STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Crest Post-Acute	50 Concordia Lane Oroville, CA 95966

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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. 45555 Based on observation, interview, record review, and review of the Centers for Medicare and Medicaid Services [CMS] Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to ensure oxygen use was accurately coded on the Minimum Data Set (MDS) assessment for 2 (Resident #17 and Resident #11) of 4 residents reviewed for respiratory services. Findings included: The Centers for Medicare and Medicaid Services [CMS] Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, Version 1.19.1, dated 10/2024, Section O: Special Treatments, Procedures, and Programs revealed, Coding Instructions for Column b. While a Resident Check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days. The user's manual further revealed, O0110C1, Oxygen therapy Code continuous or intermittent oxygen administered via mask, cannula, etc. [et cetera, and other similar things] delivered to a resident to relieve hypoxia in this item. The user's manual specified to check O0110C2, Continuous if oxygen therapy was continuously delivered for 14 hours or greater per day and to check O0110C3, Intermittent if oxygen therapy was intermittent (i.e. [id est, that is], not delivered continuously for at least 14 hours per day). 1. An Admission Record indicated the facility admitted Resident #17 on 09/15/2020. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic respiratory failure. Resident #17's Order Summary Report for all active, completed, and discontinued orders, contained orders started on 01/30/2023, to administer oxygen at 2 liters via nasal cannula as needed for shortness of breath or to maintain an oxygen saturation above 88 percent (%). The orders specified to monitor the resident's oxygen saturation every shift. Resident #17's September 2024 Medication Administration Record (MAR) revealed staff documented that oxygen was administered at 2 liters via nasal canula every shift on 09/01/2024, 09/02/2024, and 09/03/2024. The MAR also revealed staff documented that the resident's oxygen cannula tubing, oxygen tubing storage bag, and oxygen humidifier bottle were changed on 09/01/2024. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident did not receive continuous or intermittent oxygen therapy while a resident of the facility and within the last 14 days. During an interview on 09/26/2024 at 10:11 AM, the MDS Resource Staff stated the MDS Coordinator was responsible for the accuracy of the MDS. She stated the information used to complete the assessment came from resident interviews, records, and physician information. She stated if a resident utilized supplemental oxygen during the MDS lookback period, then it should be reflected on the MDS. The MDS Resource stated Resident #17 was using oxygen during the lookback period; therefore, oxygen use should have been coded on the MDS. During an interview on 09/26/2024 at 10:29 AM, the Director of Nursing (DON) stated he was ultimately responsible for the MDS. He stated he signed that they were complete, but the MDS Coordinator was responsible for the accuracy. He stated Resident #17's oxygen use should have been coded on the MDS. During an interview on 09/26/2024 at 10:54 AM, the Administrator stated the accuracy of the MDS was the responsibility of the MDS nurse. He stated the MDS should be coded accurately and if oxygen was used, it should be coded. 2. An Admission Record indicated the facility admitted Resident #11 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia with other behavioral disturbance, anxiety disorder, and depression. Resident #11's Order Summary Report for all active, completed, and discontinued orders, contained orders started on 09/27/2022, to administer oxygen at 2 liters as needed to maintain an oxygen saturation at 90 percent (%) or greater. The orders specified to monitor the resident's oxygen saturation every shift. Resident #11's August 2024 Medication Administration Record (MAR) revealed staff documented that oxygen was being administered at 2 liters every shift on 08/01/2024 through 08/06/2024. The MAR also revealed staff documented that the resident's oxygen cannula tubing and oxygen humidifier bottle were changed on 08/04/2024. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/06/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS did not indicate that the resident received continuous or intermittent oxygen therapy while a resident of the facility and within the last 14 days. During an interview on 09/26/2024 at 10:11 AM, the MDS Resource Staff stated the MDS Coordinator was responsible for the accuracy of the MDS. She stated the information used to complete the assessment came from resident interviews, records, and physician information. She stated if a resident utilized supplemental oxygen during the MDS lookback period, then it should be captured on the MDS. The MDS Resource stated Resident #11 was using oxygen during the lookback period; therefore, oxygen use should have been coded on the MDS. (continued on next page)

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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	During an interview on 09/26/2024 at 10:29 AM, the Director of Nursing (DON) stated he was ultimately responsible for the MDS. He stated he signed that they were complete, but the MDS Coordinator was responsible for the accuracy. He stated Resident #11's oxygen use should have been coded on the MDS. During an interview on 09/26/2024 at 10:54 AM, the Administrator stated the accuracy of the MDS was the responsibility of the MDS nurse. He stated the MDS should be coded accurately and if oxygen was used, it should be coded.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 35314 Based on interview, record review, and review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, the facility failed to ensure a Level I PASRR accurately reflected the presence of a serious diagnosed mental disorder and the use of prescribed psychotropic medication for 1 (Resident #30) of 4 residents reviewed for PASRR requirements. Findings included: The California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, dated 01/12/2023, revealed, Section III-Serious Mental Illness Questions 10-12 This section helps determine if the individual may have a serious mental illness and benefit from specialized services. Question 10. diagnosed Mental Illness *Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? *If yes, there will be a text box question [to] provide the type of mental illness. The guide also revealed, Question 12. Psychotropic Medication *If 'yes' a text box will appear to list all the names of prescribed medications for mental illness. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/05/2024, revealed the facility admitted Resident #30 on 02/10/2020. According to the MDS, the resident had an active diagnosis of bipolar disorder. A Psychotherapeutic Review_IDT [Interdisciplinary Team] note, dated 06/26/2024, revealed Resident #30 had a medical diagnosis of bipolar disorder. The note revealed, Noted behaviors of being easily frustrated and clenching fist. Continue to refuse ADL [activities of daily living] care. The note also revealed Resident #30 was prescribed Depakote for bipolar disorder. Resident #30's Order Summary Report revealed an order to transfer the resident to another facility on 07/02/2024, due to an emergency evacuation of the facility. The Order Summary Report also contained an active order started on 01/16/2024 for Depakote. Resident #30's Discharge Summary from the temporary facility they were evacuated to, dated 07/10/2024, revealed the resident was being discharged back to the facility after evacuation orders lifted. Resident #30's Level I PASRR, completed on 07/10/2024, revealed the question that asked if the resident had a serious diagnosed mental disorder under Section III - Serious Mental Illness was answered, No. The Level I PASRR also reflected the resident was not prescribed psychotropic medications for a serious mental illness. As a result, the Level I PASRR screening was negative for a serious mental illness, and a Level II evaluation was not required. During an interview on 09/24/2024 at 9:57 AM, the Medical Records (MR) Director stated she did not know who was responsible for ensuring Level I PASRRs were accurate. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/24/2024 at 10:01 AM, the Marketing Director stated the Director of Nursing (DON) read over PASRRs the day after a resident's admission to ensure they were accurate; however, the Marketing Director did not know what happened if one was found to be inaccurate. During an interview on 09/24/2024 at 10:10 AM, the DON stated it was his responsibility to ensure the Level I PASRRs were accurate. He stated if a resident had a diagnosis of bipolar disorder, then their Level I should have been positive and triggered a Level II evaluation. After reviewing Resident #30's Level I PASRR, the DON stated the questions had been answered incorrectly and should have reflected the resident had a serious mental illness. During a follow-up interview on 09/26/2024 at 9:53 AM, the DON stated he expected the staff to review PASRRs for accuracy and make corrections, if needed. During an interview on 09/26/2024 at 10:45 AM, the Administrator stated Level I PASRRs should be completed accurately and reflect the resident's history and diagnoses.

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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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37683 Based on interview, record review, and facility policy review, the facility failed to develop and a comprehensive person-centered care plan for 1 (Resident #34) of 4 sampled residents who had cardiac pacemakers. Specifically, the facility failed to develop a care plan for the care and treatment of Resident #34's cardiac pacemaker. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, indicated, 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and k. Reflect treatment goals, timetables and objectives in measurable outcomes. An Admission Record revealed the facility most recently admitted Resident #34 on 07/06/2024. According to the Admission Record, the resident had a medical history that included diagnoses of presence of cardiac pacemaker, atrial fibrillation, and presence of prosthetic heart valve. Resident #34's Pacemaker Follow-Up Form for follow-up visits on 03/01/2023, 09/26/2023, and 05/14/2024 and a [trademark name] Summary, dated 05/14/2024, revealed the resident's cardiac pacemaker was implanted on 02/18/2020. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/09/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) of 5, indicating the resident had severe cognitive impairment. The MDS revealed the resident had an active diagnosis of cardiac pacemaker. Resident #34's Care Plan, last reviewed on 08/08/2024, revealed no documented evidence the facility developed a care plan that addressed care and monitoring of the resident's cardiac pacemaker. During an interview on 09/26/2024 at 1:11 PM, the Director of Nursing (DON) stated the facility failed to update the care plan to reflect the cardiac pacemaker status of the resident. During an interview on 09/26/2024 at 2:50 PM, the Administrator stated that his expectation was that resident care plans reflect the resident's medical and health status.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure oxygen was administered appropriately for 3 (Residents #204, #17, and #11) of 4 residents reviewed for respiratory care. Specifically, the facility failed to ensure Resident #204 and Resident #17 received oxygen at their prescribed flow rates and failed to ensure the humidifier bottle on Resident #11's oxygen concentrator was functioning properly. Findings included: A facility policy titled, Oxygen Administration (Mask, Cannula, Catheter), revised 12/2016, revealed, The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. The policy also indicated, It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. The facility policy procedures revealed, 9. Attach the oxygen delivery device to the oxygen unit. 10. Turn the unit on to the desired flow rate and assess equipment for proper functioning. A. Airflow should be felt through the oxygen delivery device. B. Bubbles should be seen diffusing through the humidifier bottle. 11. If no evidence of oxygen flow, check connections and tubing for leaks. The policy revealed, 13. Reassess oxygen flowmeter for correct liter flow. 1. An Admission Record indicated the facility most recently admitted Resident #204 on 09/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease with acute exacerbation and acute respiratory failure. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/13/2024, revealed Resident #204 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received oxygen therapy on admission and while a resident of the facility. Resident #204's care plan, last reviewed on 09/23/2024, included a focus area, initiated on 09/10/2024, that indicated the resident was at risk for complications related to the use of oxygen. Resident #204's Order Summary Report included an active order, dated 09/24/2024, to administer oxygen at 2 liters per minute via nasal cannula as needed (PRN). An observation on 09/23/2024 at 9:32 AM revealed Resident #204 was receiving oxygen via nasal cannula at a flow rate of 2.5 liters per minute. Observations on 09/24/2024 at 8:30 AM and 09/25/2024 at 11:54 AM revealed Resident #204 was receiving oxygen via a nasal cannula at a flow rate of 3 liters per minute. During an interview on 09/25/2024 at 2:14 PM, Licensed Vocational Nurse (LVN) #1 confirmed the resident's oxygen was set at flow rate of 3 liters per minute but should be set at 2 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An Admission Record indicated the facility most recently admitted Resident #17 on 09/15/2020. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic respiratory failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #17's Order Summary Report included active orders, dated 01/30/2023, to administer oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath or to maintain an oxygen saturation above 88 percent (%). Observations on 09/23/2024 at 10:16 AM and 09/25/2024 at 10:50 AM revealed Resident #17 was receiving oxygen via nasal cannula at a flow rate of less than 0.5 liters a minute. During an interview on 09/25/2024 at 12:24 PM, Licensed Vocational Nurse (LVN) #1 confirmed that Resident #17's oxygen was set at a flow rate of 0.5 liters per minute but should be set at 2 liters per minute. She stated it was her responsibility to ensure the oxygen was set to the correct flow rate according to the orders. 3. An Admission Record indicated the facility most recently admitted Resident #11 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia with behavioral disturbance, anxiety disorder, and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/06/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS did not indicate the resident received oxygen therapy. Resident #11's care plan included a focus area, initiated on 02/17/2022, that indicated the resident received oxygen therapy related to ineffective gas exchange. An intervention dated 02/17/2022 specified the resident's oxygen setting was to be set at 2 liters per minute. Resident #11's Order Summary Report included active orders, dated 09/27/2024, to administer oxygen at 2 liters per minute as needed to maintain an oxygen saturation at 90 percent (%) or greater. An observation on 09/24/2024 at 8:32 AM revealed Resident #11 was receiving oxygen at 2 liters per minute; however, the humidifier bottle on the resident's oxygen concentrator was not producing bubbles. During a concurrent observation and interview on 09/25/2024 at 9:44 AM, Resident #11 was receiving oxygen at 2 liters per minute; however, the humidifier bottle on the resident's oxygen concentrator was not producing bubbles. Licensed Vocational Nurse (LVN) #1 stated the humidifier bottle was not screwed on completely, so it was possible the resident was not getting the proper amount of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/2024 at 10:08 AM, LVN #2 stated it was everyone's responsibility to ensure the oxygen was set accurately and indicated the certified nursing assistants (CNAs) should ask the nurse what the oxygen setting should be. LVN #2 stated the oxygen would not work properly if the humidifier bottle was not screwed on completely and could cause increased condensation in the tubing. During an interview on 09/26/2024 at 10:29 AM, the Director of Nursing (DON) stated the licensed nurse was responsible for ensuring oxygen was set according to the physician's orders. The DON stated if a humidifier bottle was not screwed on correctly, then there would be no seal, which could cause oxygen to leak and an incorrect amount of oxygen would be administered. During an interview on 09/26/2024 at 10:54 AM, the Administrator stated the staff should make sure the settings for oxygen were according to the orders and the equipment was functioning properly.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45555 Based on interview and facility document review, the facility failed to ensure the daily staffing postings were updated every shift for 24 days from 09/01/2024 through 09/24/2024. This had the potential to affect all 56 residents that resided in the facility. Findings included: An observation on 09/25/2024 at 1:23 PM, revealed the staff postings were not being updated with the actual hours worked. Daily staff postings for the timeframe from 09/01/2024 through 09/24/2024, revealed staff documented the staff hours scheduled but not the actual staff hours worked for every shift. During an interview on 09/25/2024 at 2:45 PM, the Staffing Scheduler stated she was told she had to post the staffing for the previous day, the current day, and the next day, but she was not aware the postings had to be updated every shift with the actual hours worked. During an interview on 09/26/2024 at 10:29 PM, the Director of Nursing (DON) stated the Staffing Scheduler printed the staff postings and placed them on the wall. The DON stated the postings should be updated by him or the Staffing Scheduler. The DON stated adjustments to the postings should be made after hours and on the weekends. The DON stated no one was specifically responsible, but one of the charge nurses should update the postings outside the Staffing Scheduler's door as well as the assignment sheet that was kept in the break room. During an interview on 09/26/2024 at 10:54 AM, the Administrator stated the Staffing Scheduler was responsible for the daily staff postings. The Administrator stated he was not aware that the postings had to be updated every shift. The Administrator stated that moving forward the updates would be done and the charge nurse would be responsible for updating the postings for off hours and weekends. During a follow-up interview on 09/26/2024 at 1:16 PM, the Administrator stated they did not have a policy about staff postings. The Administrator stated they should be following the regulation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35314 Based on interview, record review, and facility policy review, the facility failed to ensure pharmacy recommendations were addressed for 1 (Resident #40) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Medication Monitoring-Medication Regimen Review and Reporting, dated 01/2024, revealed, 8. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. An Admission Record revealed the facility originally admitted Resident #40 on 04/06/2023 and readmitted the resident on 12/29/2023. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia, bipolar disorder, and major depressive disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/10/2024, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #40 received antipsychotic medication during the assessments seven-day lookback period. Resident #40's care plan, included a focus area revised 01/23/2024, that indicated the resident used psychotropic medications including Abilify (used to treat schizophrenia and bipolar disorder), Depakote (used to treat bipolar disorder), and Seroquel (an atypical antipsychotic used to treat schizophrenia and bipolar disorder). Interventions directed staff to monitor, document, and report any adverse reactions of psychotropic medications including tardive dyskinesia (involuntary, repetitive movement), shuffling gait, rigid muscles, and shaking (revised 12/30/2023). Interventions directed staff to consult with the pharmacy and medical doctor to consider dosage reduction when clinically appropriate at least quarterly (revised 12/30/2023). An Interim Medication Regimen Review, dated 07/08/2024, revealed, Antipsychotics: Perform AIMS [Abnormal Involuntary Movement Scale] test within 30 days of admission &[and] every 6 months. Resident #40's AIMS assessments revealed they were completed on 01/18/2024 and on 09/24/2024. During an interview on 09/24/2024 at 11:49 AM, the Director of Nursing (DON) stated it was his responsibility to ensure the AIMS assessment was completed as recommended by the pharmacist. The DON stated the AIMS assessment had not been completed for Resident #40 timely but was only done after the surveyor inquired about it and when the DON recalled that he should do it. During an interview on 09/25/2024 at 2:31 PM, the Pharmacy Consultant stated if there was a request for an AIMS, it should be completed as recommended. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/2024 at 10:40 AM, the Administrator stated he expected the facility staff to follow the pharmacy recommendations.

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Country Crest Post-Acute	50 Concordia Lane Oroville, CA 95966

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683 Based on interview, record review, and facility policy review, the facility failed to ensure PRN (pro re nata, as needed) psychotropic medication use was limited to 14 days for 1 (Resident #7) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Psychotropic Medication Use, revised 02/2024, specified, Procedure The facility should comply with the State Operations Manual, and all other Applicable Law relating to the use of psychoactive medications, including gradual dose reductions. The policy further indicated, 3. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic drugs are limited to 14 days. a. For psychotropic PRN medications, excluding antipsychotics, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. An Admission Record revealed Resident #7 was originally admitted to the facility on [DATE] and readmitted on [DATE]. According to the Admission Record, the resident had a medical history that included a diagnosis of anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/19/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS also indicated Resident #7 received antianxiety medication during the assessments seven-day lookback period. Resident #7's Order Summary Report, contained an order dated 06/03/2024, for phenobarbital (a barbiturate and anticonvulsant hypnotic used to calm anxiety) 16.2 milligrams (mg) every six hours as needed for anxiety/SOB (shortness of breath). Further review revealed there was no stop date on the order. Resident #7's June 2024 Medication Administration Record [MAR] indicated the resident received phenobarbital 16.2 mg every six hours as needed for anxiety/SOB three times during the month of June. Resident #7's August 2024 MAR indicated the resident received phenobarbital 16.2 mg every six hours as needed for anxiety/SOB five times during the month of August. Resident #7's September 2024 MAR indicated the resident received phenobarbital 16.2 mg every six hours as needed for anxiety/SOB six times during the month of September. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's Recommendation for DON [Director of Nursing] & Medical Director, dated 09/18/2024, revealed a pharmacy recommendation to include a stop date for the resident's PRN phenobarbital prescription. During an interview on 09/25/2024 at 9:27 AM, the Medical Director stated he did not believe there were any restrictions on using phenobarbital as a psychotropic for anxiety on an as-needed basis. During an interview on 09/25/2024 at 2:28 PM, the Pharmacy Consultant stated it was her expectation that the physician clarified how long an as-needed medication would be used before writing an as-needed psychotropic prescription for anxiety. The Pharmacy Consultant stated when the physician renewed the phenobarbital prescription on 06/03/2024, he did not include a stop date. During an interview on 09/26/2024 at 11:05 AM, the DON stated that as-needed antianxiety medications should have stop dates. The DON stated he did not know why Resident #7's prescription had no stop date. During an interview on 09/26/2024 at 1:38 PM, the Administrator stated he expected staff to follow the regulation concerning as-needed psychotropic medication.

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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. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than 5 percent (%). The facility had 2 errors out of 36 total opportunities, resulting in a medication error rate of 5.55 %, affecting 2 (Resident #6 and Resident #34) of 5 residents observed during medication administration. Findings included: A facility policy titled, Medication Administration (General), dated 08/18/2022, indicated, 9. The licensed nursing or medical personnel administering the medication shall check the label at least THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 10. The following information must be checked/verified for each resident prior to administering medications: a. Allergies to medications b. Vital signs, if necessary. An Admission Record indicated the facility most recently admitted Resident #6 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of atrial fibrillation (irregular heart rate), personal history of pulmonary embolism (blockage of an artery in the lungs), and gastritis with bleeding. Resident #6's Order Summary Report contained an active order dated 05/20/2024 for aspirin 81 milligrams (mg) delayed release tablets with instructions to give one tablet one time a day for Stroke Prevention. The order specified, Do not crush or chew. On 09/25/2024 at 8:02 AM, Licensed Vocational Nurse (LVN) #3 was observed preparing and administering medications for Resident #6, including a chewable aspirin 81 mg instead of the delayed release aspirin as ordered by the physician. During an interview on 09/25/2024 at 10:19 AM, LVN #3 stated she realized as soon as she went back to the computer to sign out the medications, she saw that the order said do not chew or crush. She confirmed that she gave the resident crushable aspirin and not the delayed release aspirin as ordered by the physician. She stated she should have double checked the order with the label on the medication and ensured she had the right resident, right medication, right dose, right route, and right time. An Admission Record indicated the facility most recently admitted Resident #34 on 07/06/2024. According to the Admission Record, the resident had a medical history that included diagnoses of atrial fibrillation and essential (primary) hypertension. Resident #34's Order Summary Report contained an active order dated 12/08/2023 for metoprolol succinate (extended release) 25 mg with instructions to give one tablet by mouth two times a day. The order included instructions to hold the medication for a systolic blood pressure (top number of a blood pressure value) less than 110 millimeters of Mercury (mmHg) and apical heart rate (obtained by listening directly to the heart with a stethoscope) less than 60 beats per minute. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/2024 at 8:18 AM, LVN #2 entered Resident #34's room and obtained the resident's blood pressure with a result of 130/68. LVN #2 did not obtain the resident's pulse. LVN #2 was observed to administer Resident #34's metoprolol succinate without checking the resident's pulse first. After administering Resident #34's medication, LVN #2 realized she had not checked the resident's pulse. LVN #2 then attempted to obtain a pulse using a pulse oximeter (a device used to measure oxygen levels in the blood) but when it did not work correctly, LVN #2 obtained a radial pulse (peripheral pulse that can be felt on the radial artery in the wrist) with a result of 64 beats per minute. During an interview on 09/25/2024 at 10:23 AM, LVN #2 confirmed that she had forgotten to get the resident's pulse before administering the medication. She stated if the resident's pulse had been below 60 after she had already administered the medication, she would have needed to call the physician. She stated she should have double checked the resident's name, the medication, the dose, the route, and the time against the label on the medication and the order. She stated she should have read the order in its entirety to make sure she was following the physician's orders completely. During an interview on 09/26/2024 at 10:29 AM, the Director of Nursing (DON) stated that when the nurses were passing medications, they should compare the medication with the order. He stated if a medication order included vital sign parameters, the nurses should obtain the blood pressure and heart rate prior to administering the medication. During an interview on 09/26/2024 at 10:54 AM, the Administrator stated that when passing medications, the nurses should be following the orders as written.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37683 Based on observation, interview, and facility policy review, the facility failed to ensure sanitary preparation and service of meals. Specifically, the facility failed to practice proper hand hygiene and glove use during food preparation, and the facility failed to hold foods at safe temperatures during meal service. This had the potential to affect all residents who received meals from the facility's kitchen. Findings included: 1. During an observation on 09/24/2024 at 11:23 AM, the temperature of pizza's being served to residents was at 136 degrees Fahrenheit (F). The temperature of the pizza's was measured again at 12:17 PM, and was at 122 degrees F. It was also observed that there were three stacked pizza pans underneath the pizza, separating it from the heat source. There were four pizza slices that remained, and they were served to two unidentified residents. During an interview on 09/25/2024 at 1:47 PM, the Food Services Director (FSD) stated that the facility staff should have discarded the four slices of pizza that were served and instead served the pizza that remained in the food warmer. The FSD stated there was no facility policy specific to safe holding temperature for foods. 2. A facility policy titled, Glove Use Policy, dated 2018, indicated that gloves needed to be changed Before beginning a different task. The policy revealed gloves needed to be changed As soon as they become soiled such as when doing housekeeping duties - including mopping, removing garbage, using the phone, cleaning. During an observation on 09/25/2024 at 10:40 AM, [NAME] #7 mixed iceberg lettuce with gloved hands. He opened the walk-in refrigerator door, touching the handle, to get more lettuce of a different variety. He opened the bag and mixed in the new lettuce with the iceberg lettuce with both of his hands. At no point between touching the refrigerator and mixing the lettuce did he wash his hands or change his gloves. During an interview on 09/25/2024 at 10:43 AM, [NAME] #7 stated that the salad was for dinner for the residents. During an interview on 09/25/2024 at 11:00 AM, the Food Services Director (FSD) stated that the residents were having salad for dinner. During an interview on 09/25/2024 at 11:43 AM, the Culinary Director stated that [NAME] #7 was his newest hire. He stated that [NAME] #7 was often being written up for infractions similar to what was observed, and he often forgot to wash his hands between certain tasks. He stated that it was his expectation that staff change gloves and wash their hands after touching a high-contact surface, before touching food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 09/25/2024 at 1:47 PM, the FSD stated that she was not part of the hiring or training staff for the kitchen the food was prepared in. She stated that she had not worked with [NAME] #7. The FSD stated that if she saw [NAME] #7 touch lettuce after touching a high-contact surface, she would expect that the food be discarded, and the staff member retrained on glove use. During an interview on 09/26/2024 at 11:05 AM, the Director of Nursing (DON) deferred to dietary staff on questions regarding all kitchen related concerns. During an interview on 09/26/2024 at 1:38 PM, the Administrator deferred to dietary staff on questions regarding food temperatures and handwashing during food preparation.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 37683 Based on observation, interview, facility policy review, and review of the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code, the facility failed to ensure 1 of 1 dumpster was closed to prevent the potential for vermin and pest attraction. This had the potential to affect all 56 residents that resided in the facility. Findings included: The U.S. FDA 2022 Food Code, dated 01/18/2023, revealed Chapter 5. Water, Plumbing, and Waste, section 5-5 Refuse, Recyclables, and Returnables, included, 5-501.15 Outside Receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. (B) Receptacles and waste handling units for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit. A facility policy titled, Food-Related Garbage and Refuse Disposal, revised 10/2017, indicated, 2. All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. The policy also indicated, 5. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. An observation on 09/25/2024 at 12:10 PM, revealed the dumpster behind the building was open. During a concurrent interview, the Food Services Director (FSD) confirmed the dumpster should be closed. An observation on 09/26/2024 at 8:22 AM, revealed the dumpster behind the building was open. During a concurrent interview, the FSD stated that for as long as she had been with the facility the dumpster had always been open. The FSD stated the only things discarded in the dumpsters were paper and containers from the kitchen as well as nursing materials. During an interview on 09/26/2024 at 11:05 AM, the Director of Nursing (DON) stated the regulation required the dumpster lids to be closed. During an interview on 09/26/2024 at 1:38 PM, the Administrator stated he did not really know the expectation, but he wanted the dumpster to be closed when it could be.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37683 Based on interview, record review, and facility policy review, the facility failed to maintain a complete medical record for 1 (Resident #4) of 4 residents reviewed who had a cardiac pacemaker. Specifically, the facility failed to ensure Resident #4's medical record contained information regarding the model and/or serial number and the implant date for the resident's cardiac pacemaker. Findings included: A facility policy titled, Pacemaker, Care of a Resident with a, revised 12/2015, indicated, The purpose of this procedure is to provide information about and guidance for the care of a resident with a pacemaker. The policy revealed for monitoring the resident's pacemaker, 5. Make sure the resident has a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. The policy also indicated, 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant. An Admission Record revealed the facility admitted Resident #4 on 01/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of presence of a cardiac pacemaker, paroxysmal atrial fibrillation, and cardiomegaly. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/02/2024, revealed that Resident #4 had a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident had intact cognition. Resident #4's Care Plan, revealed a focus area initiated on 07/19/2023, that indicated the resident was at risk for pacemaker malfunction. Interventions directed staff to check the resident's pacemaker every six months and to follow up with the resident's cardiologist at the address and phone number listed. The Care Plan revealed the facility listed the pacemaker brand and the manufacturer's telephone number; however, there was no documented evidence the facility documented the model/serial number of the resident's pacemaker or the date the pacemaker was implanted. During an interview on 09/26/2024 at 2:38 PM, the Director of Nursing (DON) stated he had no pacemaker card information for Resident #4. He stated not having the information was an oversight. During an interview on 09/26/2024 at 1:28 PM, the Administrator stated that he expected staff to get the pacemaker make and model and have the appropriate pacemaker documentation in the resident's medical record when a resident was admitted . He stated that he was not sure why pacemaker documentation was missed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35314 Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure an effective infection prevention and control program was followed and maintained for 1 (Resident #38) of 1 resident reviewed for urinary catheters and 3 (Residents #37, #17, and #204) of 4 residents reviewed for respiratory care. Specifically, Resident #38's urinary catheter bag was observed on the ground or floor, and respiratory equipment was inappropriately stored to prevent infections for Residents #37, #17, and #204. Findings included: 1. A facility policy titled, Urinary Catheter Care, revised 03/2021, under the section, Infection Control, revealed b. Be sure the catheter tubing and drainage bag are kept off the floor. An Admission Record revealed the facility originally admitted Resident #38 on 01/19/2023 and readmitted the resident on 07/11/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of obstructive and reflux uropathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/19/2024, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required partial/moderate assistance with all activities of daily living (ADLs). The MDS indicated Resident #38 had an indwelling catheter. Resident #38's care plan, included a focus area initiated 01/20/2023, that indicated the resident was at an elevated risk for developing complications, including urinary tract infections (UTI), due to the presence of a suprapubic catheter related to obstructive uropathy. Interventions directed staff to observe and notify the physician of signs and symptoms of a UTI, provide catheter care daily and as needed, and keep the drainage bag below the level of the bladder (initiated 01/22/2023). An observation on 09/23/2024 from 11:03 AM through 11:08 AM, revealed Resident #38 propelling their wheelchair with their catheter drainage bag dragging across the floor. No facility staff were observed present. An observation on 09/24/2024 from 9:35 AM through 9:43 AM, revealed Resident #38 propelling themself in a wheelchair while their urine catheter drainage bag dragged across the floor of the facility. No facility staff were observed present. During an observation on 09/24/2024 at 11:07 AM, Resident #38 was observed outside of the facility propelling themself in a wheelchair while their catheter drainage bag dragged against the ground. No facility staff were observed present. An observation on 09/25/2024 from 8:47 AM through 8:57 AM, revealed Resident #38 propelling themself in a wheelchair while their urine catheter drainage bag dragged across the floor of the facility. No facility staff were observed present. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Vocational Nurse (LVN) #2 was interviewed on 09/25/2024 at 9:18 AM and stated Resident #38's catheter drainage bag should not touch the floor. LVN # 2 stated she had seen Resident #38's drainage bag on the floor before and would find a better way to hang the bag so it would not touch the floor. During an interview on 09/25/2024 at 9:25 AM, LVN #1 revealed Resident #38's catheter drainage bag should never touch the floor or ground because of bacteria. During an interview on 09/26/2024 at 9:42 AM, the Director of Nursing (DON) revealed Resident #38's catheter drainage bag should never touch the floor. The DON stated having the drainage bag on the floor could increase the risk of infection. During an interview on 09/26/2024 at 10:38 AM, the Administrator revealed he expected the facility staff to raise the catheter drainage bag so that it did not contact the floor or ground. 45555 2. A facility policy titled, Oxygen/Nebulizer Equipment, revised 06/2021, indicated Purpose To prevent respiratory infection from oxygen or nebulizer equipment. The policy indicated 2. Prevent cannula, mask, or tubing from falling to the floor when not in use. An Admission Record indicated the facility admitted Resident #204 on 09/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation and acute respiratory failure. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/13/2024, revealed Resident #204 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received oxygen therapy. Resident #204's Care Plan included a focus area initiated 09/10/2024, that indicated the resident was at risk for complications related to the use of oxygen. Interventions directed staff to observe for signs and symptoms of respiratory distress. Resident #204's Order Summary Report revealed the following active orders: - 09/10/2024 - An order to change the black microfiber oxygen tubing storage bag every month. - 09/12/2024 - An order to administer ipratropium-albuterol inhalation solution via nebulizer every four hours as needed for wheezing/shortness of breath. - 09/14/2024 - An order to administer Pulmicort suspension via nebulizer every twelve hours for severe COPD Observation on 09/23/2024 at 9:32 AM, revealed a nebulizer machine was on Resident #204's nightstand with tubing lying on top of the nightstand next to the machine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/25/2024 at 11:54 AM, revealed the nebulizer machine was on Resident #204's nightstand and the tubing was lying on top of the over-the-bed table with a small amount of fluid noted in the cannister. Resident #204 stated they used the machine several times a day and the staff changed out the equipment weekly, but stated staff did not rinse out the nebulizer medication cup. 3. An Admission Record indicated the facility admitted Resident #17 on 09/15/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic respiratory failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS did not indicate the resident received oxygen therapy. Resident #17's Order Summary Report indicated an order dated 01/30/2023, to administer supplemental oxygen at 2 liters via nasal cannula as needed for shortness of breath or to maintain saturations above 88% and an order dated 11/18/2023 to change a black microfiber oxygen tubing storage bag every month on night shift. During an observation on 09/24/2024 at 8:28 AM, Resident #17's oxygen tubing was stored on top of the oxygen concentrator with the cannula touching the surface of the machine. 4. An Admission Record indicated the facility readmitted Resident #37 on 09/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease with acute exacerbation and acute respiratory failure with hypercapnia (elevated levels of carbon dioxide in the bloodstream). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/23/2024, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident received oxygen therapy. Resident #37's Care Plan initiated 09/17/2024, indicated the resident was at risk for altered respiratory status/difficulty breathing and complication related to supplemental oxygen use such as skin irritation or tripping over the oxygen tubing. Interventions directed staff to provide extension tubing or a portable oxygen apparatus, keep oxygen tubing away from the resident's feet to minimize being tangled, and observe for signs and symptoms of respiratory distress. Resident #37's Order Summary Report revealed an ordered dated 09/17/2024 to change the black microfiber oxygen storage bag every month on night shift and an order dated 09/18/2024, to change the tubing/mask for the nebulizer machine every week and as needed. Observation on 09/23/2024 at 10:19 AM and on 09/24/2024 at 8:29 AM, revealed a nebulizer machine was on Resident #37's nightstand with the mask, medication cannister, and tubing still connected to the machine, and stored on top of the machine. The observation revealed a small amount of fluid in the medication cup of the tubing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Crest Post-Acute	50 Concordia Lane Oroville, CA 95966

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 - Some	Observation on 09/25/2024 at 10:52 AM, revealed Resident #37's nebulizer machine was on the nightstand with the mask, medication, and tubing still attached and lying next to the machine. The observation revealed a small amount of fluid in the medication cup and dried debris inside the mask. There was no bag available to store the equipment. During an interview on 09/26/2024 at 10:08 AM, Licensed Vocational Nurse (LVN) #2 stated oxygen tubing should be stored in a bag when not in use. She stated nebulizer equipment should be rinsed out and also stored in a bag when not in use. She stated the items should be replaced weekly or as needed for infection control reasons. During an interview on 09/26/2024 at 10:29 AM, the Director of Nursing (DON) stated that when supplemental oxygen was not in use, tubing should be stored in a black mesh bag to keep it from getting contaminated. He stated nebulizer equipment should also be stored in a mesh bag when not in use. He stated the staff would only rinse out a nebulizer medication cup if the resident had not taken in the entire amount of the medication. During an interview on 09/26/2024 at 10:54 AM, the Administrator stated respiratory equipment should be stored appropriately.