medication refrigerator.</p> <p>2. During a concurrent interview and record review on [DATE] at 2:38 p.m., the facility's policy and procedure (P&amp;P) titled Drug Storage dated [DATE] was reviewed with the Director of Pharmacy (DOP). The DOP acknowledged the policy indicated, Drugs will not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs will be available for use. The DOP stated that anything out of date should be removed.</p> <p>During a concurrent observation and interview on [DATE] at 9:32 a.m., an inspection of the Unit 700 Medication Cart ,d+[DATE] was conducted with the Assistant Director of Nursing (ADON). When the medication cart was opened, one nitroglycerin vial was observed stored with an expiration date of 07 24 [[DATE]]. The ADON acknowledged the nitroglycerin vial stored in the Unit 700 Medication Cart ,d+[DATE] expired in [DATE].</p> <p>3. During a concurrent observation and interview on [DATE] at 12:42 p.m., at Medication Cart 600, Resident 5's opioid (narcotic painkiller) medications were reviewed with Licensed Vocational Nurse 3 (LVN 3). The medical record was reviewed and LVN 3 retrieved the Controlled Drug Record (CDR - narcotic count sheet where licensed nurses log out narcotics from the drug supply for accounting) for the Resident 5's PRN (as needed) hydrocodone/acetaminophen (a strong opioid combining two pain medications) 5 milligrams / 325 milligrams (mg - a unit of measurement for dose) bubblepack (medication card) stored in the medication cart. The medication bubblepack indicated the prescription number Rx# 589768 and the corresponding Controlled Drug Record indicated the prescription number Rx# 587116. LVN 3 acknowledged the prescription number on Resident 5's PRN hydrocodone/acetaminophen 5 mg / 325 mg Rx# 589768 did not match the prescription number Rx# 587116 on the CDR.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on [DATE] at 1:17 p.m. with the Assistant Director of Nursing (ADON), Resident 5's medical record was reviewed. The physician's orders dated [DATE] indicated medication orders for PRN hydrocodone/acetaminophen 5 mg / 325 mg. The medication order indicated one tablet by mouth for mild to moderate pain. The medication order indicated two tablets by mouth for severe pain. The ADON acknowledged the two PRN hydrocodone/acetaminophen 5 mg/325 mg medication orders.</p> <p>During an interview on [DATE] at 4:16 p.m., Resident 5 stated it took some time for him to start receiving his PRN hydrocodone/acetaminophen medications. Resident 5 stated he has chronic pain in his ankles, knees, and shoulders.</p> <p>During a concurrent interview and record review on [DATE] at 3:15 p.m., Resident 5's PRN hydrocodone/acetaminophen medication orders, hydrocodone/acetaminophen bubblepack Rx# 589768, and the CDR hydrocodone/acetaminophen Rx# 587116 were reviewed with the DOP. The DOP acknowledged the prescription number on Resident 5's PRN hydrocodone/acetaminophen 5 mg / 325 mg Rx# 589768 did not match the prescription number Rx# 587116 on the Controlled Drug Record. The DOP stated to talk to the Supervisor Registered Nurse 1 (SRN 1) for clarification of prescription number discrepancies.</p> <p>During a concurrent interview and record review on [DATE] at 4:06 p.m., Resident 5's PRN hydrocodone/acetaminophen medication orders, hydrocodone/acetaminophen bubblepack Rx# 589768, and the CDR hydrocodone/acetaminophen Rx# 587116 were reviewed with Supervising Registered Nurse 1 (SRN 1). SRN 1 acknowledged the prescription number on Resident 5's PRN hydrocodone/acetaminophen 5 mg / 325 mg Rx# 589768 did not match the prescription number Rx# 587116 on the Controlled Drug Record.</p> <p>During a concurrent interview and record review on [DATE] at 9:54 a.m., Resident 5's narcotic drug records were reviewed with SRN 1. SRN 1 stated that nursing staff sometimes does not check to verify the prescription numbers match the narcotic supply in the bubblepack with the corresponding Controlled Drug Record.</p> <p>During a concurrent interview and record review on [DATE] at 10:21 a.m., Resident 5's narcotic drug records were reviewed with the DOP. The DOP stated, the key is excessive ordering and that there was a delay from when the Pharmacy dispensed the narcotic bubblepack to the nursing home to when the nursing staff starts using the narcotic supply from that bubblepack.</p> <p>During a concurrent interview and record review on [DATE] at 10:21 a.m., the facility's policy and procedure (P&amp;P) titled Controlled Scheduled [degree of abuse potential] Drugs, dated [DATE] was reviewed with the DOP and the SRN 1. The policy indicated, RECEIPT OF CONTROLLED SCHEDULED DRUGS .When the controlled scheduled drugs are delivered from the pharmacy, there will be a Controlled Drug Record sheet created for each drug (see Attachment A). The DOP and SRN1 acknowledged the policy and both stated Attachment A was the narcotic count sheet (CDR).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Controlled Scheduled [degree of abuse potential] Drugs, dated [DATE], the P&amp;P indicated, The [name of facility] will establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and will ensure drug records are in order and that an account of all controlled scheduled drugs is maintained.</p> <p>RECEIPT OF CONTROLLED SCHEDULED DRUGS .When the controlled scheduled drugs are delivered from the pharmacy, there will be a Controlled Drug Record sheet created for each drug (see Attachment A) .</p> <p>STORAGE, SECURITY AND ACCOUNTABILITY OF CONTROLLED SCHEDULED DRUGS .Separate drug records will be maintained for all controlled scheduled drugs in such a way that the receipt and disposition of each dose of any such drug may be readily traced.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Controlled Drugs, dated [DATE], the P&amp;P indicated, A separate record will be maintained for all controlled scheduled drugs. It will include the name of the prescriber, the prescription number, the drug name, strength and dose administered, the date and time of administration and the signature of the person administering the drug (see Controlled Drug Record).</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>35335</p> <p>Based on observation, interview, and record review, the facility did not ensure the medication error rate was less than 5% when three errors for Resident 9 and Resident 87 occurred out of 42 opportunities for a medication administration error rate of 7.14%. For Resident 9, the medication glipizide (drug to manage blood sugars) was not administered 30 minutes before meals. For Resident 87, one medication was omitted, and the medication fexofenadine (drug to manage allergies) was given to the resident at the same time as fruit juice.</p> <p>This failure had the potential to expose residents to preventable medication errors which could result in adverse health outcomes.</p> <p>Findings:</p> <p>a. During a concurrent observation and interview on 1/28/2025 at 9:27 a.m., Licensed Vocational Nurse 2 (LVN 2), at the medication cart outside of Resident 9's room, the medication glipizide was prepared at the medication cart. LVN 2 acknowledged glipizide tablet was poured into the medication cup for Resident 9.</p> <p>During an observation on 1/28/2025 at 9:40 a.m., in Resident 9's room, LVN 2 administered glipizide to Resident 9.</p> <p>During a concurrent interview and record review on 1/28/2025 at 10:54 a.m., the Nursing2020 Drug Handbook for the medication glipizide was reviewed with LVN 1, obtained from the facility's Unit 700 Nursing Station, indicated Give immediate-release tablet about 30 minutes before meals. LVN 1 stated the facility's drug handbook obtained from the nursing station indicated to give immediate release about 30 minutes before meals. LVN 2 was not available for interview.</p> <p>During an interview on 1/29/2025 at 10:14 a.m., the Director of Pharmacy (DOP) stated the facility staff uses Lexi-comp as their reference for drug information.</p> <p>During an interview on 1/29/2025 at 10:28 a.m., LVN 2 stated breakfast is served around 7:45 a.m. and residents eat between 8:00 a.m to 9:00 a.m. LVN 2 stated the resident needs food to take the diabetic medications glipizide and metformin. LVN 2 stated Resident 9 ate about 75% of breakfast on 1/28/2025.</p> <p>During an observation on 1/29/2025 at 10:30 a.m., at the medication cart outside of Resident 9's room, the glipizide medication bubblepack for Resident 9 was observed to be immediate-release tablets.</p> <p>During a concurrent interview and record review on 1/29/2025 at 3:05 p.m., the drug information for glipizide was reviewed with the DOP, obtained from the facility's Lexi-comp on 1/29/2025, indicated once daily 30 minutes before the first main meal. The DOP acknowledged Lexi-comp drug reference indicated the medication glipizide is to be administered 30 minutes before the first main meal.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/29/2025 at 3:05 p.m., the Nursing 2020 Drug Handbook for the medication glipizide was reviewed with the DOP, obtained from the facility's Unit 700 Nursing Station, indicated Give immediate-release tablet about 30 minutes before meals. The DOP acknowledged the facility's drug handbook obtained from the nursing station indicated to give immediate release about 30 minutes before meals.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Medication Pass dated 8/12/2024, the P&amp;P indicated I. PRIOR TO PASSING MEDICATIONS . D. Review Medication Administration Records (MAR) for special time medications like .medications before and after meals . II. DURING THE PASS . H. Special considerations should be noted on the MAR.</p> <p>b. During a concurrent observation and interview on 1/29/2025 at 9:07 a.m., at the medication cart outside of Resident 87's room, Registered Nurse 3 (RN 3) prepared and poured Resident 87's medications into the medicine cup:</p> <ol style="list-style-type: none"> <li>1. Amlodipine (blood pressure drug) 10 mg (milligrams - a unit of measurement for dose) x 1 tablet</li> <li>2. Atorvastatin (cholesterol drug) 20 mg x 1 tablet</li> <li>3. Fexofenadine (allergy drug) 180 mg x 1 tablet</li> <li>4. Finasteride (prostate drug) 5 mg x 1 tablet</li> <li>5. Metolazone (diuretic drug) 5 mg x 1 tablet</li> <li>6. Fish Oil 1000 mg x 1 softgel</li> <li>7. Calcium Oyster Shell (mineral) 500 mg x 1 tablet</li> <li>8. Vitamin D3 IU (international unit - a unit of measurement for dose) x 1 tablet</li> <li>9. Sodium Chloride (electrolyte) 1 gram (a unit of measurement for dose) x 1 tablet</li> <li>10. Senna (laxative) 8.6 mg x 2 tablets</li> <li>11. Telmisartan (blood pressure drug) 80 mg x 1 tablet</li> <li>12. Hydroxyzine (antihistamine) 50 mg x 1 tablet</li> <li>13. Furosemide (diuretic drug) 40 mg x 1 tablet</li> <li>14. Potassium Chloride (drug to treat low potassium levels) 20 MEQ (milliequivalent - a unit of measurement) x 1 tablet</li> <li>15. Gabapentin (chronic pain drug) 600 mg x 1 tablet</li> <li>16. Ferrous Sulfate (iron supplement) 325 mg x 1 tablet</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Veterans Home of California - Chula Vista		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Naples Court Chula Vista, CA 91911	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 1/29/2025 at 9:27 a.m., at the medication cart outside of resident 87's room, RN 3 stated she had 17 pills in her medication cup including two senna tablets.</p> <p>During a concurrent observation and interview on 1/29/2025 at 9:30 a.m., at the medication cart outside of resident 87's room, RN 3 was observed pouring orange juice into a cup. RN 3 stated it was 120 milliliters (mL - a unit of measurement) of orange juice.</p> <p>During an observation on 1/29/2025 at 9:31 a.m., in Resident 87's room, RN 3 administered all 17 medications to Resident 87 including fexofenadine with the 120 mL's of orange juice.</p> <p>During an interview on 1/29/2025 at 9:32 a.m., RN 3 stated Resident 87 drank all 120 mL's of orange juice with all the medications.</p> <p>During an interview on 1/29/2025 at 9:38 a.m., RN 3 stated all medications due at this time were administered to Resident 87.</p> <p>During an interview on 1/29/2025 at 10:14 a.m., the Director of Pharmacy (DOP) stated the facility staff uses Lexi-comp as their reference for drug information.</p> <p>During a concurrent interview and record review on 1/29/2025 at 11:15 a.m., Resident 87's medical record and physician's orders were reviewed with RN 3. The physician's orders indicated a medication order for CEROVITE TAB SENIOR .TAKE ONE (1) TABLET BY MOUTH DAILY - SUPPLEMENT. RN 3 stated that they may not have given it. RN 3 stated they were going to go administered it to Resident 87 now and that it had already been signed off in the Medication Administration Record (MAR - section of the medical record where medications are documented after they have been administered).</p> <p>During a concurrent interview and record review on 1/29/2025 at 2:56 p.m., the drug information for fexofenadine was reviewed with the DOP, obtained from the facility's Lexi-comp on 1/29/2025, indicated Administration: Oral .do not administer with fruit juices. The DOP acknowledged the Lexi-comp drug reference indicated the medication fexofenadine should not be administered at the same time with fruit juice.</p> <p>During a concurrent interview and record review on 1/29/2025 at 2:56 p.m., the facility's policy and procedure (P&amp;P), titled Medication Pass, dated 8/12/2024, the P&amp;P indicated II. DURING THE PASS .H. Special considerations should be noted on the MAR. The DOP acknowledged the policy.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Drug Administration, dated 9/24/2024, the P&amp;P indicated, Medications and treatments shall be administered as prescribed.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Medication Pass, dated 8/12/2024, the P&amp;P indicated I. PRIOR TO PASSING MEDICATIONS . D. Review Medication Administration Records (MAR) for special time medications like .medications before and after meals . II. DURING THE PASS . H. Special considerations should be noted on the MAR . L. Medications must be given as prescribed.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Medication and Treatment Administration, dated 4/15/2024, the P&amp;P indicated, I. ADMINISTRATION OF MEDICATION . I. Doses shall be administered within (1) hour of prescribed time . IV. ROUTINE MEDICATIONS AND TREATMENT SCHEDULE . medication and treatments are administered according to the following schedule: QD [every day] -----0900 [9:00 a.m.]</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>35335</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were appropriately labeled in accordance with accepted standards of practice and/or manufacturer's instructions when:</p> <ol style="list-style-type: none"> <li>1. During an inspection of one of two medication rooms, one outdated insulin vial was stored and available for resident use.</li> <li>2. During an inspection of one of two medication rooms, a bulk bottle of atovaquone (anti-infective drug) oral suspension (liquid) for Resident 39 was not stored in accordance with manufacturer's instructions and available for resident use.</li> </ol> <p>These failures had the potential for residents to receive outdated and/or ineffective medications which could result in adverse clinical outcomes.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on 1/27/2025 at 2:48 p.m., an inspection of the Unit 700 Medication Room was conducted with Pharmacist 1 (RPH 1).</li> </ol> <p>During a concurrent observation and interview on 1/27/2025 at 3:11 p.m., in the medication room, an insulin vial was observed stored with a pharmacy label indicating Do Not Use After 01/22/25. RPH 1 acknowledged the outdated insulin vial stored in the refrigerator with the pharmacy label indicating to not use the medication after January 22, 2025. RPH 1 stated the insulin vial should not go back into the medication room refrigerator.</p> <p>During a concurrent interview and record review on 1/29/2025 at 2:23 p.m., the facility's policy and procedure (P&amp;P) titled, Drug Storage, dated 8/15/2022, was reviewed with the Director of Pharmacy (DOP). The DOP acknowledged the policy indicated Drugs will not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs will be available for use. The DOP stated the outdated insulin vial should have been removed from the medication refrigerator when the resident's medication was discontinued.</p> <ol style="list-style-type: none"> <li>2. During a concurrent observation and interview on 1/27/2025 at 10:55 a.m., an inspection of the Unit 300 Medication Room was conducted with Pharmacist 1 (RPH 1). The medication room refrigerator was observed at a temperature of 38 degrees Fahrenheit (F - unit of temperature measurement) and RPH 1 acknowledged the refrigerator temperature.</li> </ol> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 1/27/2025, at 10:59 a.m., in the medication room, a bulk bottle of atovaquone oral suspension for Resident 39 was observed stored in the medication refrigerator with the manufacturer's product labeling indicated on the bottle Store at 20 to 25C [Celsius - Unit of temperature measurement] (68 to 77F); excursion permitted between 15 to 30C (59 to 86F). The atovaquone medication carton indicated Store at 20 to 25C (68 to 77F); excursion permitted between 15 to 30C (59 to 86F). RPH 1 acknowledged the manufacturer's product labeling on the medication bottle, the medication carton labeling, and the atovaquone oral suspension was stored in the refrigerator with a temperature of 38 degrees Fahrenheit.</p> <p>During a review of the Atovaquone oral suspension package insert (information on how to safely use a drug) dated December 2023, obtained from the facility, indicated HOW SUPPLIED/STORAGE AND HANDLING . Store at 20 to 25C (68 to 77F); excursion permitted between 15 to 30C (59 to 86F).</p> <p>During a concurrent interview and record review on 1/29/2025 at 2:28 p.m., the facility's policy and procedure (P&amp;P) titled Drug Storage, dated 8/15/2022, was reviewed with the Director of Pharmacy (DOP). The DOP acknowledged the policy indicated, STORAGE TEMPERATURES A. Nursing staff will review manufacturer's recommendations for proper storage to ensure that drugs are stored in appropriate temperatures. Drugs required to be stored at room temperature will be stored at a temperature between 15C (59F) and 25C (77F).</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51978</p> <p>Based on observation, interview, and record review, the facility failed to ensure a dental appointment was scheduled for one of 44 sampled residents (Resident 72).</p> <p>This failure had the potential to result in Resident 72 experiencing infection, pain, or complications from ill-fitting dentures.</p> <p>Findings:</p> <p>During a review of Resident 72's Face Sheet (demographics), dated 1/30/2025, the Face Sheet indicated Resident 72 was admitted to the facility on [DATE] with diagnosis of dysphagia (difficulty swallowing foods and liquids).</p> <p>During a concurrent observation and interview on 1/28/2025 at 10:02 a.m., with Resident 72, Resident 72 was observed without any teeth or dentures in his mouth. Resident 72 stated he had dentures but did not wear them because the dentures were uncomfortable. Resident 72 stated, I haven't been seen by dentist in a while.</p> <p>During a concurrent interview and record review on 1/29/2025 at 2:45 p.m. with Registered Nurse 4 (RN 4), RN 4 stated Resident 72 had not been to the dentist since 10/23/2023.</p> <p>During a follow up interview and record review on 1/30/2025 at 9:53 a.m., with RN 4, Resident 72's Physician's Order, dated 11/10/2024, was reviewed and indicated, Dental evaluation and treatment. RN 4 stated, the Charge Nurse should have notified the Office Assistant (OA) to arrange a dental appointment for Resident 72 and documented the notification in the record. RN 4 confirmed there was no documentation in Resident 72's record which indicated a dental appointment was requested for Resident 72. RN 4 confirmed the Physician's Order was not followed and Resident 72 had not been evaluated by the dentist.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Dental Services for Residents, dated 09/01/2024, the P&amp;P indicated, Each resident shall have an initial dental screening examination, in conjunction with complete medical evaluation, on admission to the facility.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38924</p> <p>50674</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was served at an acceptable temperature to be appetizing for residents according to the facility's resident council and the facility policy.</p> <p>This failure had the potential to affect meal and food intake which could impair the nutrition status of the residents.</p> <p>Findings:</p> <p>During a review of the facility's menu titled, January 26, 2025-February 01, 2025, the menu for Tuesday 1/28/2025 indicated, the lunch meal for a Regular diet included, Carrot Raisin Pineapple Salad, Carne [NAME]/Soft Tortilla, Pinto Beans/Corn Muffin, Tomato/Onion/Cilantro, Sour Cream/Salsa and Chocolate Cake with Icing for dessert.</p> <p>During a concurrent test tray observation and interview on 1/28/2025 at 12:50 p.m. in the 1000 Unit pod common dining area, the meal cart left the kitchen and arrived at the Unit at 12:18 p.m. The entree of carne [NAME] with tortilla was 128 degrees Fahrenheit (F- measurement of temperature) and the 8-ounce carton of 2% milk was 50.8 degrees F on the surveyor's thermometer. The regular side item, beans, were dried out. The Director of Dietetics (DD) acknowledged the low food temperatures and stated she expected the foods to be served to residents at an acceptable temperature and palatability (how pleasant a food or drink tastes and appeals to the senses).</p> <p>On 1/29/2025 at 9:33 a.m., a Resident Council meeting was conducted with residents. During the meeting, nine out of nine residents (Resident's 6, 11, 21, 38, 40, 60, 61, 73 and 75) stated the meals served to them was often cold, especially the breakfast foods.</p> <p>During a concurrent observation and interview on 1/30/2025 at 7:50 a.m. in the 400 Unit pod dining area with Resident 46, Resident 46 was seated at a table eating breakfast. Resident 46 stated some of his food was often cool when he receives his meal, and he would prefer to have his food served a little hotter.</p> <p>During a review of the 2022 Federal Food and Drug Administration Food Code (FDA Food Code), Section 3-501.16 titled, Time/Temperature Control for Safety . Holding, the FDA Food Code indicated, Food shall be maintained . held at a temperature of 54 degrees Celsius (130 degrees F) or above.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Food Preparation Guidelines, dated 8/7/2024, the P&amp;P indicated, Food preparation and holding methods allow for maximum conservation of nutrients, flavor and appearance. Food will be served at required temperatures.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38924</p> <p>50674</p> <p>Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation measures were maintained in the kitchen according to standards of practice and facility policy when:</p> <ol style="list-style-type: none"> <li>1. One plastic bin containing white colored powder was observed underneath food preparation counter and was unlabeled and undated.</li> <li>2. One bag of opened frozen peanut butter cookies was observed in the walk-in freezer and three sandwiches observed in the refrigerator were unlabeled and undated.</li> <li>3. One bag of food labeled, meat substitute was observed expired in the walk-in freezer.</li> <li>4. Five broken tiles were observed at the base of the wall in the kitchen next to the dish drying racks.</li> </ol> <p>These failures had the potential to place residents at risk for developing foodborne illnesses by exposing residents to contaminated food and unsanitary practices.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on [DATE] at 1:10 p.m. with the Food Service Manager 1 (FSM 1) in the kitchen, there was a plastic bin underneath the preparation counter which was filled with a white powdered substance. No label or date was found on the plastic bin. The FSM 1 stated the white powdered substance was a thickening agent used for pureed foods. The FSM 1 stated the bin should have been labeled and dated.</li> </ol> <p>During a review of the 2022 Federal Food and Drug Administration Food Code (FDA Food Code), Section , d+[DATE].11 titled, Food Labels, the FDA Food Code indicated, (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement.</p> <ol style="list-style-type: none"> <li>2. During a concurrent observation and interview on [DATE] at 11:00 a.m. with the Food Service Manager 1 (FSM 1) in the kitchen, a bag of frozen peanut butter cookies was found in the walk-in freezer, two peanut butter and jelly sandwiches, and one egg sandwich in the refrigerator were found unlabeled and undated. The FSM 1 stated the sandwiches did not have labels.</li> </ol> <p>During a review of the 2022 Federal Food and Drug Administration Food Code (FDA Food Code), Section , d+[DATE].18 titled, Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, the FDA Food Code indicated, A food shall be discarded if it is in a container or PACKAGE that does not bear a date or day.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a concurrent observation and interview on [DATE] at 11:05 a.m. with the Food Service Manager 1 (FSM 1) in the kitchen, a clear medium sized plastic bag of ground crumbled brown food labeled as, meat substitute was found in the freezer. The date on the bag indicated, 7 [DATE]- 7 [DATE]. The FSM 1 stated it should not be in the freezer because it is past the date on the label.</p> <p>During a review of the 2022 Federal Food and Drug Administration Food Code (FDA Food Code), Section , d+[DATE].17 titled, Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, the FDA Food Code indicated, Refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Food &amp; Nutrition Services - Food Storage Procedure Guidelines, dated [DATE], the P&amp;P indicated, A 'Use-By' date is the last date recommended for the use of the product.</p> <p>4. During a concurrent observation and interview on [DATE] at 10:40 a.m. with the Food Service Manager 2 (FSM 2) in the kitchen, multiple broken tiles were found near the base of the wall next to the dish drying racks. There were 9 total damaged tiles, 5 of the tiles had large cracks and/or were broken from the wall which resulted in holes the size of an orange. The FSM 2 stated she was unsure of how long the tiles had been broken.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Food &amp; Nutrition Services - Sanitation, dated [DATE], the P&amp;P indicated, Kitchen and serving area(s): Will be kept clean, free from litter and rubbish. Ceilings, walls, windows, floors, and doors will be kept clean and maintained in good repair [i.e. free from breaks, corrosion, holes, cracks, chips, dirt, and/or grime].</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51978</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe infection control practices were followed when:</p> <ol style="list-style-type: none"> <li>1. Enhanced Barrier Precautions (EBP - infection control practice that uses PPE-personal protective equipment to reduce the spread of bacteria) was not followed for Resident 84 during perineal hygiene care (cleaning of genital area), medication administration, and tube feeding (liquid nutrition delivered through a tube that is inserted through the skin into stomach) administration.</li> <li>2. Enhanced Barrier Precautions (EBP-infection control practice that uses PPE-personal protective equipment to reduce the spread of bacteria) was not followed for Resident 25 during medication administration via tube feeding (liquid nutrition delivered through a tube that is inserted through the skin into stomach).</li> <li>3. An opened single-use syringe labeled sterile was observed attached with a rubber band to a gabapentin (drug to manage chronic pain condition) medication bottle for Resident 51.</li> <li>4. One unsealed bottle of saline spray was observed stored missing the printed neckband.</li> </ol> <p>These failures had the potential to result in the spread of communicable diseases (illnesses that spread from one person to another) to residents, staff, and visitors. In addition this had the potential for transfer of microorganisms (germs) to the residents and/or for the residents to be treated with ineffective or deteriorated (reduced quality) supplies, which could negatively impact the resident's clinical conditions.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 84's Face Sheet (demographics), dated 1/30/2025, the Face Sheet indicated Resident 84 was admitted on [DATE] with diagnoses which included dysphagia (difficulty swallowing foods and liquids) and gastrostomy tube (G-tube, a tube inserted through the skin directly into the stomach to provide medications and liquid nutrition).</li> </ol> <p>During an observation on 1/29/2025 at 4:04 p.m., in Resident 84's room, a sign was observed outside of the room alerting staff Resident 84 required EBP. The EBP sign indicated, Providers and staff must also: wear gloves and a gown for the following High-Contact resident care activities . Device care or use: feeding tube . Resident 84 was observed lying in bed. Certified Nursing Assistant 1 (CNA 1) was at the resident's bedside holding soiled linen and a bag containing soiled cleansing wipes and a soiled brief. CNA 1 was not wearing a gown. Licensed Vocational Nurse 5 (LVN 5) was observed entering Resident 84's room. LVN 5 administered medications through Resident 84's G-tube and administered tube feeding formula (liquid nutrition) through Resident 84's G-tube. LVN 5 was not wearing a gown.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Veterans Home of California - Chula Vista		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Naples Court Chula Vista, CA 91911	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/29/2025 at 4:19 p.m. with CNA 1, CNA 1 stated she did not wear gown during perineal hygiene care for Resident 84. CNA 1 stated a gown was required for perineal hygiene care for the protection of residents and staff. CNA 1 confirmed, she should have worn a gown while attending to Resident 84.</p> <p>During a concurrent observation and interview on 1/29/2025 at 4:22 p.m., with LVN 5, LVN 5 confirmed EBP signage was posted outside of Resident 84's room but was unaware why Resident 84 was on EBP. LVN 5 confirmed she did not wear a gown during medication and G-tube feeding administration, and should have worn a gown.</p> <p>During an interview on 1/30/2025 at 12:03 p.m. with Infection Control Nurse (ICN), ICN stated EBP was required for perineal hygiene care, G-tube medication administration, and G-tube feeding. ICN stated CNA 1 and LVN 5 should have worn a gown while performing these tasks for Resident 84. ICN stated EBP was important to prevent and reduce the spread of Multiple Drug Resistant Organisms (MDRO - bacteria that are resistant to multiple antibiotics and can cause serious infections).</p> <p>During a review of Resident 84's Care Plan, dated 1/30/2025, the Care Plan indicated, Enhanced Barrier Precautions due to G-tube use.</p> <p>The facility did not provide an Enhanced Barrier Precautions policy and procedure during the survey, as requested.</p> <p>During a review of the CDC (Centers for Disease Control) Guidance, dated 4/2/2024, the guidance indicated, Use EBP for residents with indwelling medical devices, wounds, or those who are colonized by or infected with a multidrug-resistant organism. Use EBP when: Dressing or bathing, transferring, changing linens, assisting with toileting, accessing indwelling medical devices, providing wound care, other high-contact resident care activities .before entering a resident's room with an EBP sign, correctly put on a gown and gloves.</p> <p>35030</p> <p>2. During a review of Resident 25's Face Sheet (demographics), [undated], the face sheet indicated, Resident 25 was admitted to the facility on [DATE], with diagnoses of multiple sclerosis (a condition that affects the brain), dysphagia (difficulty swallowing) and status post gastrostomy (G-tube, a tube inserted into the stomach to provide medication and liquid nutrition).</p> <p>During an observation on 1/28/2025 at 9:14 a.m. outside Resident 25's room, an EBP sign was posted. The EBP sign indicated, Providers and Staff must also: Wear gloves and a gown for the following High-Contact resident Care activities . Device care or use: feeding tube.</p> <p>During a concurrent observation and interview on 1/29/2025 at 4 p.m. with Licensed Vocational Nurse 4 (LVN 4) in Resident 25's room, LVN 4 was observed administering medications to Resident 25 via a G-tube. LVN 4 did not have on a gown. LVN 4 stated, I only wear a gown when the resident has an active infection.</p> <p>During an interview on 1/29/2025 at 4:34 p.m. with Registered Nurse 4 (RN 4), RN 4 stated Resident 25 was on Enhanced Barrier Precautions and staff should have worn a gown and gloves for Resident 25's G-tube care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/30/2025 at 11:50 a.m. with the Infection Control Nurse (ICN), the ICN stated staff should have worn a gown and gloves when performing G-tube care to include medication administration. The ICN stated staff should have worn a gown and gloves to prevent/limit the spread of MDRO (Multidrug-Resistant Organisms- bacteria that has become resistant to multiple antibiotics) transmission.</p> <p>The facility did not provide an Enhanced Barrier Precautions policy and procedure during the survey, as requested.</p> <p>During a review of the CDC (Centers for Disease Control) Guidance, dated 4/2/2024, the guidance indicated, Use EBP for residents with indwelling medical devices, wounds, or those who are colonized by or infected with a multidrug-resistant organism. Use EBP when: Dressing or bathing, transferring, changing linens, assisting with toileting, accessing indwelling medical devices, providing wound care, other high-contact resident care activities .before entering a resident's room with an EBP sign, correctly put on a gown and gloves.</p> <p>35335</p> <p>3. During a concurrent observation and interview on 1/27/2025 at 2:48 p.m., an inspection of the Unit 700 Medication Room was conducted with Pharmacist 1 (RPH 1) and Registered Nurse 1 (RN 1).</p> <p>During a concurrent observation and interview on 1/27/2025 at 2:48 p.m., in the medication room, an opened single-use syringe labeled sterile was observed attached with a rubber band to a gabapentin (drug to manage chronic pain condition) medication bottle for Resident 51. The syringe was stored in Unit 700 Medication Room refrigerator inside an opened manufacturer's packaging. The syringe manufacturer's product labeling indicated Sterile. Do Not Reuse. RPH 1 acknowledged the syringe in the open manufacturer's packaging was stored and rubber banded to the gabapentin medication bottle. RPH 1 and RN 1 acknowledged the syringe manufacturer's product labeling indicated Sterile. Do Not Reuse. RPH 1 and RN 1 stated the opened syringe had risk for contamination.</p> <p>During an interview on 1/30/2025 at 11:53 a.m., the Infection Control Nurse (ICN) stated there is potential for contamination if the single-use syringes are reused on the resident.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Drug Storage, dated 8/15/2022, the P&amp;P indicated, Drugs will not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs will be available for use.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Infection Prevention and Control Program, dated 3/26/2024, the P&amp;P indicated, The [name of the facility] each maintain a comprehensive Infection Prevention and Control Program (ICP) and is an essential component of quality care. The ICP is a facility-wide system designed to prevent the occurrence or limit the spread of infections through the prevention, identification, and control of infectious organisms. The ICP is based on the facility assessment, best practices and maintains compliance with all county, state, and federal regulations.</p> <p>4. During a concurrent observation and interview on 1/27/2025 at 2:48 p.m., an inspection of the Unit 700 Medication Room was conducted with Pharmacist 1 (RPH 1).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 1/27/2025 at 2:48 p.m., in the Unit 700 medication room, one unsealed bottle of saline spray was stored with other sealed bottles, and was observed missing the red printed neckband. The manufacturer's product labeling indicated on the bottle DO NOT USE IF PRINTED NECKBAND IS BROKEN OR MISSING. RPH 1 acknowledged the saline spray was missing the printed neckband and the manufacturer's product labeling.</p> <p>During an interview on 1/30/2025 at 11:53 a.m., the Infection Control Nurse (ICN) stated there is potential for contamination if an unsealed saline spray is used on the resident.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Drug Storage, dated 8/15/2022, the P&amp;P indicated, Drugs will not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs will be available for use.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Infection Prevention and Control Program, dated 3/26/2024, the P&amp;P indicated, The [name of the facility] each maintain a comprehensive Infection Prevention and Control Program (ICP) and is an essential component of quality care. The ICP is a facility-wide system designed to prevent the occurrence or limit the spread of infections through the prevention, identification, and control of infectious organisms. The ICP is based on the facility assessment, best practices and maintains compliance with all county, state, and federal regulations.</p>