STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555830	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lompoc Skilled Nursing & Rehabilitation Center	1428 W North Ave Lompoc, CA 93436

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 50657 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents, (Resident 62), self-administration of medication was with interdisciplinary team (IDT- healthcare professionals from different specialties working together to provide patient care) approval and determination as clinically safe and appropriate. This failure had the potential for Resident 62 to unsafely self-administer medication. Findings: During a concurrent observation and interview on 2/19/25 at 9:47 a.m., with Resident 62, a rescue inhaler labeled Atrovent HFA (medication that relaxes muscles in the airways, 17 mcg (microgram -unit of measure) was observed inside Resident 62's bedside table drawer. Resident 62 stated the inhaler was brought from home to use as a back-up when going outside the facility to smoke. During an interview on 2/19/25 at 9:48 a.m. with Licensed Nurse (LN2), LN2 stated not being aware of the presence of the inhaler in Resident 62's drawer. LN 2 further stated Resident 62 did not have approval from the physician and the IDT team to self-administer own medications. During a review of the facility's policy and procedure (P&P), titled, Administering Medications, dated April 2019, the P&P, indicated in part, Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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

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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 40560 Based on observation interview and record review, the facility failed to have the most current survey results accessible to the public, in the facility survey results binder. This facility failure denied the opportunity for residents, family members, and legal representatives of residents, to be aware of the most recent survey results. Findings: During a concurrent observation and interview on 2/18/25, with the Administrator (ADM) inside the facility's main entrance, the facility's survey results binder was reviewed. The most current survey results in the binder were from 3/15/24. The survey results binder lacked the survey results from 4/8/24 through 1/30/25. The ADM acknowledged the survey results binder was not current and verbalized the survey results binder would need to be updated. During a review of the facility's policy and procedure tilted Survey Results, Examination of dated 4/7, indicated in part A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.

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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. 40560 Based on observation, interview, and record review, the facility failed to follow care plan (a document that summarizes how a patient's needs will be met, and their care will be managed) interventions for call lights, for two of 23 sampled residents (Resident 17 and Resident 44) when: 1. Resident 44's call light was out of reach, on the floor. 2. Resident 17's call light was out of reach. These failures had the potential for Resident 44 and Resident 17's needs to go unmet by staff. Findings: 1. During an observation on 2/19/25 at 10:06 a.m. Resident 44's call light was observed on the floor and out of reach of Resident 44. During a concurrent observation and interview on 2/19/25 at 10:22 a.m. with Certified Nursing Assistant (CNA 2), CNA 2 confirmed and verbalized Resident 44's call light was on the floor and out of reach of Resident 44. During a review of Resident 44's Care Plan Report undated, indicated in part, Resident 44 was at risk for falls with an approach to Ensure call light is within reach and encourage the resident to use it for assistance as needed. 49376 2. During an observation on 2/19/25 at 3:02 p.m. in Resident 17's room, Resident 17's call light was observed behind Resident 17's radio on the nightstand, out of reach of Resident 17. During a concurrent observation and interview on 2/19/25 at 3:04 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 verbalized Resident 17's call light was out of reach. During a review of Resident 17's Care Plan Report undated, indicated in part, Resident 17 was at risk for falls with an approach to Be sure The residents call light is within reach. During a review of the facility's policy and procedure tilted Care Plans, Comprehensive Person-Centered dated 3/22, indicated in part A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The Comprehensive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40560 Based on record review and interview, the facility failed to follow physician orders for three of 23 sampled residents (Resident 93, Resident 32, and Resident 12) when the facility staff did not: 1. Check Resident 93's blood pressure prior to the administration of hydralazine (a medication used to treat blood pressure). This failure had the potential for Resident 93 to receive Hydralazine, against physician orders, secondary to no monitoring. 2. Weigh Resident 32 per physician orders. This failure had the potential to adversely affect Resident 32's heart condition. 3. Check Resident 12's blood pressure prior to the administration of Lisinopril (a medication used to treat blood pressure). This failure had the potential for Resident 12 to receive Lisinopril, without following the precautionary parameters ordered by the physician. Findings: Review of [NAME] and [NAME], 7th Edition, Mosby's Fundamentals of Nursing, page 419 in the section titled, Legal Implications in Nursing Practice indicates, Nurses are obligated to follow physician order unless they believe they orders are in error or would harm clients 1. During a concurrent record review and interview, on 2/20/25, starting at 10:08 a.m., with the Director of Staff Development (DSD), Resident 93's Medication Administration Record (MAR) was reviewed. The MAR indicated, had a physician order dated 1/14/25 to administer Hydralazine HCL Oral Tablet 50 MG (milligrams) . Give 1 tablet by mouth two times a day for htn (Hypertension - high blood pressure), hold (do not give) if SBP (systolic blood pressure - pressure in the arteries/upper reading) < (less than) 110. The DSD verbalized the facility could not provide documentation indicating facility staff had taken Resident 93's blood pressure shortly before the 5:00 p.m. administration of the hydralazine on 1/14/25, 1/19/25, 1/20/25, 1/21/25, 1/23/25, 1/25/25, 1/26/25, 1/27/25, 1/31/25, 2/1/25, 2/2/25, 2/4/25, 2/6/25, 2/8/25, 2/9/25, 2/11/25, 2/12/25, 2/13/25 and 2/15/25. During a review of the facility policy and procedure titled Administering Medications dated 4/19, indicated in part Mediations are administered in a safe and effective manner, and as prescribed. 47112 2. During a review of Resident 32's Physicians Orders dated 9/16/24, the Physicians Orders indicated, weigh daily, notify MD if > (greater than) 3 lbs. in the morning for heart failure monitoring. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's Treatment Administration Record (TAR), the TAR indicated no weight was recorded for 2/11/25. During a concurrent interview and record review on 2/20/25 at 3:30 p.m. with Director of Staff Development (DSD), Resident 32's Physicians Orders dated 9/16/25, and TAR dated February 2025 were reviewed. The TAR indicated, for 2/11/25 there was no check mark in the box for Resident 32's daily weight to demonstrate the weight was taken. DSD verbalized yes, there is an order for daily weights, and there was no documentation on the TAR dated 2/11/25 that indicated Resident 32 was weighed. DSD stated, there should have been a weight taken, if there is no check mark it was not done. 50657 3. During a review of Resident 12's Medication Administration Record (MAR) dated February 2025, the MAR a physician order for Lisinopril (medicine to treat high blood pressure/heart conditions) Oral Tablet 10 MG (milligram -unit of measure), Give 1 tablet by mouth one time a day for hypertension (high blood pressure). Hold if SBP (systolic (top number) blood pressure) is less than 110. Further review of the MAR indicated, lisinopril was not given on 2/3/25, 2/4/25, and 2/16/25 and there was no documentation of Resident 12's blood pressure (BP) reading. The reasons for not giving the medication were coded as 2 (no med required - outside parameter). During a concurrent interview and record review on 2/20/25 at 2:31 p.m. with the Director of Staff Development (DSD), Resident 12's MAR and Weights and Vital Signs Summary (WVSS) dated February 2025 was reviewed. The DSD stated, the electronic health record (eHR) forces a BP entry in the MAR if a medication is administered but it does not force an entry of a BP value if staff do not administer the medication and code the reason as a 2. Upon further review of Resident 12's MAR and WVSS, after verifying the BP values, the DSD acknowledged the following: On 2/3/25 at 9:30 a.m., Lisinopril was not given. The reason provided was coded as 2 (no medication required-outside parameter). No blood pressure (BP) reading was documented on the MAR or the WVSS. On 2/4/25 at 10:40 a.m., Lisinopril was not given. The reason provided was coded as 2. Review of the WVSS indicated the BP reading was taken at 8:15 a.m., over an hour before the prescribed time. On 2/16/25 at 10:05 a.m., Lisinopril was not given. The reason provided was coded as 2. Review of the WVSS indicated a BP reading was taken at 8:05 a.m., over an hour before the prescribed time. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated in part, 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary.

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	555830	A. Building B. Wing	02/21/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50707 Based on observation and interview, the facility failed to ensure emergency drugs were available to residents when ordered. The facilities Emergency Drug Supply Kit (E-Kit) was not re-ordered timely after being opened for use. This failure had the potential for emergency drugs to not be available during an emergency. Findings: During a concurrent observation and interview on 2/19/25 at 1:27 p.m., with the Director of Staff Development (DSD) in the medication storage room, one opened E-Kit was observed in the refrigerator room with red locks. The DSD stated a red lock indicates an E-Kit has been opened by facility staff, and the nurse who opened it should have reordered it that same day. During an interview on 2/21/25 at 1:58 p.m., with the Director of Staff Development (DSD), the DSD stated the last time the E-Kit was ordered was in August 2024. There was no other documented evidence that the refrigerator E-kit was reordered from the time it was opened to 2/19/25. During a review of the facility's Policy and Procedure titled, Emergency Medications, dated April 2021, the P&P indicated, Medications and supplies used from the emergency kit must be replaced upon the next routine drug order.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on interview and record review, the facility failed to ensure medications were administered as directed and ordered when: 1. Resident 72 was not given /administered with Insulin (a medication to lower blood sugar levels) when the resident's blood sugar level /reading went above the parameter set by the physician. 2. Resident 42 was not administred with Diltiazem (medication for high blood pressure)when the resident's blood pressure level was above the parameter set by the physician. These failures had the potential medication errors secondary to non administration as ordered. Findings: 1. During review of Resident 72's Admission Record (AD), the AD indicated Resident 72 was admitted on [DATE] with diagnoses that include non-pressure chronic pressure ulcer of left heel and midfoot (a persistent, open sore located on the left heel and middle part of the foot that develops due to underlying conditions like poor circulation or diabetes), type 1 diabetes mellitus with ketoacidosis (a life-threatening complication that occurs when the body doesn't have enough insulin, the body breaks down fat producing ketones, which can build up to dangerous levels in the blood), diabetic neuropathy (nerve damage caused by diabetes), pressure-induced deep tissue damage of left heel (a serious injury where prolonged pressure on the heel area has caused damage to the underlying soft tissues beneath the skin). During a review of Resident 72's Medication Administration Records (MAR, a legal record of the drugs administered to a patient), dated 01/01/25 - 01/31/25 and 02/01/25 - 02/19/25, the MAR's indicated Insulin Aspart (a synthetic, rapid-acting insulin analog used to treat diabetes) Injection Solution 100 unit/mL (Insulin Aspart) inject as per sliding scale: if 0-99 = 0 unit, BS less than 70 mg/dl = Initiate HYPOGLYCEMIA (a condition where the blood glucose (sugar) level drops below normal) PROTOCOL: 100 - 140 = 2 Units 141 - 180 = 4 Units 181 - 220 = 6 Units 221 - 260 = 8 Units 261 - 300 = 10 Units 301 - 340 = 12 Units 341 - 380 = 14 Units (continued on next page)

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	555830	A. Building B. Wing	02/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	381 - 400 = 16 Units 16 Units MAX even if BS above 400+ per MD Upon further review of the MAR's, the MAR's indicated: On 1/6/25 at 06:30 a.m., Resident 72's BS was 140, insulin was not given, and the reason was coded as 2 (no med required - outside parameter). When the BS was checked at 11:30 a .m., the BS result was 366. On 1/28/25 at 06:30 a.m., BS was 119, no insulin was given, and the reason was coded as 2 (no med required - outside parameter). When the BS was checked at 11:30 a.m., the BS result was 389. On 2/10/25 at 06:30 a.m., BS was 114, no insulin was given, and reason was coded as 2 (no med required - outside parameter). When the BS was checked at 11:30 a.m., the BS result was 336. On 2/16/25 at 06:30 a.m., BS was 114, no insulin was given, and reason was entered as 2 (no med required - outside parameter). When the BS was checked at 11:30 a.m., the BS result was 222. During an interview on 2/20/25 at 11:02 a.m. with Licensed Nurse (LN3), LN3 stated Resident 72 should have received 2 units of Aspart insulin on 1/6/25, 1/28/25, 2/10/25, and 2/16/25 according to the insulin sliding scale and the BS results. LN3 confirmed there was no documentation in the progress notes to indicate why the insulin was not given on those dates. During an interview on 2/21/25 at 11:38 a.m. with the Director of Staff Development (DSD), DSD acknowledged the insulin sliding scale was not followed for Resident 72 on 1/6/25, 1/28/25, 2/10/25, and 2/16/25. 2. During review of Resident 42's Admission Record (AD), the AD indicated Resident 42 was admitted on [DATE] with diagnoses that include type 2 diabetes mellitus with diabetic peripheral angiopathy (a condition where a person has type 2 diabetes and narrowed arteries in the legs or arms), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), paroxysmal atrial fibrillation (a type of heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly for a short period of time), essential (primary) hypertension (high blood pressure that has no identifiable cause). During a review of Resident 42's MAR, dated 01/01/25 - 01/31/25 and 02/01/25 - 02/19/25, the MAR's indicated Diltiazem (a medicine used to treat high blood pressure), 24H ER (extended release) (CD [controlled delivery]) 180 MG CP, Give 1 capsule by mouth one time a day for A-FIB (a condition where the upper chambers of the heart (atria) beat irregularly and rapidly, instead of in a steady rhythm. This irregular beating can cause the heart to pump blood less efficiently and increase the risk of blood clots and stroke). Hold for SBP (systolic blood pressure) 100 or HR (heart rate) <60), Metoprolol Tartrate (a medication that slows down the heart which allows it to put less pressure on the body's blood vessels) Tablet 50 MG, Give 1 tablet by mouth two times a day for HTN Hold for SBP <100 or HR <55, Clonidine (a medicine used to treat high blood pressure) HCl Tablet 0.1 MG, Give 1 tablet by mouth every 8 hours for HTN Hold if SBP <100. Upon further review of the MAR's, the MAR's indicated: (continued on next page)

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	555830	A. Building B. Wing	02/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/25 blood pressure (BP) was 109/62, HR: 76 diltiazepam was not given, and the reason was coded as 2 (no med required - outside parameter). On 1/24/25 BP was 110/62, HR: 76 diltiazepam was not given, and the reason was coded as 2 (no med required - outside parameter). On 2/02/25 BP: 107/65 and HR: 85, diltiazepam was not given, and the reason was coded as 2 (no med required - outside parameter). On 2/14/25 BP: 96/54 and HR: 74, diltiazepam given. On 1/5/25 BP 100/ 60, HR: 81 at 0900 metoprolol tartrate was not given, the reason was coded as 2 (No Med Required-Outside Parameter) On 1/21/25 BP 109/ 62, HR: 76 at 0900 metoprolol tartrate was not given; the reason was coded as 2 (No Med Required-Outside Parameter) 1/21/25 BP 111/ 60, HR: 65 at 2100 metoprolol tartrate was not given; the reason was coded as 2 (No Med Required-Outside Parameter) On 1/24/25 BP 110/ 62, HR: 76 at 0900 metoprolol tartrate was not given; the reason was coded as 2 (No Med Required-Outside Parameter) 2/2/25 BP 107/ 65, HR 85 at 0900 metoprolol tartrate was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 2/3/25 BP 111/ 63, HR 69 at 2100 metoprolol tartrate was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 2/4/25 BP 104/ 54, HR 88, at 2100 metoprolol tartrate was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 2/14/25 BP 96/ 54, HR 74 at 0900 metoprolol was given. Medication was outside of parameter and should have been held. 1/7/25 BP 99/ 67, at 0600 clonidine was given. Medication was outside of parameter and should have been held. 1/7/25 BP 100/ 67, at 1400 clonidine was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 1/13/25 BP 110/ 68, at 1400 clonidine was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 1/21/25 BP 109/ 62, at 1400 clonidine was not given, the reason was coded as 2 (No Med Required-Outside Parameter) (continued on next page)

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	555830	A. Building B. Wing	02/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/21/25 BP 111/ 60, at 2200 clonidine was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 2/2/25 BP 110/ 69, at 1400 clonidine was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 2/3/25 BP 111/ 63, at 2200 clonidine was not given, the reason was coded as 2 (No Med Required-Outside Parameter) 2/4/25 BP 104/ 54, at 2200 clonidine was not given, the reason was coded as 3 (Hold/Progress Note MD Notification) 2/12/25 BP 102/ 54, at 0600 clonidine was not given, the reason was coded as 3 (Hold/Progress Note MD Notification) 2/18/25 BP 100/ 62, at 0600 clonidine was not given, the reason was coded as 2 (No Med Required-Outside Parameter) During a concurrent interview and record review on 02/21/25 at 11:21 a.m. with the DSD, Resident 42's MAR's dated January 2025 and February 2025 were reviewed. The DSD acknowledged staff did not follow medication administration parameters for Resident 42's diltiazepam, metoprolol tartrate, and clonidine medications on multiple dates. During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated April 2019, the P &P indicated, 1. Medications are administered in accordance with prescriber orders, including any required time frame.

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	555830	A. Building B. Wing	02/21/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50707 Based on observation, interview, and record review, the facility failed to ensure: 1. Six opened nebulizer (turns medicine into a mist) medications were labeled with opened dates for two sampled residents (Resident 11 and Resident 94) and three unsampled residents (Resident 43, Resident 103, and Resident 463) per facility policy. 2. Three expired test strips in one medication cart were discarded and not readily available for staff use. These failures had the potential for residents to receive expired and ineffective medications. Findings: 1. a. During a concurrent observation and interview on [DATE] at 2:14 p.m., with the Director of Staff Development (DSD) in the nurses' station, the following liquid inhalation medication solution packets were observed to be unlabeled and undated: D1 Medication Cart One Albuterol packet for Resident 463. One DuoNeb packet for Resident 463. Three Budesonide packets for Resident 103. A1 Medication Cart Two Budesonide packets for Resident 43. One DuoNeb packet for Resident 11. C2 Medication Cart Three Budesonide packets for Resident 94. DSD stated the all the inhalation solution found in D1, A1, and C2 medication carts should all be labeled with opened dates and it was not done. During a review of the facility's Policy and Procedure titled, Administering Medications, dated 2021, the P&P indicated, 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lompoc Skilled Nursing & Rehabilitation Center	1428 W North Ave Lompoc, CA 93436

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on [DATE] at 2:14 p.m., with the DSD, at the C/D nurses station, 2 vials of Coaguchek XS PT test strips (testing strips used with a device to measure how long it takes for a blood sample to clot) were observed with an expiration date of [DATE] and one vial was observed with an expiration date of [DATE] in the C1 medication cart. The DSD stated the 3 vials are expired and should be discarded. During a review of the facility's Policy and Procedure titled, Medication Labeling and Storage, dated 2021, the P&P indicated, Medication storage 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41023 Based on observation, interview and record review, the facility failed to ensure medical records for three out of 23 residents (Resident 17, 37, 94) accurately documented POLST (Physician Orders for Life-Sustaining Treatment (gives instructions for care in life-threatening medical situations) information in the electronic medical record (EMR) when: 1. Resident 94's POLST did not match the electronic health record. 2. Resident 37's POLST did not match the electronic health record. 3. Resident 17's POLST did not match the electronic health record. These failures had the potential to result in Residents 17, 37, and 94 not receiving their desired preferences for end of life care. 1. During a review of Resident 's Admission Record (AR), the AR indicated, Resident 94 is a [AGE] year-old female admitted on [DATE] with diagnosis of chronic respiratory failure with hypercapnia (inadequate breathing) and COPD (chronic obstructive pulmonary disease - lung condition caused by inflammation that limits airflow into and out of the lungs). During a concurrent interview and record review on [DATE] at 2:45 p.m. with licensed nurse (LN) 2, Resident 94's POLST dated [DATE] was reviewed. The POLST indicated, do not attempt resuscitation (DNR - means a person has decided not to have cardiopulmonary resuscitation (CPR) attempted on them if their heart or breathing stops). Review of Resident 94's EMR indicated a physician order dated [DATE] for FULL CODE (medical term used to indicate patient's preference for all possible life saving measures to be taken in the event of a cardiac or respiratory arrest). LN 2 acknowledged the EMR did not accurately match POLST did not match and stated, the EMR should have been updated to reflect DNR status when the POLST was completed on [DATE]. 2. During a review of Resident 37's Admission Record (AR), the AR indicated, Resident 37 is a [AGE] year-old female admitted on [DATE] with diagnosis of bilateral (both sides) hip fractures (a break in the upper portion of the thigh bone), osteoporosis (bone disease when structure and strength of bone decreases), difficulty walking, and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). During a concurrent interview and record review on [DATE] at 2:00 p.m. with the facility's Director of Staff Development (DSD), Resident 37's POLST dated [DATE] was reviewed. The POLST indicated, DNR. Review of Resident 37's EMR indicated a physician order dated [DATE] for FULL CODE. DSD acknowledged the records did not match and stated, The EMR should have been updated when the daughter signed the POLST on [DATE] and it wasn't. 49376 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an observation and record review on [DATE] at 10:50 a.m. on memory care unit (MCU), the Electronic Health Record (EHR) showed Resident 17, Full code, CPR [Cardiopulmonary resuscitation] with no artificial means of nutrition. During an interview on [DATE] at 10:56 a.m. with Licensed Nurse (LN) 1, LN 1 verbalized that the order for the new Do Not Resuscitate (DNR) status was not updated in the EHR to reflect the new code status. During a review of Resident 17's Physician Orders for Life Sustaining Treatment (POLST), dated [DATE], the POLST indicated, Resident 17 DNR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on observation, interview, and record review the facility failed to maintain infection control practices when: 1. Respiratory care equipment was not stored in a manner to prevent cross contamination (accidently transferring harmful bacteria) for one of five sampled residents (Resident 62). 2. Nasal cannula tubing (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not labeled and dated for three of six sampled residents (Resident 12, Resident 70 and Resident 89). These facility failures had the potential to result in cross-contamination (the transfer of harmful bacteria) that could impact residents' health and safety and cause preventable HAIs (Healthcare Associated Infections) for residents in an already compromised condition. Findings: 1. During review of Resident 62's Admission Record (AD), the AD indicated Resident 62 was admitted on [DATE] with diagnoses that include hypertensive heart disease with heart failure (high blood pressure that causes blood to move less effectively, increasing the pressure in the heart, and making it harder for the heart to deliver oxygen and nutrients to the body), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and dependence on supplemental oxygen. During an observation on 2/18/25 at 11:44 a.m. in Resident 62's room, a nebulizer (a device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs) with attached T-piece (a small, T-shaped mouthpiece that fits into a nebulizer) and tubing were observed on top of a nightstand exposed and not covered. During a concurrent observation and interview on 2/18/25 at 12:32 p.m., with Licensed Nurse (LN2), in Resident 62's room, the nebulizer T-piece and tubing were observed in the same placement as observed prior. LN2 acknowledged the nebulizer T-piece, and the tubing were exposed and not covered. LN2 stated not being aware the T-piece, and tubing had to be covered or enclosed. During an interview on 02/19/25 at 10:10 a.m. with Licensed Nurse (LN5), LN5 stated that the nebulizer tubing and mask must be stored in black antimicrobial bag when not in use. Additionally, LN5 said oxygen tubing is changed out every 7 days or sooner as needed and the tubing must be labeled with the date it was changed. During a review of the facility's Policy and Procedure (P&P) titled Administering Medications through a Small Volume (Handheld) Nebulizer, dated October 2010 was reviewed. The P&P indicated in part, When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup .When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. a. During review of Resident 12's Admission Record (AD), the AD indicated Resident 12 was admitted on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During an observation on 02/18/25 at 11:37 a.m. in Resident 12's room, Resident 12 was observed wearing a nasal canula connected to an oxygen concentrator with no label to indicate when the nasal cannula tubing was changed. Additionally, the oxygen tubing was touching the floor. During a follow-up observation on 02/19/25 at 9:33 a.m. in Resident 12's room, the oxygen tubing was touching the floor and tubing had no date label. During a concurrent observation and interview on 02/19/25 at 10:33 a.m. in Resident 12's room, with Licensed Nurse (LN6), Resident 12's oxygen tubing was on the floor and did not have a date label. LN6 stated it (referring to the oxygen tubing) is not supposed to be laying on the floor and should be dated. I will take care of it. b. During review of Resident 89's Admission Record (AD), the AD indicated Resident 89 was admitted on [DATE] with diagnoses that include acute and chronic respiratory failure with hypoxia (lungs have a hard time loading the blood with oxygen or removing carbon dioxide causing shortness of breath, air hunger, and/or confusion), and interstitial pulmonary disease (inflammation and scarring in your lungs with symptoms of shortness of breath and a dry cough). During an observation on 02/18/25 at 12:15 p.m. in Resident 89's room, Resident 89 was observed wearing a nasal canula connected to an oxygen concentrator; the oxygen tubing was touching the floor and was not labeled with the date it was last changed. During a concurrent observation and interview on 2/18/25 at 12:32 p.m., with Licensed Nurse (LN2), in Resident 89's room, LN2 acknowledged the oxygen tubing was touching the floor and was not dated. LN2 stated that oxygen tubing should not be touching the floor and the oxygen tubing, and the humidifier should be labeled with the date it was changed. c. During review of Resident 70's Admission Record (AD), the AD indicated Resident 70 was admitted on [DATE] with diagnoses that include COVID-19 (a respiratory disease caused by the SARS-CoV-2 virus). During an observation on 2/8/25 at 12:21 p.m., in Resident 70's room, Resident 70 was observed wearing a nasal cannula connected to an oxygen concentrator (a medical device used to deliver oxygen) without a label on the nasal cannula tubing. During a concurrent observation and interview on 2/18/25 at 4:00 p.m., with Licensed Nurse (LN 4), LN 4 confirmed Resident 70's nasal cannula tubing was not labeled. LN 4 stated there should be a label on the tubing. During an interview on 2/20/25 at 11:06 a.m., with the Infection Preventionist (IP), the IP stated oxygen nasal cannula tubing and nebulizers are changed every Thursday and labels are placed on tubing with date and time it was changed. The IP stated, the nurse should have labeled the oxygen tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Oxygen Administration, dated 7/1/2020 was reviewed. The P&P indicated in part, 2. Oxygen tubing and humidifier will be changed and labeled every 7 days and as needed. 50707